Disability-Competent Care Webinar Roundtable Series:
Training in Disability-Competent Care and Supports
Providing Home Modifications
Event ID 743220

Jeff: Ladies and gentlemen, thank you for standing by. Welcome to the Disability-Competent Care Webinar Roundtable Series. At this time all participants are in listen-only mode. Later we'll conduct a question and answer session. Should you require assistance on today's call or if you'd like to ask a question, please press star and then zero. Now I'd like to turn the conference over to your host, Mr. Chris Duff. Go ahead, please.

Chris Duff: On behalf of the Lewin Group, I would like to welcome everyone to the sixth 2014 webinar roundtable session, this one focusing on home modification. As Jeff stated, my name is Chris Duff and I'm a disability policy impact consultant. Under contract with the Medicare and Medicaid coordination office, as the centers for Medicare and Medicaid services, the Lewin Group has engaged myself and a few colleagues to provide technical assistance to providers working with adults with disabilities.

First of all, I'd like to introduce you to our platform for this presentation. If your slides are not advancing, please push F5 on your computer keyboard. Also, please note the two icons circled at the bottom of the screen, the green icon of a file folder, third from the right, provides you access to resources for this presentation. The center icon with the CC will enable you to use captioning. The brown icon, fourth from the left, will open a chat window for participants to pose and discuss any topic-related questions to other participants and speakers. After the brief presentation, we will also open the phone lines for participants to ask questions directly to the presenter.

As stated earlier, this is the sixth webinar roundtable session in this current series. The last two will be presented on the next two Tuesdays at this time concluding on April 8. Last year we published a comprehensive -competent care self-assessment tool describing disability-competent care in three key components--individualized care coordination provided by an interdisciplinary care team, redesigned primary care delivery, and flexible long-term services and supports.

We follow this up with nine webinars focusing on individual components of disability-competent care. All of the webinars are recorded and available along with pdfs of the slides at the link at the bottom of this current slide.

Our goal in this series is to be highly practical using experts in each topic area with organizational examples or first-person stories to demonstrate key messages. The presentation will be no more than 30 minutes, allowing the reminder of time just for questions or issues submitted by the participants. The chat feature is available to participants throughout the webinar. Beyond the chat feature and the open phone line, we will be using instant polling to ask us the questions to help guide our presentation. To demonstrate this process, here is the first polling question for today. Is your plant or organization responsible for home assessment and/or

modifications for your participant? If you could choose one of the answers and push Submit, I will review the results in just a minute.

Today we are exploring disability-competent practices related to the value of home modification. Our goal is to prepare providers within health plans for healthcare providers to support their participant's ability to live in their setting of choice and to maximize their functional independence. The presenters will discuss the importance of home assessments and the imperative to involve participants and their key caregivers in the process.

When a person acquires disability, defined as a functional limitation, or loses ability due to an illness or aging, their ability to safety function in their own home may be threatened. It is important that care coordinators continually monitor the needs and well-being of their participants in a manner comparable to how they monitor the individual's emotional and physical health. The need for modifications is to be judged not only in terms of meeting functional needs, but also in terms of prevention of injury or progression of dependence, and potentially minimize the need for assistance from others.

By modifications, we mean everything from non-skid surfaces under a throw rug, to grab bars, and reachers, all the way through ramps and structural modifications to enable independence in activities of the daily living. Decisions regarding home modifications require clear policies and procedures with inherent flexibility to modify as required for the unique situation.

Jessie, could we go back and review the polling results from the first question? I see that the majority are not currently responsible for providing those home modifications or assessments. I'm glad you're still interested in this subject. I think as more and more providers and plans assume responsibility for the whole continuum of services including waivers, it's important that everyone, regardless of whether you're directly responsible or not, become familiar with the opportunity and process for assessments and modification.

Why don't we do one more question? If you could, answer the second polling question, and then I'll hand it over to the speakers. The second polling question is, "How does your organization identify a participant's need for home assessments or modifications?" It means that you're not responsible for doing them, if you could at least state how you would identify the individual's need for this.

While you're answering that, I'll go on to introduce the speakers. Today's webinar will be presented by Brian McCarthy, a certified aging and place specialist and home modification contractor. Having lived with a disability since birth, Brian understands the importance and value of design to maximize functional independence. He does home assessments and manages modifications from design and development through remodeling, specializing in work with elderly and disabled home owners. He has experience working with counties and health plans in Minnesota and home modifications funded through home community-based labor programs.

He will be joined by Mary Larson who brings over 30 years experience in the field of occupational therapy. Much of her experience has been working with clients in their home and community settings, seeing firsthand how disability affects safety and independence and activity.

She brings a passion for identifying barriers to an individual's ability to be able to participate in their live. Through an assessment process, she recommends services, equipment, and environmental modification to increase an individual's ability to participate in life activities and improve their safety.

With Brian bringing the design and structural expertise, and Mary, her rehabilitation expertise, they together comprise a breadth of knowledge and experience necessary for most any form of modification needed.

Now, I'll hand it over to Brian who will review the second polling question and start his presentation and then Mary will follow with their presentation. Brian.

Brian McCarthy: Thank you, Chris. I'm happy to be here. I appreciate the opportunity to be involved in this webinar. I should give you a quick background into what brought me into this business. I was a home builder for 15 years over the housing boom. When the market changed in 2008, I needed to adapt my business to fit the current economy. As a person with cerebral palsy, I thought there could be an understandable fit for me to get involved in home modifications for people with special needs. I not only understand the physical structure of a home, but have possibly a unique understanding of how people live in their homes with physical limitations.

My fee is very mild to lowest but I do need to concentrate on issues that other people might not see. For instance, I plan the approaches to steps or staircases. I think we will be taking some notes on the direction of your door swing. I plan ahead for hand holds to help keep them in balance. These are normal things that I do easily share in conducting an assessment. With that, we'll go to slide number 8.

I'm going to real quick look at the polling results. I moved that screen, but on slide number 8, there are two parts that we've identified in we want to address in this presentation. We want to identify the need so we want to know a skill for the participant. It could be a new home, a new challenge in their abilities. We've got to figure what are cardinal pathways in identifying the needs. Once we've identified the needs, then we need to make a referral for assessment. Who makes the referral? Does the participant? Does the family? Many of those are raised through by the healthcare providers.

Now I have conducted the assessment, we need to get the background information. Conducting the assessment is the kind of the first part of our job. I have a chance to meet the client, see where they live, see how they can move around at home and, at this point, it's just gathering all of the facts you can and figuring out do you have strong arms or weak arms and we can always help you in conducting an assessment. Once we've done the assessment, we need to put things on paper or go to modification recommendations. In doing these we need to gather all of the inputs from everybody from caregivers to PTAs to family members. Also in making the recommendations here, we need to understand the financial limitations, so we can provide waivers for people who have health plans and pay for these. A lot of ours are private pay, so we'd rather be cognitive of how money is going to come in and what we can spend it on.

Once we have the plan paper, we need to implement the recommendations. We've got to make it work. We've got to follow it through the process. We've got to oversee the project. Who oversees the project? A lot of times in my business I continuously see the project stall out where (inaudible) or his case manager doesn't follow through on moving and put the door on, so once the laws are in place, we can move forward.

Number 6, once the modification is complete, we orientate the user to the modifications. This is also a part that we forget about a lot, but it's very important. Once we've done roller modification and your bathroom modification, it's good to take the client in for a dry run and show them why we put a grab bar in this location or show them why we're put a panel switch for a way for the person toggle switch for a light. We just needed to show the client all of what we've done to help their home environment.

Moving on to slide number 9, identifying the needs--if the healthcare provider can be the jury, you need to identify the needs for a home modification. With their busy schedule and they're to commence, you don't always have the luxury of doing a weekly home visit. There are a lot of little things that might trigger a need for a home modification. For example, you need to think of a person interested and they're ready to reclaim physical abilities. For pathways, I have elderly clients who weren't able to build grab bars. The following year they all moved to a maybe a colder climate. The next year is removing the tub and putting in a walk-in shower. Just be aware that as you age or the condition worsens, that there's a need for identifying the modification.

You may also need to ask questions of the provider. "How is your new carpet working out? Are you able to get into the new bathroom? People move. People change locations so you've got to be aware of that if a need were to arise for that kind of stuff. Also be aware that when people get new products such as a new wheelchair, don't assume that it will fit like the old wheelchair. Some wheelchairs, as we all know, are longer and taller and wider, so they might not make the curve in the hallway to get around into the bathroom quite as well. Just be aware if your client does get a new product that you might need to do a modification to make sure it works for him.

Here is another example of why they might need a modification. Not all modifications are meant for the recipients. For instance, sometimes we need to understand the limitations of a caregiver. Don't expect a 53-year-old man to be lifting a 165-pound child. We really need to plan ahead before the mother's back goes out. One of my modifications is with the caregiver involved.

Why do we do these modifications? Mainly slips and falls--the safety of our living and moving alone. The next one is, according to me, is maximizing the function of an individual. We want have people who live to their full potential. It's kind of the right thing to do. I have an example that always hits me in the heart. I had a client that had a two-bedroom house--or two-bedroom condo with heavy shag carpeting. In a wheelchair where he had a hard time pushing it around. The modification that I did that was so small but it helped him tremendously was incredible. He lived there for 15 years without the ability to get into either one of his bedrooms, so he his bed out in the main family room. By removing the shag carpeting and putting in a linoleum floor, then he had the chance to glide around in his chair, movements he make--move around in his chair and in his bedrooms. His home environment just became so much better for him.

I going to move on to I guess maybe one more thing down here. We always need to be realistic about the cost of a modification. Most modifications are relatively inexpensive. A lot of modifications are just a taller toilet bowl and a few grab bars. As a healthcare provider, we need to understand the limitations of what we can really do to be cost effective.

Can you move on the slide, please? The referrals for an assignment--as a healthcare provider we need to identify the goals in planning for the assessment. We need to be specific in what we need to get accomplished. For example, we have a primary goal of getting the participant out of the hospital, so you need to come up with a--so do they need to come home? Do we need to get wheelchair ramp? This would meet the primary goal. Do they need a bed on the main floor? Once again, this could be a primary goal.

In doing the check, you've got to look ahead at the secondary goals. In this situation it might be a functioning bathroom--maybe a new toilet and a roll-in shower. Then once again, you go look ahead and look for a long term goal which might be converting a space looking for use of their bedroom or moving the laundry facilities out of the basement to the main floor as well. This could be a three-year plan or some kind plan that you invent, as long as you realize everything doesn't need to be completed all at once. This is a very common way to make a plan and you do the modifications over a three or five-year period. I say that all of the time.

The healthcare provider, you may have the skills and knowledge to do assessments on your own. Most modifications are quite simple, for example maybe toilet, just a couple of grab bars, and that's all they need, but at times you need to understand that you may need a professional to place it in the larger projects, and the need to use professionals, such as an occupational therapist or a physical therapist. You might even involve a contractor that has structural knowledge, so he can prepare you to think through some other concerns before the actual assessment.

Conducting the assessment--once we get a referral from a care manager, we need to do the assessment of surveying the facts. Most referrals tend to be routine now. Obviously, we get the recipient's name, address, phone numbers. I also try to get the contact person and their phone numbers as well. Hopefully, it won't require (inaudible) and some of the background information that we've discussed. What are we trying to accomplish? What are our goals? What are the challenges? How are the projects going to be funded? Then it's obviously the client. Mary Larson, you could move ahead at this point.

Mary Larson: Yes. Usually, I just come in at this point and this is when I'm trying to find someone to work with on the remodel and all of that. Do you have anything else on slide 12, or should I move on to slide 13?

Brian McCarthy: No. You can go ahead with 13. Yeah.

Mary Larson: Okay. All right. It's been my experience that whenever possible it's like you'll find an occupational therapist to meet the participant in their home setting to identify what their needs and priorities are. If this isn't possible and the participant needs to be seen like in the clinic setting, I think it's important to have videos or photos of their home environment, preferably with

the participant demonstrating in the videos their barriers and abilities. How do they do the transfer in the bathroom and what are the challenges while they're doing it?

Of course, I think a full assessment is needed to be completed. I like to look at how the individual can use what function they have to the best of their abilities. Sometimes it can be if somebody is maybe quadriplegic and they only have movement in their thumb and might be looking at what could they do with that thumb. Can they operate a switch to answer their phone or the call for help from an attendant? I think there are all levels of abilities and we want to try and promote as much as we can from the client. I think being aware of how variable abilities are along with the progression of a disease is important to consider. Today might be a good day and the piece of equipment or modification might work. I like to observe or at least discuss what a bad day for them is like, so we can problem solve changes in the setup that might need to take place on those bad days.

I think a strong knowledge of available products and which piece of equipment fits the needs of the client is important as well. Often the mistakes I've seen is when a great piece of equipment is ordered or a nice modification is made, but it doesn't fit or work for the participant. For example, a wonderful bath bench has been ordered and it may be too big for the participant's bathroom, or it might be assembled incorrectly with the arm rail on the wrong side of the bath bench. A raised toilet seat might be ordered, but it doesn't fit their toilet.

Moving on to slide 14, when I first meet with a client, I do like to access the full living space. While my primary focus may be seeing the areas the participant has identified as problem areas, I may see other things or make other recommendations to improve functional abilities in other areas of the home. It's possible that I may identify an area that the participant just assumed they could never improve their safety or independence in. They may be unaware that there is a solution out there to help them.

I also like to review their daily routine and which tasks are most difficult. Oftentimes it's breaking the task down and asking them about each step of it and where does the problem begin? I like to ask them where are your biggest barriers, challenges, and frustrations? Sometimes there are low cost solutions that can be trialed prior to a remodel project. I like to borrow from an equipment loan program whenever possible. Sometimes I've worked a lot with a medical supply company and they may be willing to borrow me a piece of equipment to try out during a session or send a representative from the medical supply company if it's a complex or expensive piece of equipment.

It's also nice to meet out there, the people who may be installing the ramp, just to be there as a representative also for the client or the participants that you are conscious if there is difficulty with communication or memory, vision--any of those efforts--so that I can help guide the participant or bring up topics I know they were interested in. I think that we always want to consider the amount of work that needs to be done to make the environment functional, and it's a good topic to discuss with the participant. Sometimes I like to introduce other options just to make sure this is really where they want to stay on term, so bringing up the options of moving to another home, to an assisted living, to a more accessible apartment that may better meet their needs.

Certainly when you're going to do remodeling, you want it to be a long term project. At this point, I'm going to hand it off to Brian and he will be discussing step four--modification recommendations and plans.

Brian McCarthy: Once we've had a chance to meet with the client and visit their house, we can begin to have an analysis and start putting something down--a recommendation--down on paper. Finally, this plan might also be referred to as the assessment of the project scope or the proposal. Anyway, we need to get the stuff down on paper before we finalize a recommendation. It's always prudent to even discuss with family members that this plan is a workable plan. Let the caregiver see the plan and get their input. Ask the referring agency for their recommendations. There might be financial limitations that you need to consider. Once the assessment is complete, most healthcare providers get two or three bids on the cost of the project. Also, be aware there might be multiple funding sources to complete the project. Don't forget you need to complete--you can complete a large modification plan over a period of years. Mary, do you want to finish it up?

Mary Larson: Yeah. Thanks, Brian. On slide 16, it has been my experience that a successful project involves teamwork. I think Brian alluded to this earlier in the presentation, but I like to prioritize also the list of challenges and barriers with the participant. I like to make sure the participant is fully aware of all aspects of the final plan. I also like to make sure they are comfortable with the plan and that they believe it fits their needs.

I feel like at times projects are unsuccessful when we don’t have total buy-in from not only the clients or the participants, but also the caregivers. I try to clarify with the participants that this project will be done in phases, that this is a process. It is possible that once the project is completed, they may need training to successfully utilize pieces of equipment or to access the environment properly. As far as setting expectations for the project, I think it's important to explain or describe what to expect as a timeframe, talk about what it will be like once construction is underway. Will there be like--talk about the noise and the dust and the number of people coming in and out of the home. I also like to educate the participant on what the outcome might be and any limitations that may still exist or that need to be addressed.

Available funding and costs may decide the route the participant takes. They may need to prioritize and choose one area of the home to remodel or to improve accessibility and then choose lower cost items to improve accessibility in another area, and so that more funds are available. For example, Brian talked about someone coming home from the hospital and they need a ramp, and they need a ramp to be able to get in and out of their home. That's a safety issue, and maybe they also need their bathroom remodeled. The participant may be willing to do simple low-cost changes in the bathroom for safety reasons and then choose to go with the ramp which is going to be a little bit more of an out-of-pocket expense.

I think it can be tough to manage your life during construction. Whenever possible, it might be best to look into another place to stay or at least go out as much as possible during the day when construction is taking place.

On slide 17--this slide has a list of possible modifications the participant might be considering--ramps, accessible doorways, grab bars, etcetera. As you look at this list, you might notice that all of the modifications address physical barriers. Physical barriers are often the easiest to identify, but it is important to keep in mind cognizant and visual impairments as well. Will this person have the ability to learn or remember how to use this modification? Will they be able to see all of the features of the modification and use it properly? Might they need training to learn how to use the modification? Should we consider a visual strategy such as use of contrast to define work areas and improve the ability to see? For example, if a microwave was being chosen during a kitchen remodel, consider there are some issues and look the use of contrast. Don't choose a white microwave with white buttons.

Also consider culture. I think this is really important and will the home modification interfere with any cultural beliefs? I had an example of that I'd like to share. I actually saw a woman that had two different raised toilet seats in her apartment and neither one of them were being used. It had to do with her accessibility for cleansing herself which is a cultural thing that was done and she could not do that while using a raised toilet seat. I think it's just some of those little things that maybe people aren't thinking about and they're thinking about what is the best model and what's the safest option.

On slide 18, as far as orientation of the participant and caregivers to the modifications, again Brian mentioned this earlier in the presentation a little. I don’t think we should assume that the participant or caregiver knows what to do when the project is complete. I think we need to walk through the changes that have been made with the participant and caregivers. Have them demonstrate use of that modification or equipment. Sometimes there's more than one caregiver and make sure that either of the ones you have trained is going pass that along or come back when you can connect with another caregiver and do that as well.

Bringing the project to completion is really important, so if you've been there and you've shown them how to use it but you know the equipment is difficult to deal with, with their memory and you're not 100% confident they're going to remember, refer the person on. Maybe there is a therapist that they see on a regular basis or a family member that you can train so that they can keep going through the training with them, but remember to refer them on so that they get the support that they need to be successful.

Chris, is there anything you would like to add at this point?

Chris Duff: Yeah. I'd just like to thank Brian and Mary for their presentation. It was quite interesting. I'm just going to summarize and then we can open it up to questions. In summary, modifications can and do make the difference between living in one's home or needing to move to a setting that's more restrictive or perhaps even an institutional setting--for instance, the significance and importance of the assessment and following up with the recommendations.

To be optimally effective, the care manager, assessor, or home modifier must consistently involve the participant and their caregivers, for they commonly have the best ideas for improvements. While some modifications can be quite involved and extensive, the majority are simple and low cost. If the costs are more than the help center provider or individual can support,

other sources of assistance and support can be found with some creativity on the part of everyone involved in the process.

Now, at this point, Jeff, could you open the phone lines, please?

Jeff: Ladies and gentlemen, if you'd like to ask a question please press star and then zero on your touchtone phone. You'll hear an acknowledgement tone. An operator will take your name and further instruct you. If you're using a speaker phone, please pick up the handset before pressing the numbers. Once again, if you have a question, please press star and then zero at this time. One moment please, for the first question to queue up.

Chris Duff: Thank you. Before I move into the open discussion session, I would first like to call your attention to the survey link. We very much appreciate everyone taking a minute at the end of the session to answer just a few questions to give us feedback so we can better tailor future sessions and written products. Before going to the discussion, I'd like to ask one more polling question and that is, "Does your organization have a policy to guide staff in regards to funding home modifications?" Potentially, a lot of this will end up coming down to funds and the availability of funds, so if you can give us a sense of how your organization handles that, I'd appreciate it. While you all are voting, I'm going to jump in here with a question. Brian or Mary or both, could you give an example of a modification that you worked on that involved multiple funding sources, in talking about your role as the assessor and the role of the care manager?"

Mary Larson: Now, at first I'm thinking about sometimes some of the examples that Brian brought up where someone is coming home from a hospital and maybe they already have a care manager involved with them who is calling to say, "Can you go out and assess their home, figure out what they're going to need? They're coming home in a wheelchair. They're weren't in a wheelchair before." I think again some of the quick things that maybe they were willing to offer as payment for was the ramp to into the home, maybe the raised toilet seat, and then sometimes what I like to do is come back and then the client sometimes identifies additional needs and at times they've been willing to pay for them. If they've needed a new phone, I've used the TED program so the telephone assistance program. Then also I had a gentleman recently that was able to get a computer from a local VFW who did some fundraising for him.

Chris Duff: Brian, do you have any examples?

Brian McCarthy: Well, on my side it would be, private pay is always struggling to come up with the funds for modification. Some families just don't have the couple of thousand dollars that it might take to do what needs to happen. There are a lot of neighborhood organizations like the Neighborhood Revitalization program or the Center for Energy and Environment. That's the one fund insured by the federal government that very rarely is tapped into. If you can be able to offer some of these funding ideas to a private funds situation, it's very helpful. Yes. I see that quite often.

Chris Duff: I think there is no shortage of creativity here. I note that just a couple of days ago a former client of mine sent me an email--actually his last email--so a lot of people I'm sure asking for financial assistance to repair his van. I think it's just creativity. You look at their lives. Look

at who's in their lives. Look at how it affects the community and see how you can pull in those people who are in your lives to assist in the process.

Let's go back to the polling question, if we could, and look at the answer. Again, most of you are not currently responsible for those assessments. What I'm really very pleased to see is that those of you who are involved, you do fund some of your modifications, but that your decisions are being made on a case-by-case basis. I think that's very important. As we say throughout this, every component of healthcare, you need to look at the individual, their needed context, in order to make a decision about what's best for them. Most state programs that are able to fund waivers, are able to fund home modification through waivers, may have a lifetime limit or an annual limit or whatever, and of course you need to live within the limitations of the program you operate within, but also even within those limitations, you can be creative--creative in terms of prioritization and so on.

One example of creativity is a gentleman who I worked with many years ago, and he had progressed to the point to where he needed a scooter in order to access the community. The problem is that he didn't want the scooter in his house. That was kind of difficult. We lived in a northern state--cold most of the year or good portions of the year. We could've put a ramp in the house--in front of the house--and he could've kept the scooter either in the hallway or in his living room or wherever. That wasn't his preference but if that was what was needed, that was fine.

Once we sent them out to the house, it became clear, just because of the layout of house on that plot of land that a ramp would've had to kind of wind around the side of the house and would've been quite expensive to have that. I think it was somewhere in the range of $8,000. Instead what the consumer suggested and as we researched it, we proceeded with is we purchased a shed--a shed that was on footers so it was on the ground and so therefore it frost-protected. It also was secure so the scooter would not be stolen, but it was in his yard, and so therefore the scooter did not sit in the middle of his living room. He was able to secure the scooter for his use once outside of home, and that met his needs, and that was best for him. I think that really that's just an example of how you need to step back and look at individually what works for different individuals.

Jeff, did you have someone on the line?

Jeff: Not at this moment, but as a reminder, once again, if you have a question, please press star and then zero. If you've already given your name to an operator then please press star and then one.

Chris Duff: Brian, why don't we take one of the questions that were submitted? Can you talk a bit about the different kinds of ramps and from built to temporary to modular, ramps outside doors and garages, whatever? Can you just kind of give a sense of the type of range of ramps that people can consider?

Brian McCarthy: Yeah, I sure can, Chris. A lot of the times we're just going to need a temporary ramp--under six months, let's say. If the homeowner can get by with a metal ramp that they can

rent for six months and return, that's ideal. However, that's not always the case and in Minnesota here, the ramps that--mostly put up are wood and green treated lumber that sits on the ground. They have a process now where ramps don't need to be set in footings, and so they don't need to be cemented into the ground. They can kind of, what they say, float on the soil. We do a lot of wood ramps as well. Also being here in Minnesota, we try to get ramps into the garages, if possible. Why? Because there's only one or two steps into the service door of the garage. If you have a two-car garage, obviously, you're going to give up one of the spaces for the ramp, but on the flip side, if the wind is roaring and the snow is coming down, it's pretty nice to be able to drive your van into the garage, close the door, and have the time to get out of the thing and onto the ramp and into the house. When it's a little more warm or tempered, you it can always go shut.

I've also seen people concerned about ramps in their front yard, as maybe a--so we can look as there's an older person in the house who really can barely leave, so in looking at it, it could be a chance to break into the house, per se. A lot of times we'll sort of hide a lot more of these ramps into the garage just so they're not exposed to the front yard and all of the people around.

Chris Duff: Thank you, Brian. I appreciate it. We have a question here from Martha from Inland Empire Health Plan, and actually we had that from a couple of people--is how do you handle rental apartments who need modification? I think it really boils down to a couple of things. One is if--the question is, if the person does not own their own place that's being modified, what are the things you need to consider? Then secondly, if they're going into a shared living setting or assisted living, what is the line between what the individual is responsible for and what is the landlord or owner of that residential setting responsible for? Brian, why don't you take a first shot at that and then, Mary, if you could fill in?

Mary Larson: Okay.

Brian McCarthy: I've seen it go both ways, where--you know, obviously, if it's a rental apartment, you need a letter from the landlord stating that you can put a ramp in the front yard or stating that you can put a door opener on the front door. As far as financing goes, I've seen it kind of go both ways, where they might split the cost with the landlord. If that didn't happen, a lot of times the state or the labor program will up the entire cost of the door opener. Yeah. That's kind of what I know.

Chris Duff: Mary, what's your experience?

Mary Larson: My experience has been that usually people want their tenants to be safe and they don't want them to have injury while they're in their building. I just feel like when I have been in a situation where someone lives in assisted living or a rental apartment that if I go down and talk to the building manager and explain with the permission of the purchase plan, of course, but explain what it is we're thinking about and the possibility of it. Then I feel like there is some negotiation that starts to occur between the participant and the building manager and if there's a care manager involved, and somehow it's worked out and it's decided who is going to pay for what. Certainly, so I had one example where there was someone that did not have a toilet that met ABA requirements, and the building manager was totally--took responsibility for changing

that out to a higher toilet. This was a unit that was something that was needing to be done anyway in this building. That's kind of some of what I know.

Chris Duff: Mary, that's a great example of so much that is just simply getting engaged with people and seeing how they can help out. It's just doing the asking, and so that's a great example of that flexibility. Maybe you could each answer this question, and that is, "Do home assessors need to be certified and, if so, what qualifications? I know each of you do some home modifications, so if you could each kind of talk about what you know about certification and then about your background.

Mary Larson: Do you want to go ahead, Brian?

Brian McCarthy: Okay. You know my background and my only certification that I have is CAPs--a certified agent in place, and that's just a certification. It's not a license, but it's a great core step. They keep updating their analogy of different tricks of home modifications. Chris, I can't bring out the correct term. Sorry.

Chris Duff: I think what you're saying that there really is no national certification for home assessors. I think some people--and I think Brian's training that he's gotten is really focused on aging and place and is there anything to look for. Mary, in your work, those OTs and PTs are trained very broadly. Is there specific training within those disciplines that you think is of particular importance to this subject?

Mary Larson: There are a few things. I think that a therapist who is used to working in the home or the community's financial setting is more skilled at really looking at what the person needs and having them demonstrate for them how they're doing it now. When you're in a clinic setting, it's mainly their education. It's just their experience within a clinic setting so they don't have the opportunity to see that person functioning in their home. Sometimes I feel like experience is good to be looking at and I certainly feel that if anybody has any extra certifications or experience with the vision or cognitive issues, there is assistive technology professionals which someone can have that certification and then be an OT, a speech therapist. They can be a number of different people, but they are familiar with how to set up assisted technology and home access, that sort of thing.

There are a number of different professions out there that do a variety of things, but I don't know if there's any specific certification to home modification.

Chris Duff: I think if I were not knowing kind of where to start, I would call my local Center for Independent Living or the Triple-A or the Health and Disability Research Center in your area. They would have written names of people who could help with this and would have some expertise. Similarly, a question came in from Becky about being in a rural setting. "How do you find competent and specialized providers to do a home modification? What's important--and I think, Brian, I know sometimes when you look--I know sometimes when you work with waivers, you need to get three bids. What do you look for in accepting a bid from a contractor? First of all, how do you find good contractors, and secondly, what do you look for as minimum qualifications for the contractors?

Brian McCarthy: As you know, I am probably one of the contractors that are bidding on the project, so I'm against the two other contractors. Because it's a rural setting, that's tough. You're out in the middle of nowhere. I would just contact a lead builder in the area that has a good reputation and you might have to work through the project kind of slowly and thoughtfully and get creative. I think doing home modifications--it's all about creativity and developing the space. You know, it's not a cookie-cutter type of real model. It's taking out a floor, removing toilet bowls--kind of a strange remodel we've worked. I was just thinking you go for the best builder that you can get regarding being out in the country.

Chris Duff: Mary, do you have anything to add on that?

Mary Larson: I have had the opportunity the past year to work with a company that actually has a grant in the state of Minnesota and their mission is to go out and assess people in rural Minnesota and their adaptive equipment needs, and that's been really exciting because I've never seen anything like that before. Anymore it's really hard out there to find people who can do that work and then do the training and follow-up after.

Chris Duff: That's interesting. If people want any further information on that, Mary's email is on one of the other slides here. You can follow up with her and she can put you in connection with them. I think my only answer to it--my only addition would be to go back to those Centers for Independent Living and Triple-A. They are the ones who have their feet on the ground in the community. A lot of this is word of mouth. It's the same thing that we would look for as we're trying to have some work done in our homes. I think licensed and bonded is certainly something we would look for in any contractor we would work with. I think a similar mindset would be used here.

Another question came from Nancy M. and that is an interesting matter. "Due to response, I'm aware of Standard Glides being sold on the Internet secondhand. Are you aware whether these are easy to reinstall in another home and whether people have had good luck doing this?" First of all, it's a question about Standard Glides and their ability to apply in different homes. Then secondly, it's about accessing used equipment--are there major concerns with that?

Brian McCarthy: Chris, I have heard of people doing that, but I don't know if you're buying some realistic problems. Obviously, a Standard Glide can range in price from $3,000 to $8,000 depending on the landings and the turns and this kind of stuff. If it was a straight run that might be workable, but when there's a turn or a landing, most of those stair lifts are manufactured down to that exact space, down to the eighth of an inch to micro inch. It would be so nice--and I think you could do it with a straight run, but I think it would be hard to fit an old one in a house with an angled staircase.

Chris Duff: I think what Brian is--what you're saying, Brian, is total staircase, of course, that would not have crossed my mind--what that points to is I think you would want to find someone who can install willfully, who will help you research the product before you purchase it, someone with some expertise, whether it's a local supplier of that actual Standard Glide product

or whether it's a contractor such as Brian who has done installations of Standard Glide. I'd want to make sure I get an expert before proceeding with the purchase of anything for that purpose.

Brian McCarthy: An interesting point on that is I'm a general contractor. I have a general contractor's license. I have several contractors that work for me to install lifts, because there's a whole separate license. You need an elevator license to install a stairwell, and that's a license that I don't have. It may be tricky to get an installer that's licensed to put in a used piece of equipment.

Chris Duff: That makes sense. That's great. Before I ask the last question--our time is winding up here--so I just wanted to take a minute to review the resources we have listed on a latter slide here. I believe it's slide 24. These are some resources that are readily available to everyone. They are really more along the lines of checklists and so on. First, I would just focus on safety, because a lot of the assessments that are being done are, first of all, mostly focused on safety. That's like step one of the whole modification. These are some references. One of these, in particular, is really quite long and involved, but by at least going through it, you'll get a sense--and I believe that's the third one there--you'll get a sense of what's involved in doing this kind of work. I would encourage you to spend some time with those resources.

In closing here, we would like to solicit your opinion on this series, as well as past webinars and supplemental resources. Please take the time to complete our survey at the end of the webinar and send us your ideas for future topics and content. Contact information is listed on one of the latter slides.

With that, I'm going to ask one more question that has come in, and that is related to the idea of modifications to meet the unique needs of the individual. "Are there situations where a client's choice about aesthetics is allowed? This is especially when you're looking at externally funding such as a waiver. If so, is the client responsible for any additional costs to get a certain look or style, or are they limited by just what's being recommended by the assessor?" Both Brian and Mary, if you could quickly comment on that, I'd appreciate it.

Brian McCarthy: In my situation up here in Minnesota, we have a few of the big box stores that are insuring (inaudible) and my material that I buy--my tile, my paint, and my faucets--I usually can get anything down the middle of the road and priced accordingly middle of the road regarding these box stores. However, if I do have a client that wants a fancy tile and tile can go for $40 a square foot. Obviously, I just would let the client pay that above and beyond the waiver. That doesn't happen all that often, but I give my clients a little bit of a leeway to buy what they want. Most of my clients will leave me in charge of picking out tiles and faucets, but if they are ever interested in getting involved, yes, they can go and pick it out and if there's enough charge--you know, we charge accordingly.

Mary Larson: Yeah. For me, my feedback would just be, if there is something that they need a certain one because of vision or something like that--if there is a justification, I will try and explain it to whoever is paying.

Chris Duff: Thanks, Mary. Thank you, Mary and Brian for your presentation today. We look forward to continuing our work this year to support plans and providers, mainly people with disabilities. Next week, we'll resume this series. Our topic will be focusing on establishing the relationships between community-based organizations such as the Centers for Independent Living and Triple-A, and health plans--partnering to build a partnership between the two. Thanks everyone for your attendance today and we look forward to having you involved next week. Thank you.

Jeff: That does conclude our conference for today. Thank you for your participation and for using AT&T Executive Teleconference service. You may now disconnect.