Oregon's Caregivers Assessment Tool Guidelines

Assessment Tool

The Oregon Caregivers Assessment Tool (OCAT) is used to systematically gather information about an unpaid caregiver's situation, identifying their specific needs, strengths, and challenges to develop a personalized care plan that supports both the Caregiver's well-being and the care recipient's health by assessing their physical, emotional, and social aspects of caregiving.

The OCAT shall be completed by a trained case manager or care coordinator, as stated in the New State Performance Report (SPR), to administered direct contact with the Caregiver, including contact through a home visit, the Internet, telephone, teleconference, or in-person interaction (OAA Sec. 372(a)).

Fourteen of the twenty-six questions within the OCAT have required indicators marked * asterisks arranged to coordinate and monitor an optimum service plan to meet the Caregiver's requests within 60 days of the initial contact. Once you have answered all the necessary questions, please place your points next to the appropriate response within the OCAT Risk Scale Level Calculation.

Note-

No services can be awarded to the Caregiver until the Assessment and Risk Score Level Calculation are completed

Once the Caregiver initial assessment have been completed, the caregiver shall be re-evaluated annually, to track needed changes, progress or discharge. Services should be incorporated into existing person-centered plans as appropriate.

Assessment Tool Model

The OCAT is an Assessment/Reassessment tool designed to understand the needs of unpaid Caregivers, and provide services to determine what will best empower the Caregiver's outcome through its support plan. The Assessment Tool is based on an Evidence-Informed assessment model that combines research, evidence, practitioner expertise, and the Caregiver's experiences to design and implement their support plan.

> *The Administration for Community Living (ACL) defines evidence-informed caregiver assessment practices as best practices based on evidence and used to improve care planning and access to services and support for caregivers. The National Caregiver Support Collaborative (NCSC) Technical Assistance and Coordinating Center (TACC) collects and shares evidence-informed caregiver assessment best practices.*

Below are the contents of an Evidence-Informed approach method:

An evidence-informed approach blends knowledge from research, practice and people/caregivers. This is a process for making informed decisions about the delivery of supports and services within the assessment tool.

OCAT Risk Score Level Calculation

The OCAT Risk Score Level Calculation enables you to understand the severity of a caregiver's distress from high tension and frustration while meeting OAA sec—372 (b) and prioritizing services. Caregiver's care will be positioned in the order of points status, and actions will be established to reduce the Caregiver's potential effects. The Risk Score prioritizes populations to be served, which includes as stated within OAA final rules 1232.83
Client and Service Priority by:

1) Caregivers who are older individuals with the most significant social need and older individuals with the greatest economic need (with particular attention to low-income older individuals);

2) Caregivers who provide care for individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and

3) If serving older relative caregivers, older relative caregivers of children or adults with severe disabilities.

To better assist the case manager in this task, the required 14 questions are numbered to correlate within the risk scale to follow up with the ranking scale.

Once the Assessment is completed, identify each risk score within the relevant 14 sections and place the designated points from the answer on the far right under the scoring section. The maximum number of each question is located on the right side of each box. Once all scores have been placed, calculate the total at the end for the maximum of 39 points.

Support Plan – 1321.91 Final Ruling FCSP Support Services

(a) Family caregiver support services are community-based interventions outlined in Title III, part E of the Act, which meet standards set forth by the Assistant Secretary for Aging and which may be informed through the use of an evidence-informed or evidence-based caregiver assessment, including:

(1) Information to family caregivers about available services via public education;

(2) Assistance to family caregivers in gaining access to the services through:

  (i) Individual information and assistance or
  (ii) Case management or care coordination

(3) Individual counseling, organization of support groups, and caregiver training to assist family 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 caregiving roles;

(4) Respite care to enable family caregivers to be temporarily relieved from their caregiving responsibilities; and

(5) Supplemental services, on a limited basis, to complement the care provided by family caregivers.

NOTE- To provide services listed in paragraphs (a)(4) and (5) of this section to families of adults aged 60 and older or of individuals of any age with Alzheimer's disease or a related disorder, the individual for whom they are caring must be determined to be functionally impaired because the individual:

(1) Is unable to perform at least two activities of daily living without substantial assistance, including verbal reminding, physical cueing, or supervision.

Review the **Title III Data Elements and Definitions** to understand the State Program Performance Report (SPR) data requirements for Caregivers Services.

Methods and Approaches to Consider

Case Manager Caregiver Conversational approach may include-

Who are the caregivers in this particular case?

- Who functions as a family in this case? Care recipients may receive care from various people who function as our culture presumes family would – sharing in the obligatory and emotional roles of sharing care.
- What are the distinct needs of caregivers, given their official/legal roles, that may include or exclude them from participation in care delivery systems, sharing care information, and sharing in decision-making?

What assessments of the care recipient's condition have been done?

- Are they adequate in your professional opinion?

- Do family members have the results of those evaluations?
- What have family members been told by professionals?
- What do family members understand or misunderstand from the results?
- To what degree do they accept the diagnosis?
- What have they learned from informal sources about their loved one's illness or Disability?

What is the etiology of the illness or Disability? The common symptoms?

- What is the expected course or trajectory of that condition?
- How will care demands change over time if the illness or Disability progresses?
- Which symptoms are currently the most challenging for the care recipient?
- Which symptoms are currently the most challenging for the Caregiver?

What is the family context of care?

- What is the family's development stage?
- Who are the primary and secondary caregivers?
- How much stress and burden are the caregivers suffering?

- What are the social, cultural, and spiritual contexts of the family's caregiving experience?
- In what stage of caregiving is the family?
- What are the logistical, financial, and psychological impacts of the illness or Disability on the family?
- How are care responsibilities distributed among primary and secondary caregivers?
- To what extent are family members satisfied with the distribution of care responsibilities?
- What are the reasons that the Caregiver takes on the role?
- Specify how the service provider intends to satisfy the service needs.

While uncertainty is a certainty with caregiving, a caregiving support plan can give caregivers foundation and strategies to help them navigate the ups and downs and twists and turns. It allows caregivers time to think about how best to care and what supports will help. It also allows caregivers to manage better what's in their control and what's not.

Creating a personal caregiving plan is driven by the Caregiver's needs and is tailored to what will give them the greatest support to reduce emotional and physical stress.

Assessment Definitions

Activities of Daily Living (ADLs) – refers to the basic personal care tasks that individuals perform regularly to maintain their well-being, including things like bathing, dressing, eating, using the toilet, getting in and out of bed, and walking; essentially, the everyday actions needed to live independently. Assessing

ADL skills is crucial in healthcare settings to determine a person's functional ability, especially when dealing with disabilities or aging.

Caregiver Assessment - means a defined process of gathering information to identify the specific needs, barriers to carrying out caregiving responsibilities, and existing supports of a family caregiver or
older relative Caregiver, as identified by the Caregiver involved, to appropriately target recommendations for support services described in section 373(b).

Caregiver - an individual who has the responsibility for the care of an older individual, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an older individual. (OAA (102) (18) (B))

***Care* Recipient** – an adult with a chronic illness or disabling condition or an older person who needs ongoing assistance with everyday tasks to function daily. The person needing assistance may also require primary and acute medical care or rehabilitation services (occupational, speech, and physical therapies). A care recipient is an adult who needs ongoing assistance with daily tasks due to a chronic illness, disabling condition, or aging. Care recipients may need help with activities such as:

- Household chores, Personal hygiene, Taking medications, Coordinating medical treatments, Transportation to medical appointments, Managing finances, etc.

Disability - means except when such term is used in the phrase "severe disability", "developmental disability," "physical or mental disability", "physical and mental disabilities," or "physical disabilities" - a disability is attributable to mental or physical impairment, or a combination of psychological and physical impairments, that results in substantial functional limitations in one or more of significant life activity. (Condensed from OAA 102 (13))

Guidance Questions - to assist (if needed) the Case manager's conversation with the Caregiver to help them effectively assess the Caregiver's lifestyle by identifying their needs and developing a personalized support plan by prompting them to gather crucial information and exploring different aspects of the care recipient's life during the case management process.

Older Relative Caregiver means a caregiver who is 55 years and older, lives with, is the informal provider of in-home and community care, and is the primary Caregiver for the child or the individual with a disability.

Care Recipient's Behavior Definitions followed with Guidance Questions

1-Alzheimer's Disease/ Neurological and/or organic brain dysfunction (3 pt)

The diagnostic criteria for Alzheimer's disease (AD) described in DSM-5-TR require a decline in memory and learning and at least one other cognitive domain among six cognitive domains, and also interference with the activities of daily living (ADL) because of decline in these cognitive functions; as such, DSM-5-TR

The DSM-5TR recognizes several subtypes of functional neurologic disorder, as listed below. There are many ways to differentiate between organic disorders and these subtypes of functional neurologic disorders. Psychogenic nonepileptic seizures – This is the most common subtype of functional neurologic disorder.

(DSM-5 diagnosis)

Guidance Question

Has your care recipient(s) been diagnosed with any medical conditions or special needs? [When applicable] Does the care recipient have a dementia diagnosis or symptoms?

2- Behavioral Challenges (1 pt)

Behavioral challenges are behaviors that are harmful to the person or others around them or prevent the person from participating in daily activities. Behavior can be described as challenging when it is of such intensity, frequency, or duration as threatening the quality of life and/or the individual's or others'

physical safety. It will likely lead to restrictive, aversive responses or exclusion.
(NIH)

Guidance Question

Does your care recipient experience any of the following symptoms -–aggressive behavior (such as verbal abuse, threats, and physical violence), destructive behavior (such as breaking or destroying furniture and other objects and setting fires), disruptive behavior (such as repetitive screaming, smearing feces, setting off fire alarms when there is no fire, calling the emergency services when there is no emergency), self-injurious behavior (including self-biting, head banging), sexually harmful behavior)?

3-Emotional Challenges (1 pt)

An emotional challenge is complicated and requires a lot of effort and determination. It can also refer to being concerned with emotions and feelings.
(Collins)

Guidance Question

Does your care recipient experience any anxiety, depression, feeling overwhelmed, panic attacks, helplessness, or hopelessness?

4- Geographic Isolation (2 pts)

Geographic isolation is the experience of being physically cut off from broader society due to location. It is when a group of people is physically separated from other populations by geographical barriers like mountains, rivers, or large distances, limiting their interaction and potentially leading to unique cultural development, social structures, and even distinct genetic traits due to limited intermixing with other groups.

Guidance Question

Does your care recipient live in a geographic area outside towns and cities?

5. Physical Disability (1 points)

A physical disability limits a person's physical functioning, mobility, dexterity, or stamina. Other physical disabilities include impairments that limit other facets of daily living, such as respiratory disorders, blindness, epilepsy, and sleep disorders.

Guidance Question

Has your care recipient(s) been diagnosed with any medical conditions or special needs?

6- Intellectual Developmental Disability – (1pt)

Significantly subaverage intellectual functioning:

70 or an IQ of approximately below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).

Intellectual Disability does not denote an illness or a single disorder entity but a behavioral syndrome of variable etiology characterized by intellectual and adaptive functioning below the level expected for the person's age, education, and socio-cultural context. Strictly speaking, it is not a mental disorder like a mood or psychotic disorder. Formal definitions of ID have evolved. The modern ones are tri-factorial, requiring impairment in (1) intellectual functioning, (2) adaptive functioning, and (3) onset before age 18.

(DSM-IV TR Diagnostic Criteria)

Guidance Question

Has your care recipient(s) been diagnosed with special needs?

7- **LGBTQIA2S+** - **(1 pt)**

An acronym that stands for a range of diverse sexual and gender identities, including:

- **L**: Lesbian, **G**: Gay, **B**: Bisexual, **T**: Transgender and/or gender expansive
- **Q**: Queer and/or questioning, **I**: Intersex, **A**: Asexual,**2S**: Two-Spirit

The terms used to describe sexual orientations and gender identities are constantly changing and being updated to represent people better. It's important to ask people what terms they use to describe their sexual orientation, gender identity, and gender expression before assuming or assigning them a label.

Guidance Question

Does your loved one see themselves within the LGBTQIA2S+ community?

8- **Limited English proficiency (1 pt)**

Through the Americans with Disabilities Act (ADA) and Section 504, the protections apply equally to LEP individuals with disabilities or who are Deaf or hard of hearing (HOH). Many assistive technical (AT) devices are available to LEP individuals with disabilities.

Guidance Question

People whose first language is not English, people who struggle or cannot communicate in English. Are there other languages other than English that you prefer to speak? Are there challenges for the individual to navigate information in English?

9-Minority or marginalized Community (1pt)

Minoritized communities are social (racial) groups that are marginalized or persecuted because of systemic oppression. For example, Black Americans are a minoritized community. A minority community is a numerically smaller Community of two groups constituting a whole.

Guidance Question

What is your care recipient's nationality?

10. **Native Hawaiian/American Indian/Native American(1pt)**

The descendants of the original inhabitants of North America and South America before the arrival of white settlers from Europe were also called Indians or American Indians.

Guidance Question

Does the care recipient belong to a tribal nation or Community?

11- **Social Isolation** (2 pts)

A state in which the individual lacks a sense of belonging socially lacks engagement with others, has minimal social contacts, and is deficient in fulfilling and quality relationships. It differs from loneliness, reflecting a temporary and involuntary lack of contact with other humans.

(NIH - National Library of Medicine)

Guidance Question

Does your loved one avoid social interactions? Do they have anxiety or panic when thinking about social interactions?

The goal of assessment…..

> "The goal of assessment should be to help the person in need of care and the family providing the care achieve the best possible quality of life in accordance with their values, needs, resources, and preferences." ~

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