

Provision of Title III Services Policy #10: Caregiver Support Services

This content is part of a public comment period. For more information, refer to [Minnesota Board on Aging – State Plan on Aging](#).

Authority Reference	OAA, Sections 371 - 373 45 CFR 1321.83 and 1321.91
Operating Category	Provision of Title III Services

Policy

1. The MBA recognizes the value and extensive contributions of caregivers and directs state policy accordingly. The intent of the National Family Caregiver Support Program in Minnesota is to build capacity that affects lives by improving the quality and duration of the care provided by family or informal caregivers, and reduces long-term care expenditures.

A. For maximum benefits for caregivers, the AAAs in partnership with local stakeholders will plan and implement a seamless and flexible support system for their regional community. The MBA's vision is to build a caregiver-focused system that recognizes the realms, phases, and roles of those caregiving (including family, unmarried partners, friends or neighbors) for an older adult or a person of any age with Alzheimer's disease or a related disorder. It offers caregivers easy access to assistance – when they need it - from a variety of entry and referral points across the formal, quasi-formal, and informal health and community service systems network. Assistance to caregivers includes the following: (1) information; (2) access assistance; (3) counseling, education and training, and support groups; (4) respite services; and (5) supplemental services. This system maximizes coverage by primary payers (e.g., Medicare, Medical Assistance, private insurance, etc.). This is a collaborative caregiver system with the informed, trained, and healthy caregiver from any culture or ethnic background directing care decisions and providing quality care for as long as desired.

B. This policy gives direction on how services should be prioritized, funding specifications, service development and delivery, service and support categories, and standards for quality assurance.

2. Prioritization of Services

A. In accordance with Sec. 372 (b) and 373 (c) of the OAA, the AAAs must direct service providers to give priority to the following populations:

- i. Caregivers who are older individuals with the greatest social need, and older individuals with greatest economic need (with particular attention to low-income individuals).
- ii. Caregivers who provide care for older individuals with Alzheimer's disease and related disorders with neurological or organic brain dysfunction.
- iii. Older relative caregivers of children, or adults with severe disabilities.
- iv. AAAs must assure that culturally competent services are provided to prioritized populations in at least the same proportion as found in the general population. This can be accomplished through development of a partnership with one or more organizations that provide culturally competent health and/or social services.

B. The AAAs will implement plans for establishing broad-based community access to caregiver support from a variety of key medical, social services, and other community organizations (e.g., employers, faith-based organizations, community centers, physician clinics, county case management, providers of Title III services, hospital discharge, Pre-Admission Screening(PAS)/ Long-Term Care Consultation, private case management, care coordination through health plans and Minnesota Senior Health Options, tribal health clinics).

C. Each AAA shall make use of trained volunteers to expand the provision of the available services described in 45 CFR 1321.91 and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants in community service settings.

3. Specifications on Use of Funding

A. No more than 10% of the allocation may be used for grandparents or older individuals who are relative caregivers of children who are not more than 18 years of age.

B. No more than 20% of the allocation for Supplemental Services as defined in 45 CFR Part 1321.91 (a)(4) and (5).

C. Funding will address service gaps, but will not duplicate or supplant other programs or services (public or private pay programs).

4. Service Development and Delivery

A. AAAs will use data and local input to plan, develop, implement, and modify Title III-E caregiver services. The AAAs will determine the criteria for which services in the categories listed within 45 CFR 1321.91 will be funded. The AAAs will assure that both initial and on-going collaborative service planning and development activities address all of the following components:

- i. Services that maximize involvement by individuals receiving and providing caregiving in all care decisions including service planning and delivery.
- ii. Coordinated use of volunteer organizations, employers, service clubs, churches, social service agencies, schools, community agencies, professional groups, etc.
- iii. Coordination and management of formal and informal services to produce less expensive alternatives.
- iv. Early intervention whenever possible involving the use of consistent screening and assessment criteria that helps identify caregiver stage, level of stress and needs.
- v. Confidential exchange of client data and information among providers and referral sources.
- vi. Comprehensive menu of services that is adaptable, flexible, and sensitive to caregiver needs, values, preferences, and cultural issues.
- vii. Integration within the existing senior service infrastructure with linkages with county, health and social service systems, payment systems, and other community networks.
- viii. Strategies to assure on-going growth and development to meet changing caregiver needs, including out-of-town caregivers.
- ix. Application of evidence-based or evidence-informed models of caregiver support wherever possible.
- x. Efficient use of resources.

B. In planning, the AAAs must address all of the following allowable service categories for eligible persons as defined in the OAA, 45 CFR 1321.91, and in accordance with state set priorities as defined in area plan instructions [OAA, Part III-E, Sec. 373 (b)]:

- i. Information about Available Services. This includes information via public education for purposes of creating greater public awareness and attention towards caregiving needs, outreach for identifying potential caregivers, and linkages to local and national resources on caregiving through the existing services such as the Senior LinkAge Line® (SLL) and websites (e.g., www.MinnesotaHelp.info®).
 - a. The AAAs should retain sufficient SLL staff to meet the needs of caregivers as demand increases. Development of marketing and training activities should be in accordance with current SLL standards.
 - b. These services may include but are not limited to: SLL, public information, and public awareness.
- ii. Access Assistance. An individual one-on-one service, through the SLL or other health or community networks that: (a) identifies and/or evaluates caregiver need; (b) provides current information on available services and supports; (c) connects caregivers to services; (d) assures that services are delivered within a practical context; and, (e) offers follow-up opportunities to caregivers. This service also helps track individual needs and makes appropriate referrals throughout the entire senior care or other community networks.
 - a. Services may include but are not limited to: outreach, senior advocacy, senior coordinators, care coordination, health insurance counseling/benefits review; transportation and assisted transportation, legal services, information and assistance, care coordination, specialized access, and referrals to other home and community-based services.

- iii. Counseling/Support Groups/Education and Training. Individual counseling, organization of support groups, and caregiver training to assist caregivers in those areas in which they provide support, including health, nutrition, complex medical care, and financial literacy, and in making decisions and solving problems relating to their caregiver roles.
 - a. These services may include but are not limited to: individual or family counseling, coaching, skills-based caregiving education and training, goal setting, and specialized disease education programs.
- iv. Respite care to enable family caregivers to be temporarily relieved from their caregiving responsibilities. This can include (1) an out-of-home placement, (2) an in-home service or (3) a facility-based service. Services may include but are not limited to: medical or social adult day care, adult foster care, personal care assistant, nursing care, and accompaniment to medical appointments.

Priority is given to those caring for:

 - a. A person needing assistance with at least two Activities of Daily Living;
 - b. A person who requires substantial supervision due to a cognitive or other mental health impairment.
- v. Supplemental. Services that complement, on a limited basis, care provided by family caregivers. Services may include but are not limited to: home safety management, home modifications, assistive technology, emergency response systems, homemaking, and transportation.

Priority is given to those caring for:

 - a. A person needing assistance with at least two Activities of Daily Living;
 - b. A person who requires substantial supervision due to a cognitive or other mental health impairment.
- vi. Caregiver Consulting. Includes, at a minimum, a comprehensive caregiver assessment to identify the caregiver's needs, and values, and strengths related to their caregiving role, and development of a customized plan that includes goal setting, problem solving, coaching, and ongoing support to reach established goals.

Title III-E funded consultants will conduct a caregiver assessment with caregivers receiving ongoing support. This assessment will address the caregiver's needs, risks, strengths and abilities, and informal support network.

5. Standards for Caregiver Consultants

A. Standard 1: Professional Qualifications.

Caregiver Consultant shall possess the knowledge, skills, and experience necessary to competently perform caregiver coaching/consulting service activities, including meeting at least one of the following three options for professional qualification requirements.

1. A bachelor's degree from an accredited program in social work, nursing, counseling, gerontology, health education, rehabilitation therapy, health and human services or a related degree
 - **and** have at least **two** years of experience using assessment, problem-solving and goal-setting skills with individuals
2. A Community Health Worker certificate from an accredited Minnesota program.
 - **and** have at least **two** years of experience using assessment, problem-solving and goal-setting skills with individuals
3. At least **four** years of experience using assessment, problem-solving and goal-setting skills with individuals

B. Standard 2: Ethics and Professional Values

Caregiver Consultant shall have knowledge of ethics and practice according to the ethical guidelines, principles and standards of their discipline and setting (e.g. NASW Code of Ethics).

- Primacy of client needs and self determination
- Clearly communicates the distinctions between coaching, consulting, psychotherapy and other support professions

- Refers client to another support professional as needed, knowing when this is needed and the available resources
- Meets privacy and confidentiality standards – must comply with local, state and federal mandates related to confidentiality and privacy of client information
- Professional judgement in the use of confidential information shall be based on best practice, ethical and legal considerations (including HIPAA)
- Is trained as a mandated reporter per the Minnesota Vulnerable Adults Act

C. Standard 3: Cultural Awareness/Responsiveness

Caregiver Consultants have knowledge and respect for the history, traditions, values, and family systems of client groups, as they relate to home and community-based services, health care services and decision making. Caregiver Consultants adapt standards of practice to meet cultural norms and values.

This includes:

- Knowledge, competency and skills to work with individuals and families from a variety of communities including, but not limited to, communities of color, American Indians, Alaska Natives, veterans, LGBTQ+ communities, and persons with disabilities.
- Skills to meet the needs of individuals and families with disabilities, and lesbian, gay, bisexual and transgender individuals who are caregiving.
- Awareness of disparities and barriers across cultures and economic groups in gaining access to and funding for home and community-based and health care services.
- Taking responsibility for self-reflection regarding the impact of their personal cultural beliefs on their professional and personal life.
- Understanding of the intersectionality of historical trauma, cultural beliefs, self-identity, gender, etc.
- Understanding of the community system and knowledge of specific cultural resources available.
- Committing to ongoing education and knowledge of the resources for new subsets of populations.
- Culturally responsive care, including but not limited to, creating a culturally safe environment, using cultural negotiation, and considering the impact of culture on patients' time orientation, space orientation, eye contact, and food choices.

D. Standard 4: Knowledge Base

Caregiver Consultants have a working knowledge of current best practices. They keep current on emerging knowledge and trends and integrate this knowledge into practice.

This includes:

- Basic knowledge of family systems and family dynamics.
- Basic knowledge of common chronic illnesses and/or conditions.
- Understanding of Alzheimer's disease and related dementias, management of behaviors and communication, and community resources/referrals.
- Assuming personal responsibility for continuing professional education according to standards of their discipline and setting (e.g. geriatric nurse practitioner).
- Participates in professional development training by the MBA or a designated contractor (annually or as offered).

E. Standard 5: Assessment

Caregiver Consultants gather information regarding the caregiver/client's situations to create a comprehensive plan. These assessments establish trusting relationships between the consultant and the caregiver.

Consultants completing assessments should:

- Ask questions and probe for clarification.
- Uses strength-based person-centered and family-centered approach.

- Address principles and seven domains of caregiver assessment developed by the Family Caregiver Alliance.

F. Standard 6: Goal setting, intervention, planning and follow-up

Caregiver Consultants facilitate the development and implementation of a self-directed action plan with client.

This can include:

- Using problem-solving techniques and coaching tools and strategies.
- Providing ongoing education, building self-advocacy skills and providing support.
- Assisting caregivers in evaluating outcomes and modifying the plan.
- Obtaining ongoing feedback from caregiver on process and plan.

G. Standard 7: Supporting Self-Advocacy

Caregiver Consultant teach caregivers systems navigation and self-advocacy skills needed to fulfill the plan.

This can include:

- Advising about navigating between health and long-term services and supports.
- Teaching self-advocacy skills, such as communicating needs, identifying, and resolving problems and making decisions related to the care, provider services and benefits, as caregiver is able and willing.
- Developing collaborative relationships with other health, mental health, and allied health professionals, and transfers these relationships to caregiver as able and willing.
- Striving to enhance inter-professional, intra-professional, and interagency cooperation on behalf of the caregiver.

H. Standard 8: Documentation/Information Movement

Caregiver Consultants maintains records and provide information updates to persons who need to know.

This includes:

- Maintaining records or documentation of caregiver services reflecting pertinent information for assessment, interventions, and outcomes in accordance with administrative policies within their organization.
- Complying with privacy and confidentiality standards including obtaining release of information forms.

This can include:

- Instructing caregivers about how to organize and manage essential information (e.g., records, prescriptions, treatments, benefits, financial information, advanced directive, power of attorney for health care).
- Facilitating the flow of information between all "care team" members.
- Communicating with a caregiver's physician to ensure that there is a caregiver designation in the caregiver's medical record and provide updates to the medical care team as to the health and mental health status of the caregiver as agreed upon (with permission).

I. Standard 9: Performance Improvement

Caregiver Consultants conduct ongoing, formal evaluations of their practice to assess quality and appropriateness of services, to improve practice and to ensure competence.

This includes:

- Monitoring caregiver health and wellness through the caregiver plan with goals (e.g., stress, depression, and other wellness measures)
- Incorporating individual feedback into plans on an ongoing basis
- Incorporating feedback from client satisfaction surveys and other methods into service components.

Procedures

Caregiver Consulting Procedures

1. Training requirements for caregiver consultants include the following courses offered in a virtual format:

A. Required

Minnesota Board on Aging (MBA) Caregiver Consultation Core Curriculum Trainings (4 – 5.5 hours)

- i. Overview of Caregiving
- ii. Defining Caregiver Consultation
- iii. Assessment
- iv. Planning and Follow-up
- v. Common Caregiving Support Needs

MBA 201-205 Tools for Your Practice in Cultural Communities (3.5 hours)

Annual Update Training and recertification* (1 hour)

Additional Topics

- Support group facilitation
- Family meeting facilitation
- ALS caregiving*
- Dementia-related training**
- Older Relative caregiving*
- Elderly Waiver Foundations (AASD-EWF1)

*These trainings yet to be developed

**MBA100 dementia series is currently available. New training may be developed.

2. Required Screenings for Caregiver Consultation Assessments (For Title III-E Providers)

These screenings must be done in each caregiver consultation assessment and recorded in PeerPlace. These screenings MUST be part of a comprehensive assessment that includes all seven areas of assessment for caregivers.

A. Emotional Wellbeing – 1 score

Consultants will use the Zarit Burden Interview Screen (4-item)

- The Zarit Burden 4-item screen results in a single number score.
- The score will be entered into PeerPlace for each assessment.

B. Physical wellbeing – 1 score

Consultants will ask each caregiver the following question, "How would you describe your own health?"

Answer options are

- 5 – Excellent
- 4 – Very Good
- 3 – Good
- 2 – Fair
- 1 – Poor

Consultants will enter the number of the score into PeerPlace.

C. Social wellbeing – 1 score

Consultants will ask each caregiver the following question, "How often do you feel lonely?"

Answer options are

- 1 - Always
- 2 - Usually
- 3 - Sometimes
- 4 – Rarely
- 5 – Never

Consultants will enter the number of the score into PeerPlace.

D. Financial wellbeing – 1 score

Consultants will ask the question: "How much of a financial strain would you say that caring for (care receiver) is for you? On a scale of 1 to 5, with 1 being no strain at all and 5 being very much a strain."

Answer options are on a continuum from 1-5 with 1 being no strain at all and 5 being very much a strain. The score will be entered into PeerPlace.

3. Required elements of Caregiver Consultation Assessment

Caregiver consultants MUST complete an assessment with caregivers that includes the seven areas of assessment identified as best practice by the Family Caregiver Alliance. More information on assessment and details on each area are available on their [website, here](#).

Assessment Areas

1. Context/ Caregiver relationship to care recipient
2. Caregiver's perception of health and functional status of care recipient
3. Caregiver values and preferences
4. Well-being of caregiver (Including required screenings)
5. Consequences of caregiving
6. Caregiver skills/abilities/knowledge to provide care
7. Caregiver resources

Guidelines for completing Caregiver Consultation assessment

For Caregiver Consultants, these assessment areas should be used as guides when assessing caregivers and adapted to the unique context of each program and situation.

1. Background on the caregiver and the caregiving situation (context)

Areas to assess:

- Physical environment (home, facility)
- Household status (number in home, etc.)
- Financial status
- Quality of family relationships
- Duration of caregiving
- Employment status (work/home/ volunteer)

2. Caregiver's perception of health and functional status of the care recipient

Areas to assess:

- Activities of daily living (ADLs; bathing, dressing) and need for supervision
- Instrumental Activities of Daily Living (IADLs; managing finances, using the telephone)
- Psycho-social needs
- Cognitive impairment
- Behavioral problems
- Medical tests and procedures

3. Caregiver's values and preferences with respect to everyday living and care provision

Areas to assess:

- Caregiver/care recipient willingness to assume/accept care
- Perceived filial obligation to provide care
- Culturally based norms
- Preferences for scheduling and delivery of care and services

4. Health and well-being of the caregiver

Areas to assess:

- Self-rated health
- Health conditions and symptoms
- Depression or other emotional distress (e.g., anxiety)
- Life satisfaction/quality of life

5. Consequences of caregiving on the caregiver

Areas to assess:

- Perceived challenges
 - Social isolation
 - Work strain

- Emotional and physical
- health strain
- Financial strain
- Family relationship strain
- Difficulties with formal providers
- Perceived benefits
 - Satisfaction of helping family member
 - Developing new skills and competencies
 - Improved family relationships

6. Care-provision requirements (skills, abilities, knowledge)

Areas to assess:

- Caregiving confidence and competencies
- Appropriate knowledge of medical care tasks (wound care, etc.)

7. Resources to support the caregiver

Areas to assess:

- Helping network and perceived social support
- Existing or potential strengths (e.g., what is presently going well)
- Coping strategies
- Financial resources (health care and service benefits, entitlements such as *Veteran's Affairs*, Medicare)
- Community resources and services (caregiver support programs, religious organizations, volunteer agencies)

8. Availability of Trualta

The Minnesota Board on Aging (MBA) in partnership with AAAs and Aging Network service providers has implemented Trualta, an online education and resource portal for caregivers. Trualta is another tool that Caregiver Consultants can utilize to further support family, friends and neighbors caregiving. Additional information including portal updates can be found on the Minnesota Trualta Staff Space: MNCaregiving.org/r/StaffSpace