Pierce County FAST Teams

Monthly Team Meeting

Pierce County Emergency Operations Center
December 10, 2013

Agenda

1. Introductions/Announcements

2. Chronic Health Issues; Denise Porter, Pierce County Community Connections

3. Scenario Based Discussion

4. Future meeting dates/times
    a. Second Tuesday every month.

5. Adjourn

Next meeting:
January 14, 2014 1:30-3:30 pm
Pierce County DEM
2501 South 35th Street, Suite D
Tacoma, WA 98409

Pierce County Community Connections

Aging and Disability Resources

Aging and Disability Resources Center

Aging and Disability Resources Center 253-798-4600 or 1-800-562-0332

- Telephone information and referral service
  - Information and assistance
  - Case management
  - Family Caregiver Support
  - Long Term Care Ombudsman
  - Memory Care and Wellness
  - Living well with Chronic Conditions
  - Veterans Directed Home and Community Based Services
  - Care Transition Services (from hospital to home)
  - Long Term Support Options Counseling
  - Benefits Counseling
  - Employment Options Counseling
  - Referral to other programs
  - Crisis Intervention
  - Planning for the future
  - Telephone check in

Aging and Disability Resources

- Our clients are between 18 years old to infinity
- We are divided up into teams and have geographic areas that we serve. Each team has 7-8 case managers that are social work background and 1 -2 registered nurses are also a part of the team. Each case manager has around 100 clients, each nurse has around 40 clients and consults on any clients from case managers that are medically fragile.
- We also have bilingual case managers and nurses that include Korean, Cambodian, Spanish, Tagalog , Ilacano, Samoan, Russian, Vietnamese

- Our clients are eligible for these programs based on financial criteria and needing assistance in activities of daily living.
- Our client are on Medicaid Personal Care, COPES, New Freedom or Roads to Community Living.

Medicaid Personal Care

- Client's must meet financial requirements for medicaid and are usually on SSI
- This program offers personal care services that can be in client's home or residential (Adult Family Home)

COPES -Community Options Program Entry System

- This program also provides personal care in client's home or residential care in adult family home, assisted living, skilled nursing facility
- Besides personal care we have the option of using waivered services to help keep client's safely in their home

COPES waivered services

- Adult Day Health or Adult Day Care
- Environmental Modifications
- Home Delivered Meals
- Home Health Aid
- Personal Emergency Response Systems (PERS)
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Client/Caregiver Training
- Transportation – that is not met by another source
- Nurse Delegation
- Private Duty Nursing

New Freedom

- Consumer driven program
- Client/consumer works with the case manager on what they need and a plan is formulated

Roads to Community Living

- This program assists people who have been in a nursing facility for over 6 months to transition back to a less restrictive setting.
- There are special funds set aside for provider to work with these clients in finding housing, adjusting to living in a less restrictive setting, setting up there new living environment, obtaining caregivers.

Common Medical Diagnosis

- Diabetes both insulin dependent and non insulin dependent
- COPD/asthma/Congestive Heart Failure
- Kidney Failure/Renal Dialysis
- Quadriplegia or Paraplegia, Multiple Sclerosis, ALS, Fredricks Ataxia and other neurological disorders
- Strokes/Brain injuries
- Mental Health Disorder
- Addiction
- Arthritis
- Fibromyalgia
- Morbidly obese
- Dementia
- Terminal illnesses like cancer, AIDS, Hepatitis C, organ failure

- Our services are client driven.
- We assess our clients every year or if there has been a significant change in their health
- Our assessment is very thorough and takes on average 2 hours to complete. We assess how much assistance client's need with ambulation both in and out of their home, with transfers, bed mobility, toileting, eating, help with medications, falls, cognitive problems. At the end of the assessment the client is authorized so many hours of care a month.
- We review this with the client and or their family and the plan is put into place
- We also know what if any waivered services are needed and discuss with client a plan for putting these services in place.
- If we disagree with client's choices, we review with our supervisors the risk to the client and what if anything should be done.
- We can not force our client s to accept any services they do not want and we do not force people out of their homes into residential settings.
- If we are concerned about client's safety we utilize several approaches talking to client, talking to family or social supports to client (with client's permission), working with client's physicians, utilizing client training, and referring if necessary to Adult Protective Services.

Pierce County FAST Teams
Chronic Health Scenarios
December 10, 2013

1. A 65 y/o woman comes into the shelter, her breathing is labored and she is only able to talk 1 – 2 words at a time due to shortness of breath. She has a small oxygen tank with her and she brought a full bag of medications and wants you to call her "nurse". She will not go to the hospital and doesn't want to talk to a doctor.

2. A man comes into the shelter on his scooter. He is around 600 lds, his clothes appear dirty, his legs are very swollen. They are red and there is clear liquid coming from at least one leg and forming a puddle on the floor. He arrives with 3 family members 2 are in the 20s and disruptive in the shelter. He also has a grade school age child. He tells you that one of the 20 y/o family members is his caregiver; however the grade school age child is the one doing the care.

3. A 30 y/o women comes into the shelter, while there you notice she has some short-term memory problems and difficulty with impulse control. She seems to get along well in the shelter and is happy to be getting fed three meals a day. On the second day in the shelter she becomes quite teary and discloses she does not want her caregiver to come to the shelter because the caregiver is calling her names and borrowing money from her. She states the caregiver has told her if she tells, than she will have to go to a nursing home.