On-site Home Assessments

Assessments are performed for the purposes of gathering the information needed to design a successful stay-at-home care plan. We can perform a low cost informal one or two hour home walkthrough of the home where the focus is on safety and the report is handwritten and without pictures. We also have more formalized assessments for safety, Aging-In-Place, temporary and permanent disability due to accident and illness, frailty, sensory impairment, and dementia stage 5 (mildest) and stage 4. Our assessments are non-medical with focus on the home modifications, technologies, services, and processes needed to ensure your loved one can remain in their home for as long as possible. We write a detailed report organized by room, criticality, and cost that can be used to guide you on the home modifications that would be helpful to your loved one's stay at home, and helpful to their caregiver. This report can also be used to discuss home modifications with contractors. We always advise home modifications related to safety be done first. Many of these modifications tend to be simple and effective solutions to potential safety threats to your loved one. Sometimes the need to share the basics of your loved one's health conditions is necessary for us to plan the assessment focus and goals. For such situations we do require the completion of a HIPPA form to ensure the care recipient is in agreement with the sharing of such information.

Age-in-Place and Disability Home Planning

Age-In-Place is a term originated by a joint effort between AARP and the National Association of Homebuilders (NAHB). These assessments are

generally performed in situations where it is foreseeable that a person could remain in their home for an extended period of time provided home modifications are performed that will provide for autonomy and independence. Often, simple home modifications, useful technologies, and some level of custodial care can keep your loved one safe and at home for a long time. Most home modifications can be implemented for the cost of two to six months of assisted living costs, or one to three months of skilled nursing facility costs. We can guide you in determining the true costs of your loved one living at home as well as help you plan their future care setting. Our assessments are the most detailed assessments we know of and reflect the concerns of many organizations for the aged. Our reports can be used as contractor bid documents.

Frailty, Sensory Impairment, Dementia Home Planning

Some of the true causes behind many hospital emergency admissions are frailty (inability to successfully negotiate our environment), sensory Impairment (inability to collect the environmental information we need to remain safe and secure), and dementia (a brain illness that can cause confusion, forgetfulness, missed process steps, wandering and other harm causing maladies). We have assessments that specifically target your loved one's ability to cope with these aging concerns when living at home. While an assessment has not been written that will guarantee total safety and security for all possible scenarios, our assessments are based on research and sufficiently detailed to provide a clear idea of what must be done in the home, (optimal mix of home modifications, technology, and service

provisions), to provide maximum autonomy and independence while alleviating the caregiver stress and pressures associated with caregiving for persons afflicted with these conditions. As with all of our services, you are in control and make the final decisions on recommendations stated within our plans.

Emergency, Facility Discharge and Care Transition Planning

We work with your preferred EMS and Emergency Department providers to determine the documents needed to be on hand when an emergency occurs. We can provide blank documents for you and your loved one to complete or we can do the job for you.

BeHome4Ever solutions consider the biological, psychological, and social aspects of your loved one and your unique caregiver experience. Based on our research of factors causing hospital readmission we have developed a program that indicates the approximate complexity of care coefficient for your loved one based on previous hospitalizations as well as information available on most discharge documents, and care giver knowledge. We use this model to determine the factors most likely to cause readmission and work with you to plan ways to mitigate these risks where possible. We use home assessments and interviews to gather additional information that is needed to build a custom solution for your specific care needs. We will implement that solution for you as a private case management effort or assist you at any level you prefer to meet the care needs of your loved one.

Facility discharge can sometimes be unplanned, or, the planning by the facility does not meet your needs. We use custom designed forms (Face Information Sheet, Care Transition Survey, Contact Record, Goals Sheet, and Services Plan) to efficiently collect, document, process the information needed to develop care goals and services plans for a successful care transition based on the Dr. Eric Coleman and Dr. Mary Naylor models, as well as our complexity of care prediction model. We use all of the information we collect to develop patient-centered care transition goals to be met by members of the care team (Dr., Nurses, PTs, OT, ST, HHC, HHA, Care Recipient, You, Others). In cases of "Medicaid spend down" our forms should be easily understood and become the initial record used effortlessly by social service workers and care transition navigators often employed by state Department of Medical Assistance (DMA) and/or Department of Health and Human Services (DHHS). As with all of our services, our goal is to give you the amount of help you direct and that fits in your budget.

Home Technology Coaching, Planning, and Set-up

Technology is best used when it is augmented to restore or improve user functioning, and, when it is used to gather information for future care planning. Technology should never be used as the basis for a decision to remove a loved one from their care setting of choice. We use technology to help your loved one do for themselves as many of the Activities of Daily Living, as well as the Instrumental Activities of Daily Living (IADLs) as possible. We identify assistive technology to maintain your loved one dignity and independence while lowering your costs of care, stress, and time away from personal needs. As with all of our services,

you are in control and our role is “technology coach”. We assess and recommend technologies that can be implemented by you or by us for you, and we can train you and other care providers on the effective use of these technologies.

There are many very useful and inexpensive technologies that can be used to assist memory, physical functioning (ADLs and IADLs), monitor motion/movement and usage of facilities (indicators of depression and UTIs), aide in socialization and memory exercise, and can be used to monitor the effective use of home health medical care and non-medical custodial care. Technology can be used to compliment a custodial care plan and lower the cost of care thereby stretching those family care dollars. We work to help you understand and effectively use these technologies. We have adopted the “No Technology Without Me” approach of the Veteran’s Administration as a guide to help all stakeholders reach agreement on the amount and type of technology as well as the manner in which information obtained by technology will be used, and whom it will be used by in the care situation. Cost, available resources, and complexity of care should be the decisive factors to determine the best care setting, not personal information gathered through technology. Technology should only be used to help the care situation and keep the care recipient at home for as long as possible.

Goal-oriented Solutions for Living at Home

All of our plans are tailored sets of goals placed in an easily readable services plan that can be monitored at intervals determined by the care recipient and care givers. Each goal has five aspects which make it a

SMART goal: Specific, Measurable, Attainable, Relevant, and Time bound. SMART goals are designed to eliminate the ambiguity and uncertainty as to whether or not the goal has been met or the service should be continued. We help you develop the goals you feel are important to your loved one's care, and can meet with care team members to ensure knowledge of the goals. Each goal can be monitored and modified to meet the concerns of all stakeholders in the care giving process. As with all of our other forms, Service Plan goals are traceable from their origin to closure or the current date (as applicable) which gives social workers an immediate view of the status of care giving, services used, and future care concerns and needs. The Service Plan becomes a living document.

Senior Advocacy

The BeHome4Ever, Inc. mission is a mission of advocacy through assessment, planning, goal structuring, service provision, monitoring, and technology augmentation to create the best possible home situation for your loved one. Our goal is to advocate for the care recipient as well as the care givers. Our hope is that through our advocacy your loved one will remain safe in the care setting of their choosing and that the caregiver will experience reduced levels of stress and illness as well as increased engagement in their own life and the life of their loved one. We welcome any suggestions you may have to help us serve your needs better.