Show Me Options

Aging and Disability Resource Center of Northwest Missouri

Module 3

Roles and Functions

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Review of Purpose and Values

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Purpose & Values

What is Show Me Options about?

Streamlining hospital discharge-planning so that older adults and people with disabilities can stay in the community...

Providing comprehensive information and referral to help older adults, people with disabilities, and their caregivers make informed choices about community care options...

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Purpose & Values

Challenges & Problems

Long-term Care

- Rapidly aging population
- Mushrooming cost of long-term care
- Lack of access to information and services

Hospital Discharge Planning

- Existing system does not prepare discharge planners to support patients, their families & caregivers in making informed choices regarding post-hospitalization care needs
- Too many avoidable re-admittances due to lack of HCBS

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Purpose & Values

Values & Goals of ADRC

Values

- Person-centeredness
- Informed Choices
- Better Access to Long-term Community Supports

Goals

- Creating Awareness & Information of LTC Options
- Opening Access to LTC Services and Programs
- Providing Assistance

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Roles & Functions

Vision

The creation of a single, coordinated system of information and access for all persons seeking long term support services. Such centers will be highly visible and trusted places where people of all incomes, ages and disabilities can turn for information on the full range of long term support options, public and private.

Centers for Medicare and Medicaid Services (2003)

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Roles & Functions

Missouri's ADRC System: Operations

Continuum of Support:

» Public Education

» I & R/A

» Options Consulting

}

- Responds appropriately to needs
- Flexible – not pre-determined
- Will grow in time

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Organizational Structure

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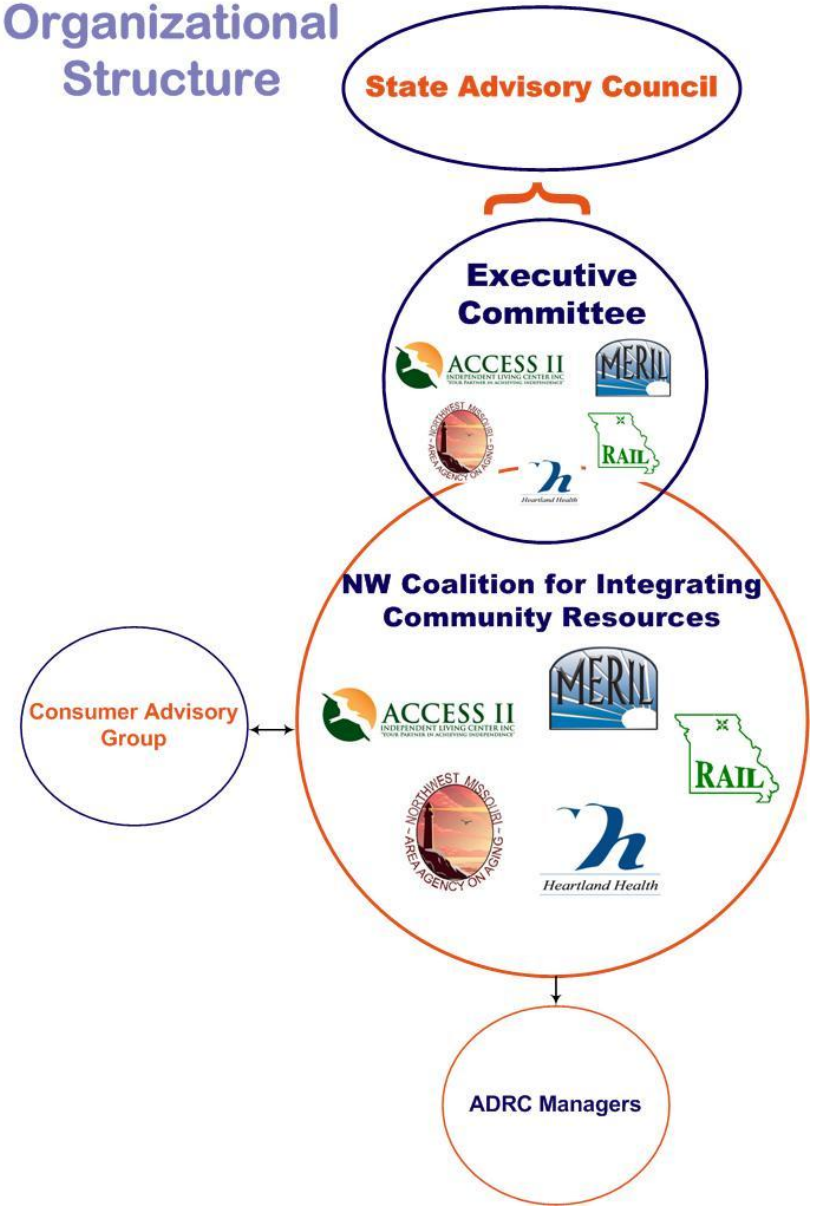
Organizational Structure



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Organizational Structure

Executive Committee

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Organizational Structure

Northwest Coalition

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Organizational Structure

Other Elements

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Other Elements

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Other Elements

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Organizational Structure

Questions?

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The Art of Options Consulting

Training for Show Me Options staff
who support individuals and families
in decision making

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The Art of Options Consulting

Learning Objectives

- Have a working understanding of the term Options Consulting (OC) and how it is different from information, referral, and assistance;
- Understand the components and core competencies of OC;
- Learn how to identify consumers in need of decision support and what level of support is needed;
- Learn principles of self-determination and strategies for supporting it;
- Understand resources and networking skills needed to locate services and information for consumers.

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The Art of Options Consulting

3 Primary Functions of Show Me Options Staff:

- Basic I & R/A
  - ✓ Options Consulting
  - ✓ Public Education

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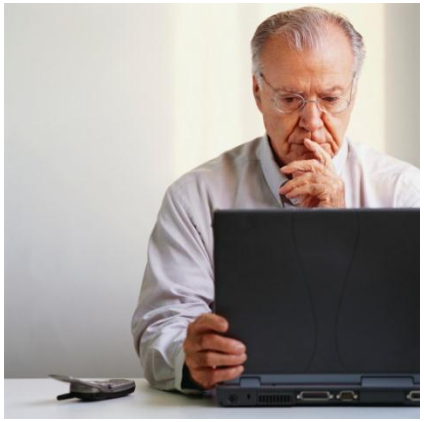
Basic I & R/A

- Entry Points:

- Call to toll-free #
- Call to CIL or AAA
- Visit to office
- Email
- Website hit



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Basic I & R/A

- Need/request fulfilled immediately…

  - ✓ Warm transfer if possible
  - ✓ Record Show Me Options activity as directed by your organization

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Basic I & R/A

- Request cannot be dealt with immediately…
  - ✓ Begin OC at the organization that took the call
  - ✓ Refer to a partnering organization for OC
  - ✓ Refer to a non-partnering organization

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The Art of Options Consulting

What is Options Consulting?

- Defining OC
- Understanding the value of OC for our consumers

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Defining OC

- Long-Term support Options Consulting is an interactive decision-support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer's needs, preferences, values, and individual circumstances.

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Options Consulting is the "value added" for ADRCs

The Lewin Group (2009)

The Art of Options Consulting

Value of Options Consulting

- **Issue:**
  - ✓ People need access to community-based options

- **Show Me Options Solution:**
  - ✓ One call or click connects people to a range of options and the opportunity for decision support

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Value of Options Consulting

- **Issue:**
  - ✓ Information can be overwhelming and confusing.

- **Show Me Options Solution:**
  - ✓ Options Consultants can help individuals and families identify, sort through, and evaluate options.

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Value of Options Consulting

- **Issue:**
  - ✓ Few people plan ahead for long term support needs.

- **Show Me Options Solution:**
  - ✓ Options Consultants assist people in assessing current and future needs and considering the short and long-term outcomes of their decisions.

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Decision Support

Individualized support helps people make informed choices

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Decision Support

Information

=

Knowledge?

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Decision Support

INFORMATION +

EDUCATION +

PERSONAL EXPERIENCE

= KNOWLEDGE

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Decision Support

- Building Blocks of Decision Support:
  - ✓ Firm foundation in quality information and referral/assistance
  - ✓ Elements from the aging network
  - ✓ Elements from the disability network
  - ✓ Tools to assist families in decision making
  - ✓ Learning through practice and experience

The Lewin Group (2009)

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Where does OC happen?

- **In person (face-to-face)**
- **Home visit**
- **Over the phone**
- **Online**
- **In the hospital**

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When does OC happen?

Individual or Family Situations

- ✓ An individual has immediate or short range care needs
- ✓ A family caregiver needs help
- ✓ An individual is leaving the hospital or nursing facility
- ✓ A young adult with a disability is transitioning from a school-based system to the adult service system

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When does OC happen? (Cont'd)

System flow

- ✓ During I&R
- ✓ During benefits counseling
- ✓ During an assessment of need
- ✓ When applying for publicly funded benefits
- ✓ While waiting on an application to be processed
- ✓ After applying unsuccessfully for public programs
- ✓ As part of hospital discharge planning
- ✓ After admission to a long-term care facility
- ✓ As part of nursing facility transition

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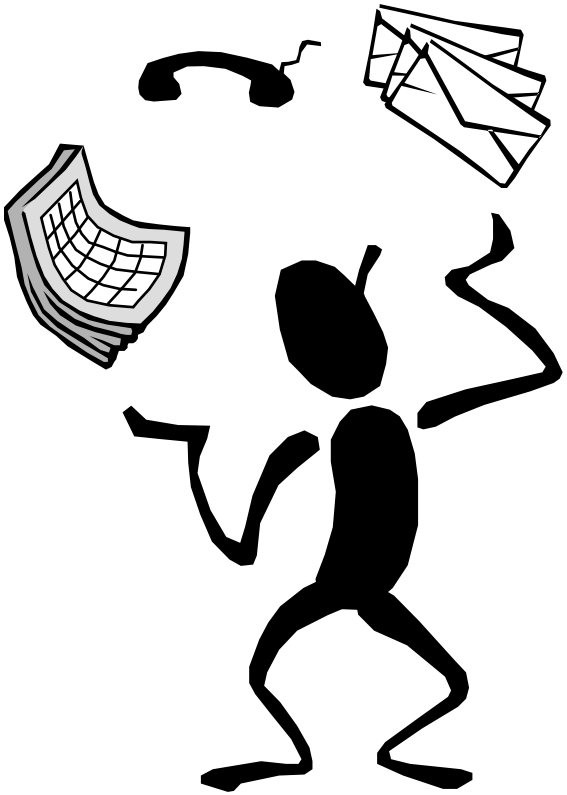
Core Competencies of Options Consulting

- Skills Sets Needed by Options Counselors



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6 Key Skills

1. **Determine the need for OC**
2. **Assess needs, values, preferences and risks**
3. **Understand public and private sector resources**
4. **Demonstrate respect for self-determination**
5. **Encourage future orientation**
6. **Follow-up**

ACTIVE LISTENING SKILLS

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#1: Determine the Need for OC

- During the initial contact with Show Me Options, staff determine if OC is appropriate

✓ Listen for verbal cues

✓ Ask what the person is hoping for from this call/visit

✓ Ask if they want help making difficult decisions

The Lewin Group (2009)

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Example Cues from Consumers

"Maybe I…"

"I'm not sure…"

"Where do I…"

"I don't know…"

"I can't…"

"Someone told me I need…"

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Needs, Values, Preferences

How to Determine???

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Individual and Family Needs

- If decision support is requested, find out about..
  - ✓Demographics (name, address, phone number, age)
  - ✓Physical and/or mental needs
  - ✓Support System (family, friends, neighbors, etc.)
  - ✓What is important to the individual?

- Decide how you will gather additional information and begin to form relationship with individual and family
  - ✓Introductory phone call
  - ✓Home visit
  - ✓You may have to “dose” information and support

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Risk Assessment

- Who
- When
- How

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#2: Assess Needs, Values, Preferences, & Risks

1. Intake form
2. Needs assessment/narrative
3. Risk Assessment if necessary at any point in the process

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#3: Understand Public and Private Sector Resources

- Staff must have working knowledge about resources beyond public programs (e.g. private services, community resources)

Your organization's database/directory

Show Me Options database

Your mental file

Your partnerships with other entities/professionals

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#3: Understand Public and Private Sector Resources Cont'd

- Options consultants must be prepared for situations in which there does not seem to be a resource to meet the needs expressed

> ***"Just because you don't link someone with a service, does not mean you have not done them a service"***

http://www.oregon.gov/DHS/spwpd/sua/docs/tae-art-opt.pdf?ga=t

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#3: Understand Public and Private Sector Resources Cont'd

- Conduct outreach to local organizations and agencies:
  - ✓ Initiate potential partnerships with them
  - ✓ Add their offerings to your database, for example:
    - Financial planners
    - Elder law
    - Transportation services
    - In-home services

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#4: Demonstrate Respect for Self-Determination

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#4: Demonstrate Respect for Self-Determination

- "Self-determination is a process that differs from person to person according to what each individual determines is necessary and desirable to create a satisfying and personally meaningful *life.*"

NACDD (2011)

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Self-Determination

Self-Determination

Better employment outcomes
Independent living
Quality of life

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Self-Determine in Practice

Principles

- **Freedom. . . . to plan a real life**
- **Authority. . . . over your resources**
- **Support. . . . for building a life in your community**
- **Responsibility. . . . to give back to your community**

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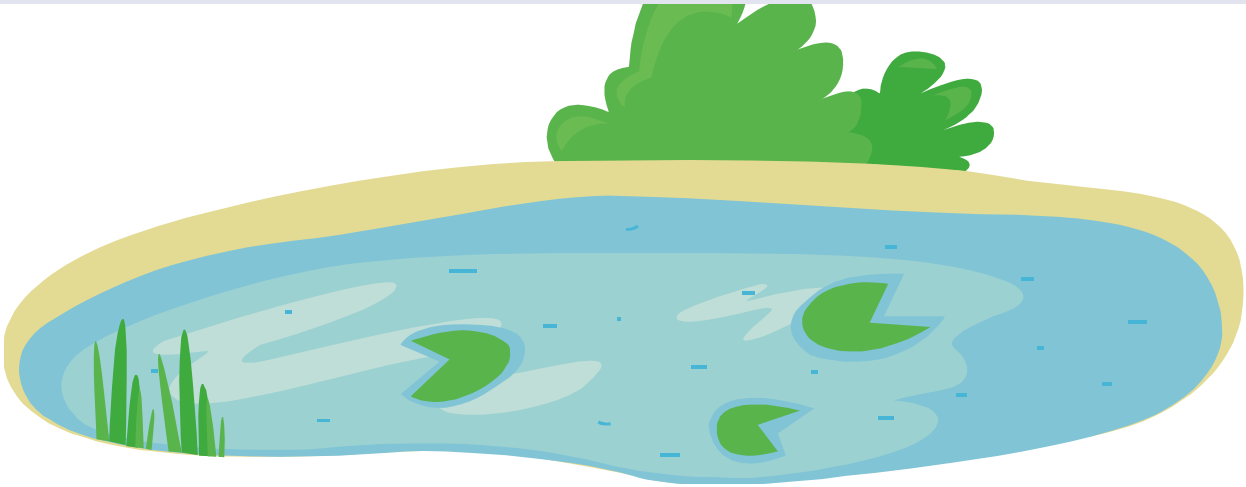
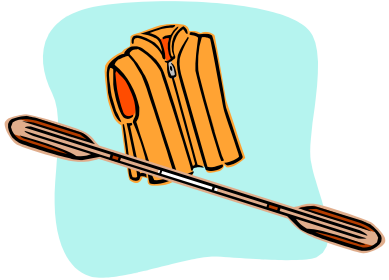
Process?





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#4: Demonstrate Respect for Self-Determination

- Help people explore, define, and weigh their own pros and cons.
- Consider individual circumstances.
- Get people to name and own their goals and action steps.
- Connect to services once an informed choice is made by the individual.

NACDD (2011)

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#4: Determine Respect for Self-Determination

- Pros and Cons are Highly Individual!

✓ Let's discuss the resource choices you have – what would you like to start with first?

✓ Can we compare the different options for this?

✓ What might be some good outcomes if you made this choice? What downside could you see?

✓ You've said that (x) is important to you. Are there some options here that would help with (x)?

✓ Which choice makes the most sense to you? Why?

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The Action Plan

- Goals
- Concrete Steps
- Who is Responsible

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Self-Determination and the Action Plan

- Where would you like to start?
- What are your first priorities?
- What are the first steps for each priority?
- What, if any, support will you need to get these done?
- Who could provide support?
- Can I call you back to follow up on whether these steps worked?
- Is it ok if I leave a message with someone else at your home?

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Self-Determination Role

Role Play:
Emma and Trish

NRCSLC (n.d.)

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#4: Demonstrate Respect for Self-Determination

- What are the central issues?
- What communication skills were helpful and why?
- What resources and approaches to sharing resource information were helpful?
- What challenges exist for the OC?
- How were the principles of self-determination honored?

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#5: Encourage Future Orientation

- Look beyond immediate needs by encouraging individuals to proactively consider future possibilities, and outcomes of decisions

- Reach out to family caregivers (especially adult children) in helping them anticipate and plan their future needs

NACDD (2011)

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#6: Follow-Up

Follow-up serves a critical role in assessing the usefulness of services as well as strengthening the individual's relationship with Show Me Options.

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Active Listening Techniques, and Practices

- Paraphrase, reflect and ask open and closed-ended questions
- Articulate, clarify and challenge assumptions
- Understand that people may not know what they want or need
- Take time to listen
- Evaluate pros and cons

ADRC (2009)

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Key Questions to Ask

	Yourself	Individual/Family
Feelings	What bias do I bring? Do I have a strong opinion about what they should do?	Where are they in their ability or willingness to make a decision? Are they anxious or laid back?
Knowledge	Do I have a handle on all of the potential resources in the community that may be useful to this family? Who else should I consult for ideas?	What information have they received already? How much information can they handle right now? What do they see as options?
Skills	What clinical skills are **most** important in this situation? (empathy, creativity, motivational interviewing)	What strategies have they already tried? How likely are they to follow-up after discussions?

Lewin (2009)

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A PERFECT WORLD?

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Not So Perfect?

A ***Not*** So Perfect World

How can you still do Options Consulting?

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Family Profile:

June, Maria, Malcolm, and Marty

See Handout 8

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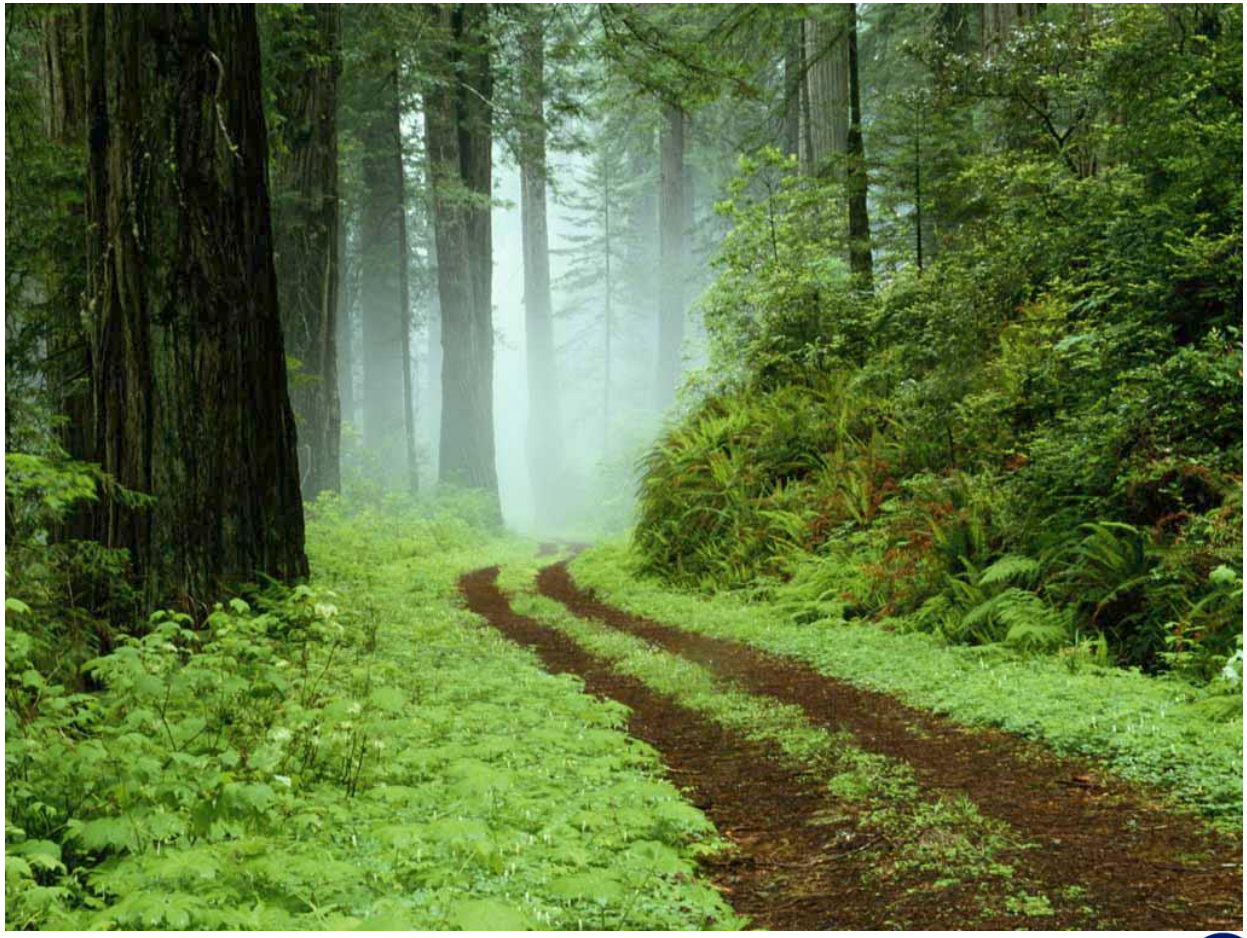
Our job is to give people the tools they need to choose the right path for themselves…



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Public Education

- Who
- Why
- How

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Social Marketing

Strategies:

- Advertising
- Public Relations
- Media Advocacy

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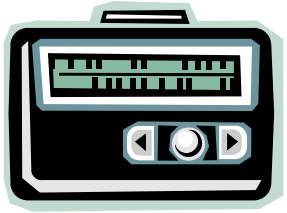
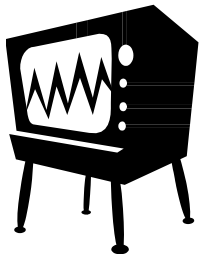
Social Marketing

Tools:

- Websites
- Brochures
- Presentations
- Health fairs
- Radio
- TV ads
- Billboards
- Newsletters





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Social Marketing

Critical Pathways

- Hospitals
- Physicians
- Other healthcare professionals
- Service providers
- Satisfied participants

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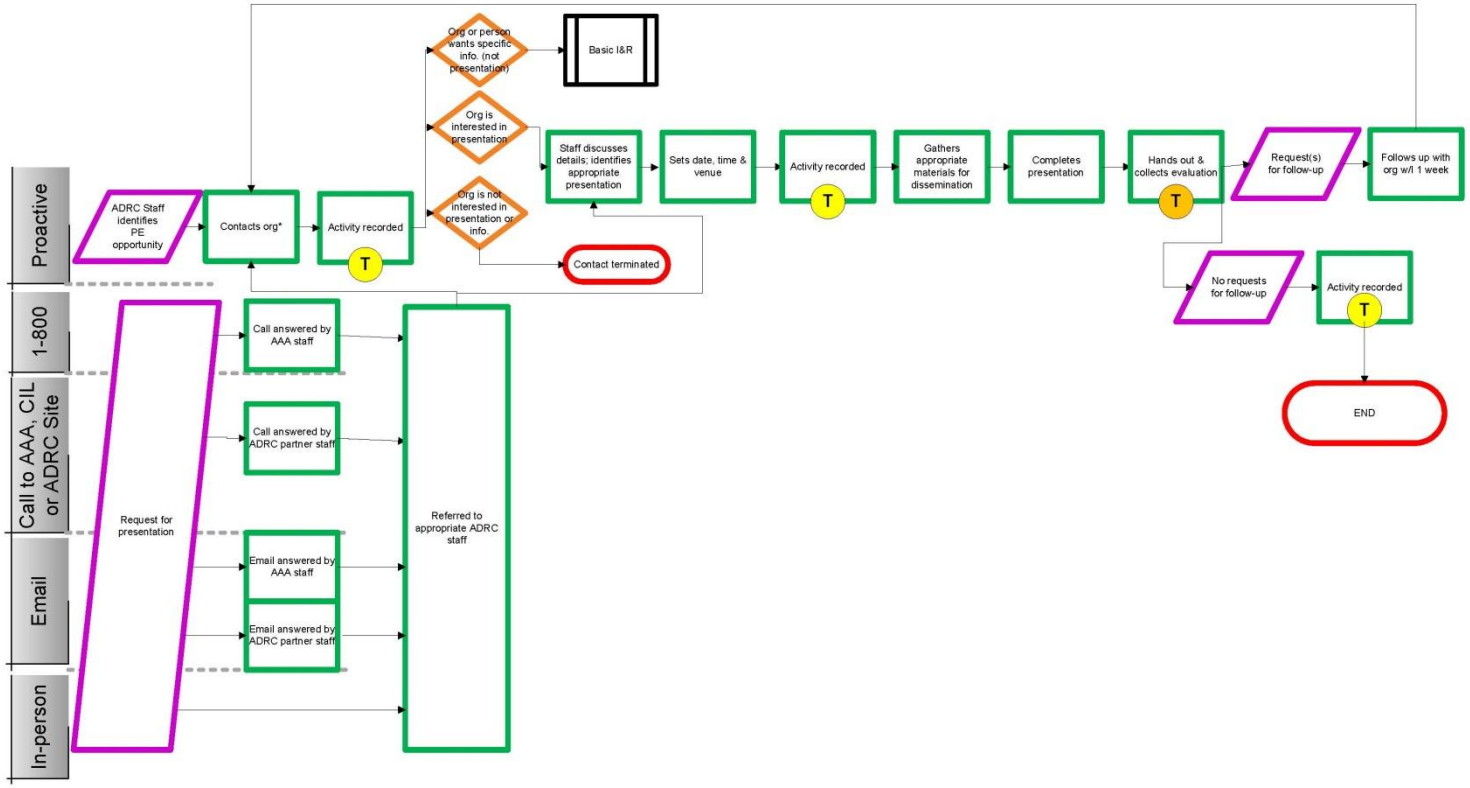
Activities: Public Education



Notes:

*Contact is telephone-to-telephone, or email-to-email, unless otherwise requested.

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Limits and Boundaries for Options Consultants

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Limits and Boundaries

What Options Consultants are NOT

- Therapists
  - ✓ Remember you are not there to do counseling of any sort; only there to disseminate information and facilitate conversations. Avoid getting too involved with feelings and any advice giving.
- Attorneys or other Legal Experts
  - ✓ Even if you believe you know the answers avoid giving legal advice or recommendations. Again remember this is not your job!
- Medical Advisers
  - ✓ Any direct medical questions about ones health should not be directly tackled. Medical advice is not our area of expertise in this position. It's all about providing information and the facts. Forget your desires to give advice even if you think you may know these answers.
- Prescriptive
  - ✓ (Telling people what exactly to do.)

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Limits and Boundaries

What Options Consultants ARE

- Resource Information Providers
  - ✓ Provide information from objective sources or ways for the individual to evaluate.
  - ✓ Provide info about sources of "quality ratings" of specific options, e.g., CMS report card or DMH information about community providers.
  - ✓ Provide a checklist to consumers with objective criteria for evaluating options.
- Facilitators of the Decision Making process
  - ✓ Objective and non aligning to any specific outcome.

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Limits and Boundaries

Be careful!

- Of Recommendations
  - ✓Avoid any appearance of endorsement, e.g., pens, business cards, or other promotional materials from specific agencies that we might receive from various health fairs, etc.
  - ✓***Instead give clear descriptions of all options and allow individuals to evaluate.

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Limits and Boundaries

Emotional Issues

- ******Avoid emotional involvement******
  - ✓ Be wary of your own feelings and how you are handling the situation.
  - ✓ If you feel yourself becoming too involved stop and remind yourself that these decisions are about them. Look at what they need outside of your own needs and remember why they are there.
  - ✓ If the situation permits it, you can also call someone in the central office to discuss what's going on and some options of handling it.
- Remember to be friendly, but not a friend
  - ✓ Does not mean you do not care, but important to avoid personal involvement
    - E.g., provide info about interviewing a possible community provider, and even info about transportation; but should not go with people to interviews or conduct interviews for them
- Be Open & honest
- Your relationship with individuals is a professional relationship, not a personal relationship

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Limits and Boundaries

Relationship Boundaries

- Always gauge your objectivity

- Do not make the relationship more personal than it should be (i.e. Having lunch with those you are consulting or other activities that may change the dynamic of your position as an options consultant)

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Limits and Boundaries

Privacy and Confidentiality

- Assure and respect privacy when meeting, talking, or planning with individuals
  - ✓ Environmental concerns and protections
    - Saying things that might be overheard by others in any public setting.
    - Any talks of this nature need to be done in a safe and private setting to ensure the confidentiality of those we are aiding. (This also holds true for inside our own offices; always be alert to who is around when things are said, i.e. having conversations on the office phone that may be overheard by others.)
  - ✓ Personal protections
    - Making sure personal identify is protected for the personal safety of those involved.

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Limits and Boundaries

Confidentiality

- In simple terms: “The non-disclosure of certain private information about others except to another authorized person.”
- What is discussed with individuals should not be shared or discussed with others

- ***Be careful in assuming family members, friends, etc. know certain information about those you are aiding. Perhaps they do not know. Always tip-toe on the side of caution. Bottom line: Never Assume!***

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Limits and Boundaries

Example #1

- Consultant learns through a conversation that the person served (client/consumer) was a victim of a scam that robbed her of most of her savings. She is ashamed and doesn't want anyone to know about it. Client's daughter visits consultant with concerns over her distraught Mother, thinking that she need medication or placement. Daughter has no idea that her Mother has been the victim of a scam and is wondering if her Mother needs medication or hospitalization.

✓ Action?

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Limits and Boundaries

Example #2

- Grandmother ran up huge credit card debt raising her grandchildren. She successfully kept it from her husband, but debt collectors are starting to contact her at home. Grandmother is convinced that her husband will leave her if he finds out. The couple visits consultant to explore ways to meet prescription costs, but husband is very confused why they don't have enough money for the medications. Tension in the room is huge.

  ✓ Action?

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Limits and Boundaries

Example #3

- Person served visits Consultant to find ways to pay for medications. Consultant learns that client is purchasing narcotics from more than one pharmacy. Consultant knows that the client has signed an agreement at the pain clinic, not to obtain medication at more than one provider.

  ✓ Action?

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Limits and Boundaries

Example #4

- Consultant is having lunch at a busy restaurant with a colleague that is sharing concerns about a person that you both serve. This colleague is a highly respected professional in the community, and you would like to work for the organization that he represents. You rationalize the conversation because he is not using the client's name even though you are feeling uncomfortable.

  ✓ Action?

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Limits and Boundaries

Example #5

- You and a close friend work for the same organization; the colleague has parents that are using the agency's services for Prescription Drug Coverage. The colleague is a nurse, and asks you for a list of her parent's medications.

  ✓ Action?

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Limits and Boundaries

Example #6

- Person that you are serving shared information about her troubled family relationships. The consultant thinks that the spouse is aware of this information, but isn't sure. The couple arrives at the office, what action does the consultant take to ensure that information will not cause dis-comfort and/or harm the family or professional relationship?

  ✓ Action?

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Limits and Boundaries

What have we learned?

- Options Consultants are there to provide information and facilitate discussions, not to give advice and/or recommendations.
- Options Consultants are to maintain proper boundaries and avoid emotional involvement where their judgment might be clouded. (Remember what you can do if you feel this happening.)
- Remember to ensure the confidentiality and privacy of those we are aiding. Also remember to not assume that certain people know specifics about a situation. Always be cautious!
- Always be aware of your surroundings when the issues of those you are aiding are being discussed.
- Lastly…. be open, honest, & friendly!

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Show Me Options Operations

Nuts & Bolts of Making Show Me Options Work

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Show Me Options Operations

Options Consulting Activities

3 primary functions of Show Me Options staff:

- Basic I & R/A
- Options Consulting
- Public Education

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Options Consulting Activities

Protocol Maps:

- Provide direction for Show Me Options' activities
- Ensure standards for Show Me Options' activities
- Make referrals from Show Me Options' agencies more seamless

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Protocol Maps

Main Elements

= Pathways into Show Me Options

= Data in; what initiates an action

= Specific action taken

= Decision needed

= End of activity

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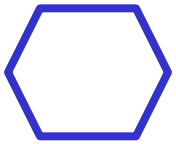
Other Elements

= Another SMO activity interfaces with current activity



= Specific skill needed

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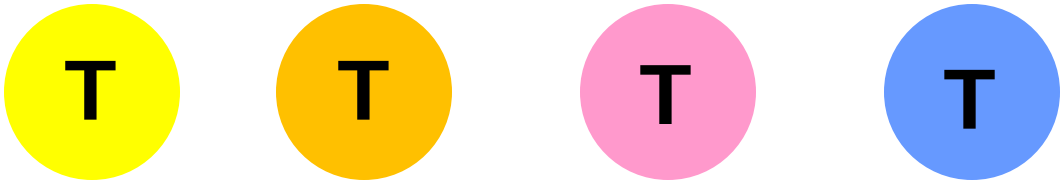
Protocol Maps

Tools



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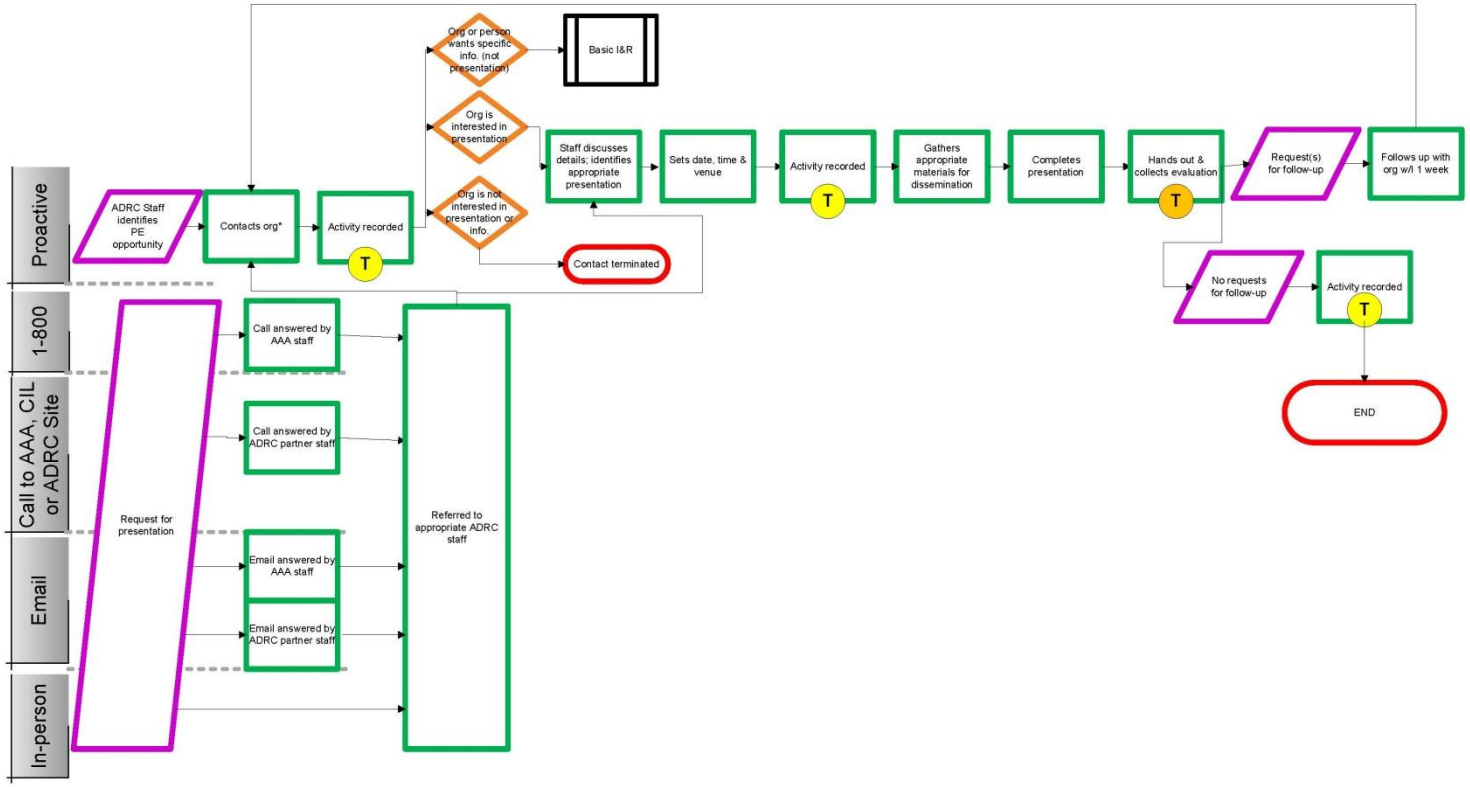
Activities: Public Education



Notes:

*Contact is telephone-to-telephone, or email-to-email, unless otherwise requested.

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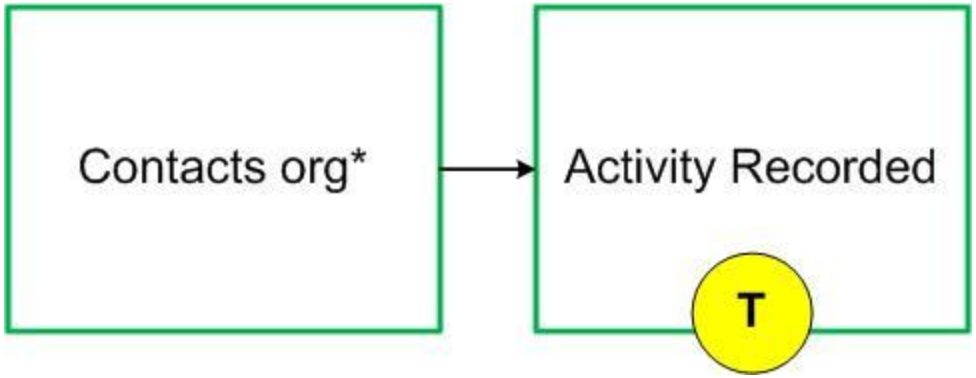
Public Education Map



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Public Education Map

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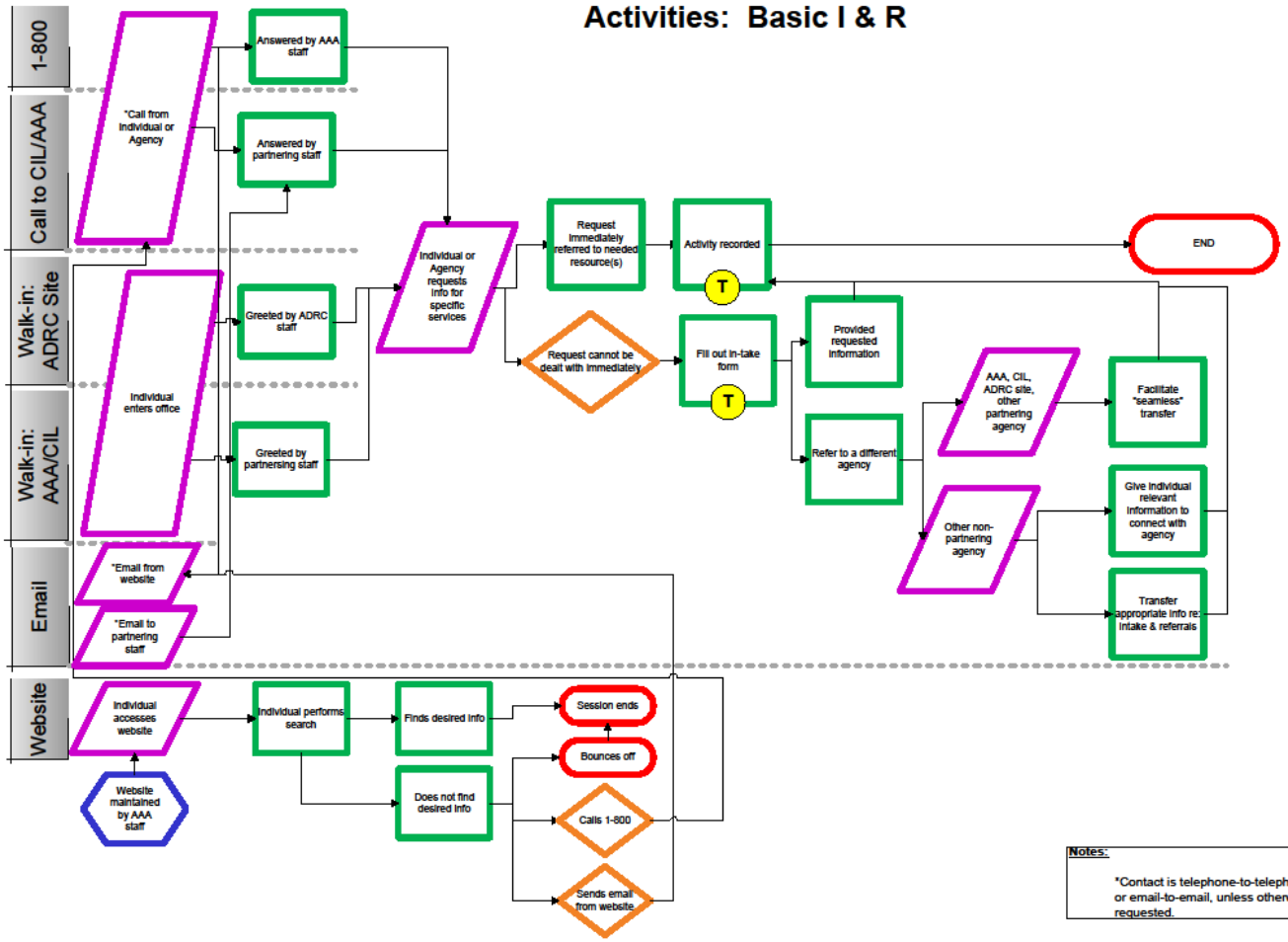
Activities: Basic I & R



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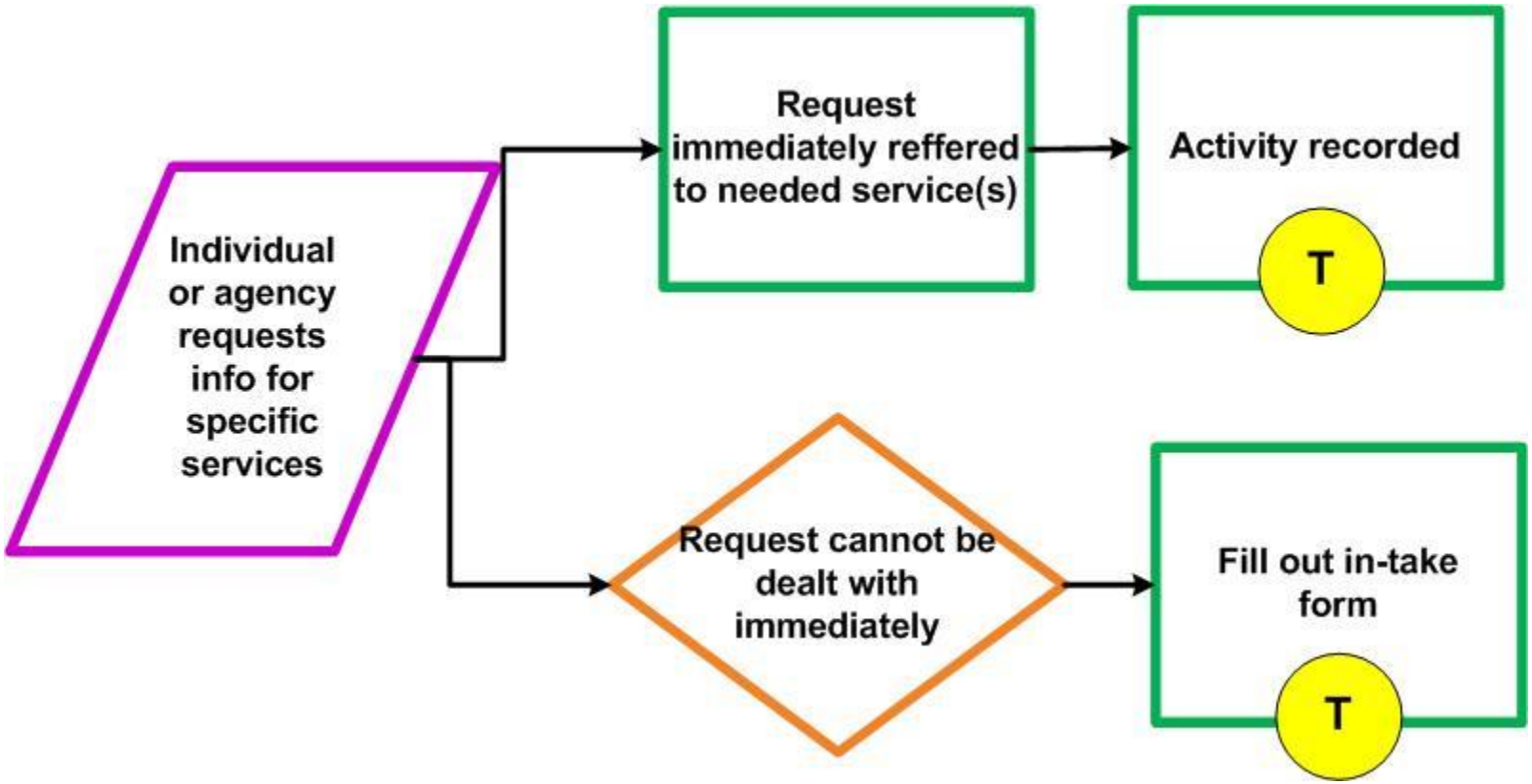
Basic I & R Map



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In-take Form

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Intake and Referral Form

Staff Name: _____

Date: _____

Service Participant: _____ DOB: ____/_____/_____

Address: _____ City/State: _____

Zip: _____ County: _____ Phone: _____

Email: _____ ___ Male ___ Female ___ Rural ___ Urban

Race: ___Caucasian ___African American ___American Indian ___Asian ___Pacific Islander

Ethnicity: ____Hispanic/Latino ____Non-Hispanic

Eligibility: __60 or older __ 18-59 w/disability __Caregiver for Older Adult __Caregiver for person w/disability

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Partnered ___Separated

Caller (if not service participant): _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Relationship to participant: _____

Does the participant know this call is being made? ___Yes ___No

Emergency Contact (if not caller): _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Relationship to participant: _____

Living Arrangement: ___House ___Apartment ___Long-term Care ___ Assisted Living ___Mobile Home

___ Homeless Other: _____

Total number of people living in household: _____
Relationship(s) to participant: _____

Home is: ___Rented ___Owned Other: _____

Finances: $_____ Individual Monthly Income $_____ Household Monthly Income

Benefits: ___Medicare ___Medicaid ___Medigap ___LIS ___LTC Insurance ___Veterans

Income Sources: ___ SS ___SSI ___SSD ___Wages ___Pension ___Interest or Dividends ___ Other

Additional Financial Considerations: _____

Means of Contact: _____Walk-in ___Telephone ___Email Other: _____

Referral Source: ___Internet ___Advertisement ___Professional/Agency ___Friend/Family ___Other

Subject of Inquiry (Check all that apply):

___Abuse, Neglect ___Adult Day Care ___Assistive Devices ___Community/Social Contact ___Financial Services

___Home Repair ___Housing Options ___In-Home Service ___Legal Services ___LTC

___Medicid/MSP ___Medicare ___Reverse Mortgage ___SSA/SI/LIS ___Veterans Benefits

___Part D-Prescription Assistance ___Other: _____

Goal Statement: What is the caller hoping to accomplish by contacting the ADRC?: _____

_____

_____

Support System:	Support Provider	Service Provided
Formal	_____	_____
	_____	_____
	_____	_____
Informal	_____	_____
	_____	_____
	_____	_____

Action steps to be taken by caller: _____

_____

Action steps to be taken by ADRC: _____

_____

Verbal Release of Information: "In order to take the action we discussed, we may need to share the information you have given us today. We will only do so if necessary. Do you give us permission to share that information?"

___Yes ___No ___Yes, with the following limitations: _____

"May we contact you for feedback on our services in the future?" _____Yes _____No

Follow-up: Date of follow-up: _____ Follow-up contact: _____

Service status is: ___Successfully completed __Incomplete, but no further action to be taken by ADRC ___Ongoing

Explain Incomplete or ongoing: _____

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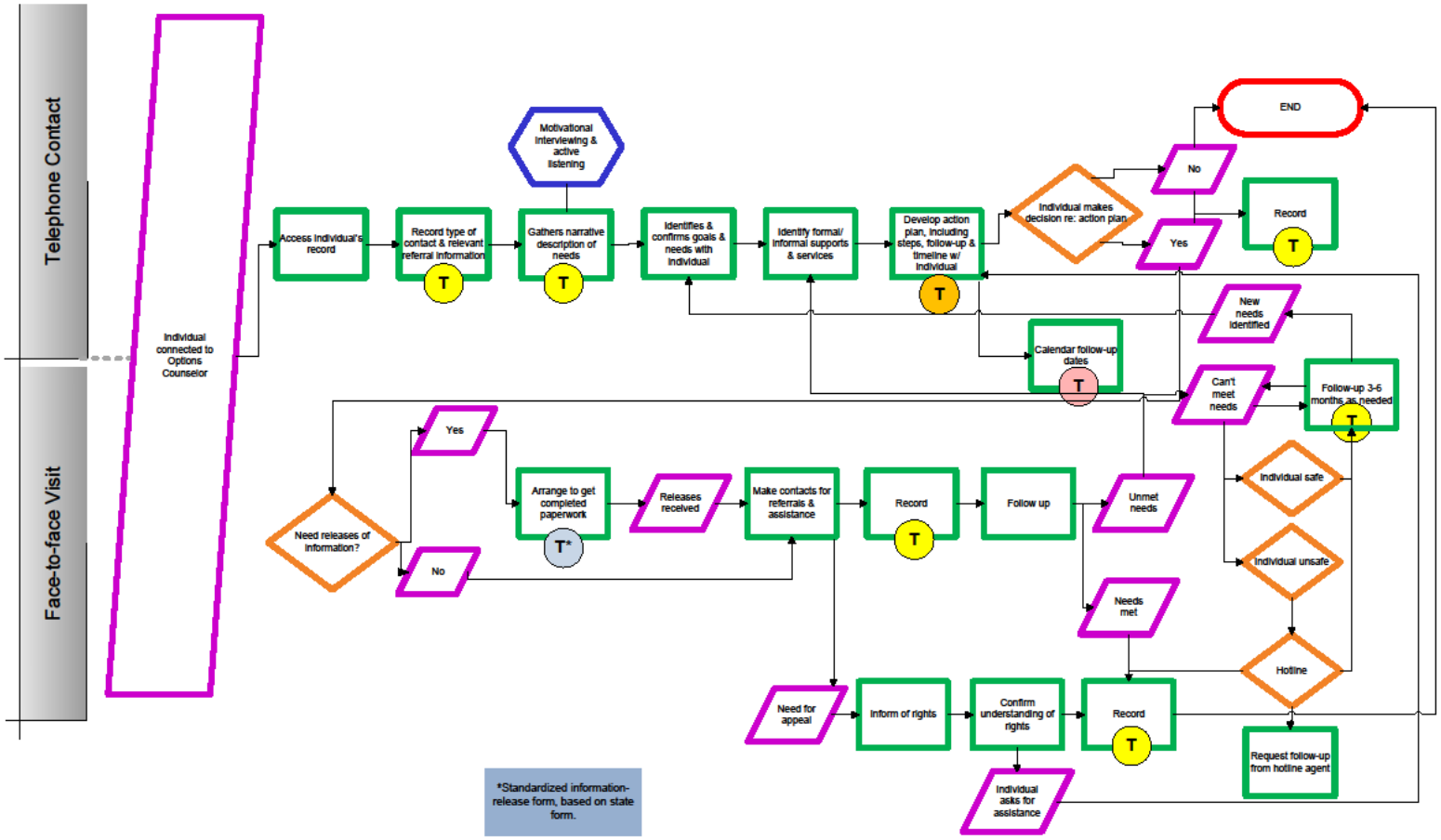
Activities: Options Consulting



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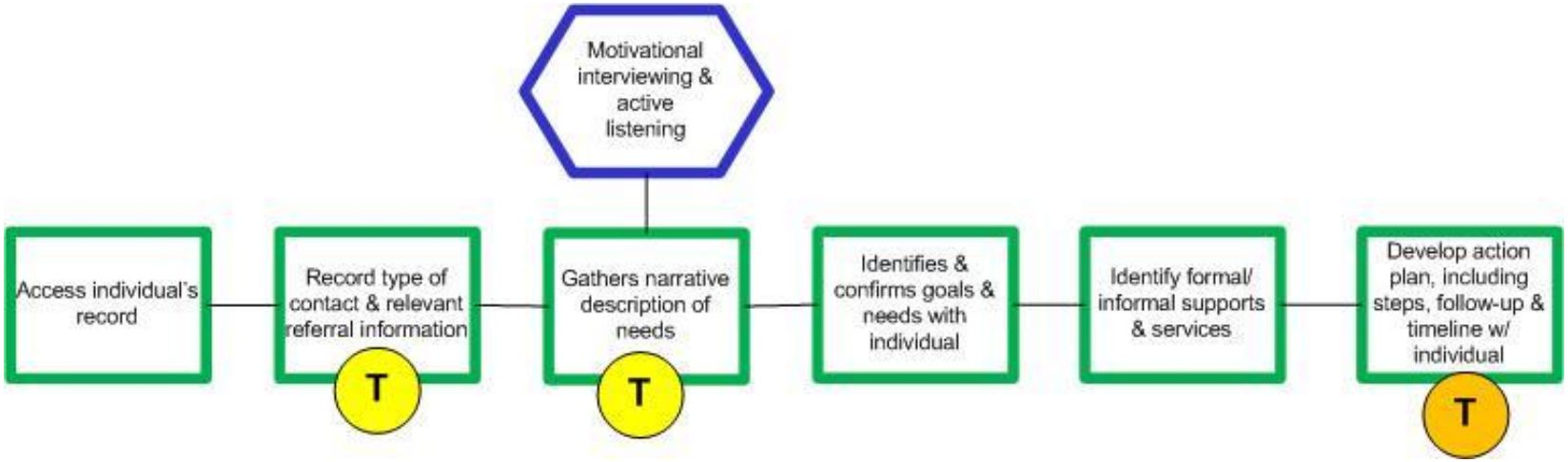
Options Consulting Map



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Needs Assessment

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ADRC Needs Assessment

1. If you needed assistance to remain at your present residence, who would provide this?

   ☐ Spouse/Partner
   ☐ Adult Child
   ☐ Relative Other than Child
   ☐ Friend/Neighbor
   ☐ Agency
   ☐ Other:
   ☐ Don't Know

2. If you needed assistance to remain in your present residence, how would you pay for this?

   ☐ Family
   ☐ Reverse Mortgage
   ☐ Medicare
   ☐ Medicaid
   ☐ Savings
   ☐ Long Term Care Insurance
   ☐ Health Insurance (including HMO's)
   ☐ Other:
   ☐ Don't know

Health Status Information

3. If you have any of the following problems/disabilities, please check all that apply:

   ☐ Breathing Problems
   ☐ Developmental Disability
   ☐ Hearing Problems
   ☐ Learning Disabilities
   ☐ Memory Problems
   ☐ Mental Illness (Including depression)
   ☐ Mental Retardation
   ☐ Mobility Problem (ability to move around)
   ☐ Physical Disability
   ☐ Speech Disability
   ☐ Thinking/Decision-making Disability
   ☐ Visual Problems
   ☐ Other:

4. What barriers may prevent you from receiving services? Please check all that apply:

   ☐ Age
   ☐ Availability of services in your area of residence
   ☐ Cultural
   ☐ Health
   ☐ Language
   ☐ Money
   ☐ Transportation
   ☐ Do not know what services are appropriate or available
   ☐ The need to contact multiple agencies to obtain information or assistance

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Risk Assessment

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ADRC Risk Assessment

1. Is there an Alzheimer's or other dementia present?	☐ Yes	☐ No
2. Have there been many hospitalizations in the past year?	☐ Yes	☐ No
3. Is there a lack of financial resources?	☐ Yes	☐ No
4. Is there little informal support available?	☐ Yes	☐ No
5. Are there complex medical or emotional diagnoses of concern?	☐ Yes	☐ No
6. Is the individual at great risk of falls?	☐ Yes	☐ No
7. Is the individual on the COP waiting list?	☐ Yes	☐ No
8. Has Adult Protective Services been involved in the past?	☐ Yes	☐ No
9. Are there presently issues of self-neglect/abuse?	☐ Yes	☐ No
9. Is there a high level of Caregiver Stress?	☐ Yes	☐ No
10. Are there significant alcohol or drug abuse issues?	☐ Yes	☐ No
11. Have there been episodes of challenging behaviors toward self or others?	☐ Yes	☐ No

4 or more "yes" marks above indicate potential risk. Follow up with individual and/or caregivers.

Is the individual willing to accept help with services?	☐ Yes	☐ No
Is this individual at risk?	☐ Yes	☐ No

Comments:

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Options Consulting Map: Needs

Unmet Needs

Met Needs

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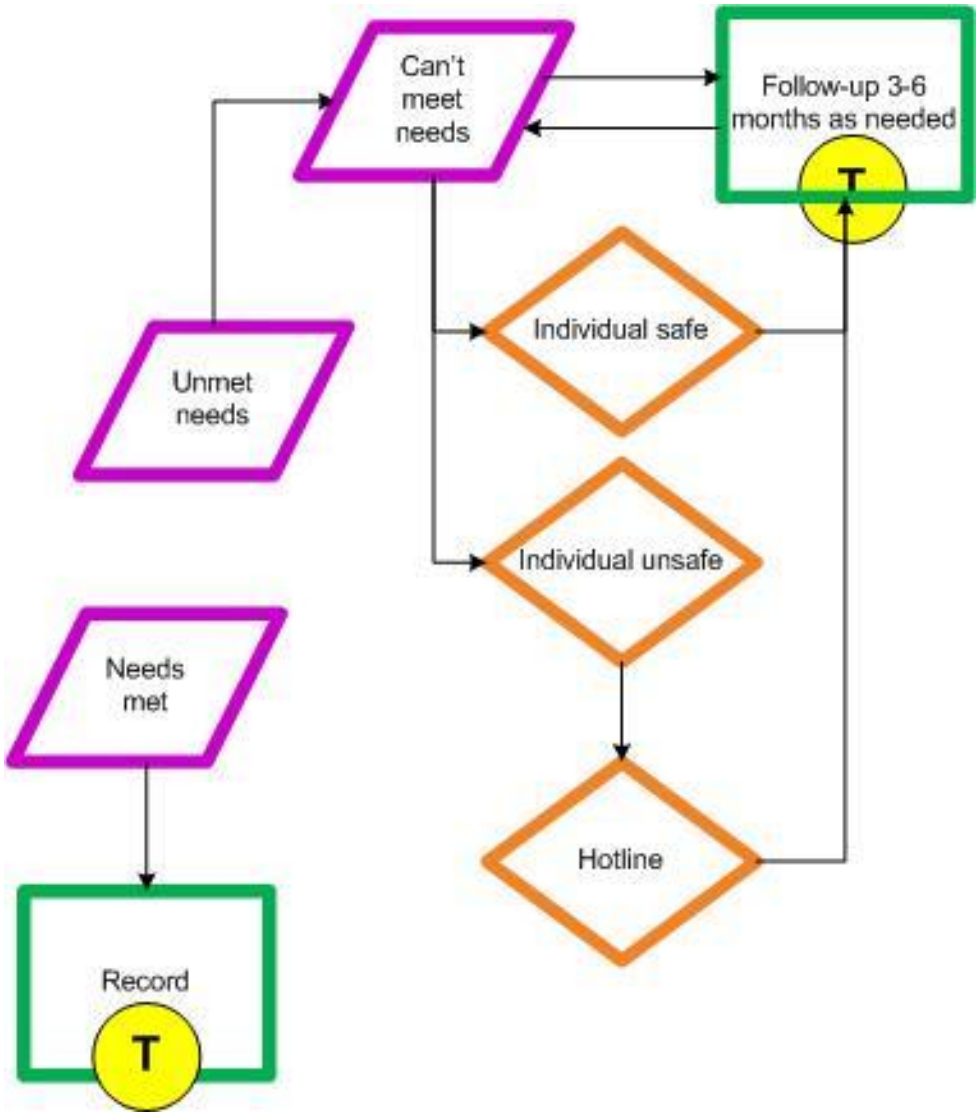
Options Consulting Map: Unmet vs. Met Needs



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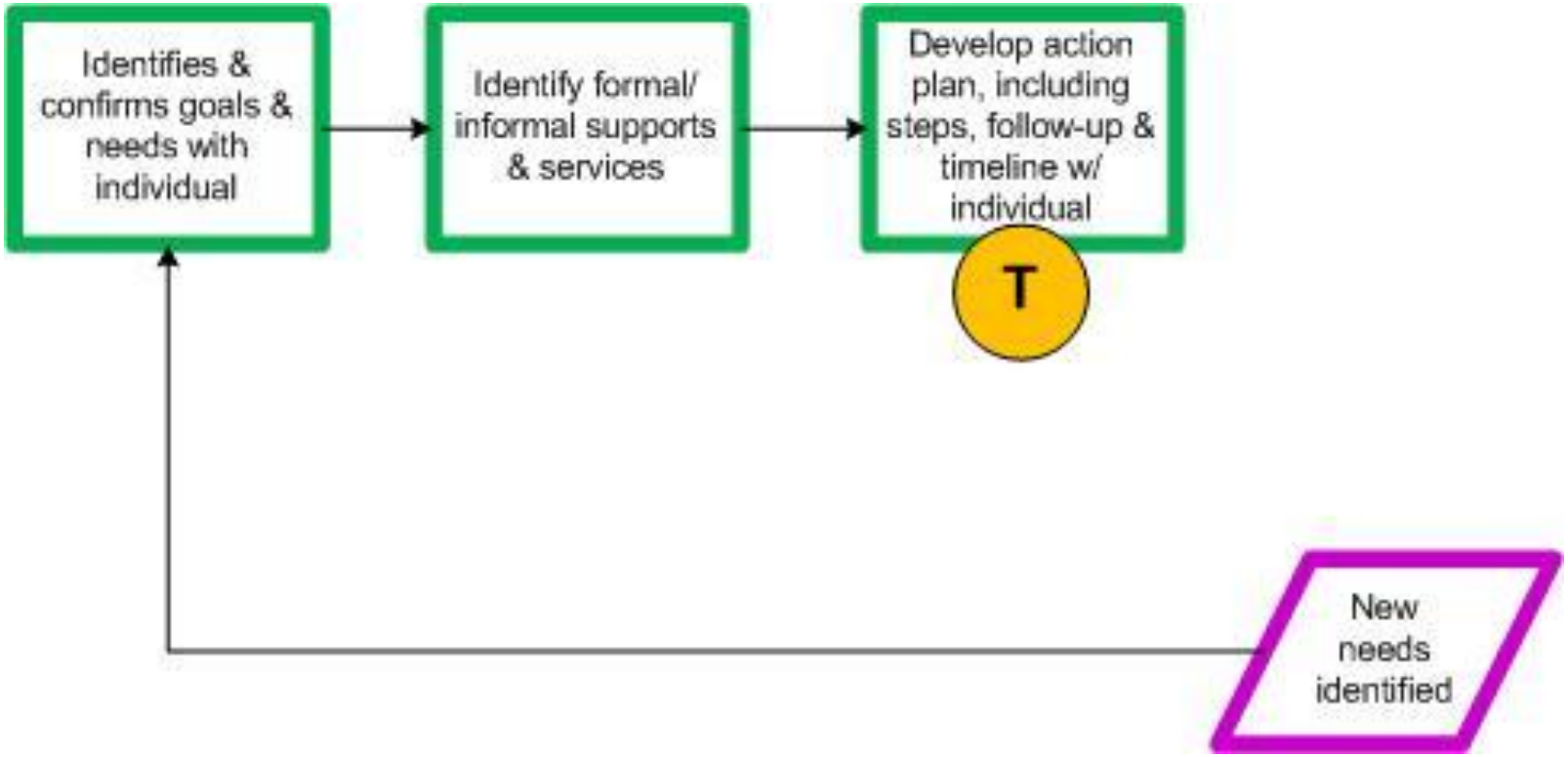
Options Consulting Map: New Needs



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Working with Discharge Planners

Supporting discharge planners is an important function of OC

- Older adults and adults with disabilities who are in the hospital are often at a higher risk for institutionalization as well as readmission.
- Discharge-planning is a fast-paced activity!

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Working with Discharge Planners

Discharge Planners may…

- Request Basic I & R
- Request a hospital visit on behalf of an individual
- Send a *Red Flag Tool*

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Working with Discharge Planners: Red Flag Tool

REFERRAL CRITERIA: Anyone 18 and older with a disability or anyone 60 and older.

Communications Tool: ADRC Options Consultants

Patient Name:
Hospital:
Date:

DP Name:
DP Telephone:
DP Email:

Flag	Reasons	Notes & Recommendations
☐	Problems with living environment:	
☐	Inadequate accommodations for:	
☐	Poor or no family or community support ☐ Has ☐ Needs { ☐ Guardianship ☐ DPOA invoked ☐ Conservatorship	
☐	Financial distress ☐ Medication ☐ Clothing ☐ Food ☐ Housing ☐ Loss of support ☐ Other	
☐	Functional or cognitive decline ☐ Disoriented ☐ Wanders ☐ Depression ☐ Alzheimer's ☐ Poor memory ☐ Comatose ☐ Frequent falls ☐ Diagnosed MI/MR/DD	
☐	☐ Over 80 years old ☐ Living alone	
☐	Caregiver stress:	
☐	Problems with access ☐ Transportation ☐ Insurance issues ☐ No PCP or healthcare home ☐ Delay in assessment for service coordination	
☐	Communications Issues ☐ Low vision/Blind ☐ Deaf/Hard of Hearing ☐ Low literacy ☐ Low English proficiency ☐ Other	
☐	Problems with discharge plan:	
☐	Description of disability or chronic condition:	
☐	Readmissions	
☐	Previous nursing facility placement	
☐	Nonadherence:	
☐	Potential danger:	
☐	Temporary care-facility placement	Facility:
☐	Other:	

Referrals made:

☐ Request Follow-up on: _____

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Working with Discharge Planners: Red Flag Tool

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☐	Financial distress ☐ Medication ☐ Clothing ☐ Food ☐ Housing ☐ Loss of support ☐ Other	
☐	Functional or cognitive decline ☐ Disoriented ☐ Wanders ☐ Depression ☐ Alzheimer's ☐ Poor memory ☐ Comatose ☐ Frequent falls ☐ Diagnosed MI/MR/DD	

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Working with Discharge Planners: Red Flag Tool

☒	☒ Over 80 years old ☐ Living alone	Spouse has dementia. Starting to wander. Sometimes violent. Put in touch with Alzheimer's Assoc. & AAA.
☒	Caregiver stress:	
☐	Problems with access ☐ Transportation ☐ Insurance issues ☐ No PCP or healthcare home ☐ Delay in assessment for service coordination	
☒	Communications Issues ☒ Low vision/Blind ☐ Deaf/Hard of Hearing ☐ Low literacy ☐ Low English proficiency ☐ Other	Macular degeneration. Contact CIL or rehab services for the blind.
☐	Problems with discharge plan:	
☒	Description of disability or chronic condition:	Anxiety, diabetes. Needs talking glucometer; support services for caregivers.
☐	Readmissions	
☐	Previous nursing facility placement	
☐	Nonadherence:	
☒	Potential danger:	Spouse's behavior is unpredictable.
☐	Temporary care-facility placement	Facility:
☐	Other:	

Referrals made: Alzheimer's Assoc for info on respite. Spoke to Joan Doe. Will mail info to pts house. Set up home health to begin 2/1/12.

Request Follow-up on: _____

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Examples

Flags	Possible Options	Consultant Support
Problems with Living Conditions • Homeless • Unsanitary living conditions • No utilities	• Apply for utility assistance • Identify housing options	• Identify shelters • Hotline
Inadequate Accommodations for: • Stairs • Inaccessible bathroom	• Identify new housing/shelter options	• Contact CIL for home modifications
Poor or no Family or Community Support • No family • Needs guardianship or conservatorship	• Find area lawyers • Contact Legal Aid	• Contact Public Administrator • Get information from Dept. of Health and Senior Services
Financial Distress • Unable to afford medications • Unable to pay rent • Unable to buy food	• Assist in applying for food stamps • Find programs to help with Rx expenses	• Help with HUD Housing info & application • Assist with Medicaid info & enrollment
Functional or Cognitive Decline • Lack of mobility • Physical frailty • Confusion • Dementia diagnosis	• Identify alternative housing • Identify nursing facilities with dementia units • Find home health options	• Identify area physical therapists • Connect to Alzheimer's Association for info & programs • Arrange for home safety evaluation
Over 80 Years Old • Living alone	• Connect with AAA • Connect with Senior Centers • Identify transportation programs	• Identify meal sites and meal delivery programs • Identify Rx assistance programs
Caregiver Stress • Older caregiver • Caring for 1+ people	• Connect with AAA • Connect with local CIL	• Help set up services in the home • Identify respite programs
Problems with Access • No transportation • No PCP	• Identify transportation programs • Identify area physicians	• Assist with Medicaid info & enrollment
Communication Issues • Blind or low-vision • Deaf or hard of hearing • Low literacy/unable to read	• Identify interpretation services • Connect with Vocational Rehabilitation	• Locate assistive technology • Assist with completing forms • Connect with area CIL
Problems with Discharge Plan • Inadequate discharge plan • Change in home situation • Patient is over-confident	• Help arrange home health	• Make home visits
Disability or Chronic Condition • Cancer • COPD • Cancer • Diabetes • Hypertension	• Identify out-patient care-management programs • Identify wellness programs	• Assist with arranging home health
Readmissions • Nonadherent with Rx, diet, etc. • No transportation for follow-up visits	• Find area case manager • Find area transportation programs	• Locate medication dispensers • Find education classes on specific condition/disease
Previous Nursing Facility Placement • Recent discharge from nursing home	• Explore community-based care options • Assess for risks & needs	• Help arrange for community supports
Nonadherence • Rx • Diet • Self-care plan	• Find education on self-management	• Locate area case managers
Potential Dangers • Dogs • Drugs • Guns • History of violence	• A warning for OCs to proceed with cautions & reasons why	
Temporary Care-facility Placement • Name of short-term care facility • List of possible needs to return home	• Assess risks & care needs to return home	• Identify community supports • Help with program enrollment
Other • Patient returned home with outstanding care/support needs	• Arrange for in-home services • Arrange for meals program	• Arrange medical alert service

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Questions?

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Incorporating Person-centered Values and Practices

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Person-centered Values & Practices

Goals

Upon completion participants should be able to:

- Identify the basic values and assumptions of person centered planning/work.
- Compare and contrast system centered from person centered principles.
- Given your role at the ADRC, give examples of practices that reflect person centered values.
- Given a description, indicate if a planning process is consistent with the values and assumptions.

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Person-centered Values & Practices

Personal futures planning is an approach for learning about people with disabilities and creating a lifestyle that can help people *contribute* in community life. Personal futures planning is much more than a meeting; it is an ongoing *process of social change*. The effectiveness of a plan depends on a support group of concerned people who make a dream reality by *learning* to solve problems, build community and change organizations together over time. The locus of change is away from the person with a disability toward change in social roles, responses, and existing organizational structure. As an *ongoing process of innovation* it can help liberate people from oppressive environments and processes that are harmful.

--Beth Mount, 1992

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Person-centered Values & Practices

In the beginning, person-centered planning…

- Was designed to be an alternative to system planning;
- Had a focus on social change, not about fixing people;
- Focused on creating and sustaining **valued social roles** for people;
- **Sought to inform and change the way services work;**
- Involved community members in a grassroots change effort;
- Was designed to creatively solve problems so people have a life that makes sense…now!

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Person-centered Values & Practices

Different approaches emerged with common themes:

- Seeing people first
- Ordinary language and images
- Searching for gifts & capacities in the context of community life
- Strengthening the person's voice
- Evaluate the person's current situation w/ ref to valued experiences
- Define a desirable future

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Person-centered Values & Practices

Two views of George: Service vs. Connections Perspective

Congregate Service Perspective		Connections Perspective	
Who is George?	**What does he need?**	**Who is George?**	**What does he need**
• A person with a mental age of 4 years 3 months • A person with IQ >30 • A person who is severely mentally retarded • A person who has "an indication of organicity, including difficulty with angles, closure, retrogression, over-simplification and an inability to improve poorly executed drawings." • A person with acute temper flare-ups directed at staff	• A program for children • To be protected from the world • To learn very simple tasks • To learn these skills separately from non-disabled people because he is so different from them • Highly specialized staff who can address issues of retrogression, closure, etc. • An environment where his temper can be controlled • To be repaired and sent back to the real world when he is better controlled	• A 40 year old man who has missed most typical experiences and has never had a real job • A person with no income who is poor • A person who has been isolated all his life • A person who has no contacts or connections to the wider community • A person who has little control over the direction of his life • A person who has more difficulty learning new skills than most people • A person who is treated as a child by his mother • A delightful man who makes a difference in the lives of those who care about him	• A lot of experiences • A real job • An income • To be included and present in the community • Relationships to other people, connections to community • Friends • Vision for the future and support in getting there • Someone who can speak out on his behalf • A lot of support for learning • More people who see and treat him as an adult • People who can enjoy him • More people who see and treat him as an adult • People who can enjoy him

Person-centered Values & Practices

Person-centered…

- Thinking
  - ✓ Incorporate the values into how we see people, community and the service system.
  - ✓ Influences our interactions and behavior.
- Planning
  - ✓ Intensive focused planning with an individual
  - ✓ An approach to support innovation
- Work
  - ✓ Implementing the plan & taking action
  - ✓ Ongoing work in which planning informs community members and policy makers
- Systems
  - ✓ Incorporate values into practices

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Incorporating Person-centered Values and Practices

Ongoing Planning with People

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Ongoing Planning

When does person-centered planning make sense?

- When major change is occurring or is desired.
- Not in crisis; time to think, reflect, explore and implement desired changes is needed.
- People with complex support needs.
- Innovative community options are being considered.

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Ongoing Planning

When does person-centered planning make sense?

"Person centered planning is a way of helping people make some changes in their life. It is an empowering approach to helping people plan their future and organize the supports and services they need. *It seeks to mirror the way in which 'ordinary' people make plans."*

–Sanderson et al., 1997

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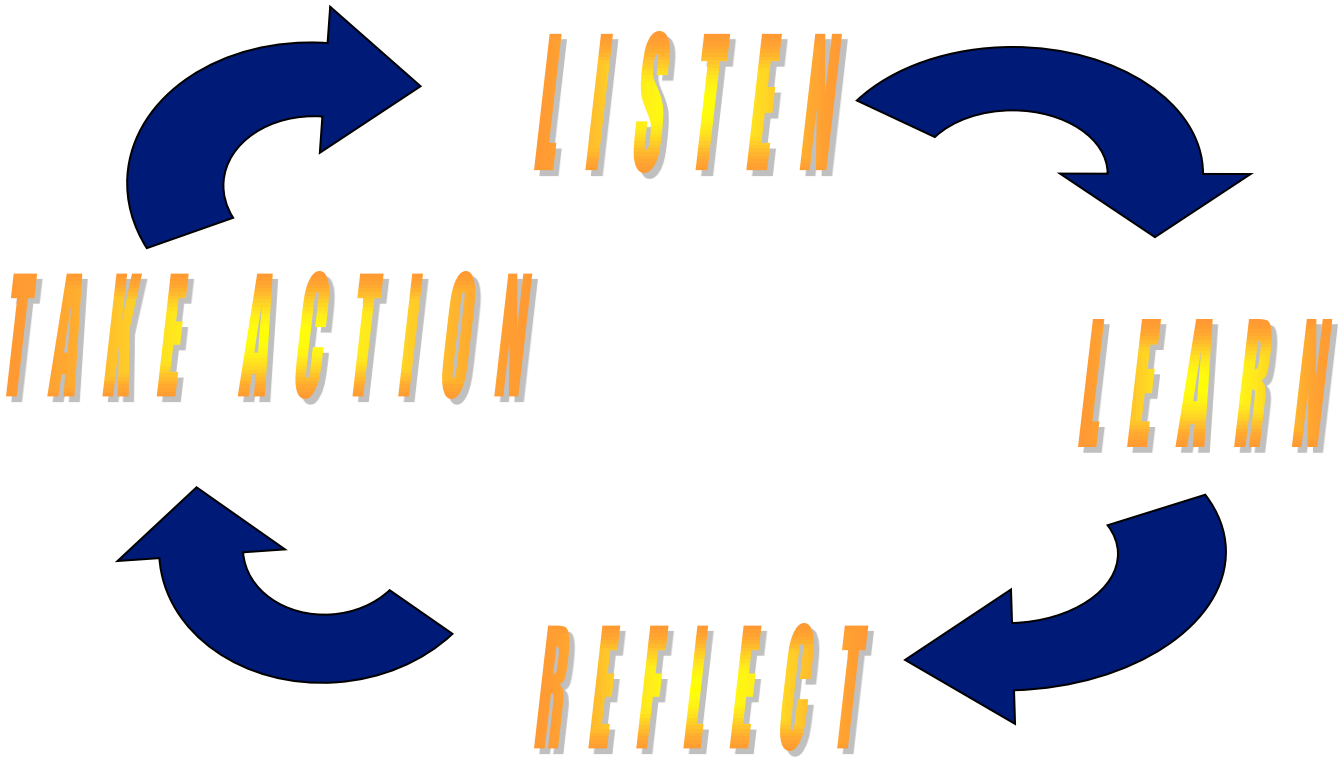
Ongoing Planning

Planning Process



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Ongoing Planning

Planning Process

- Preparing to plan.
- Learning about the person.
- Discovering a future that makes sense.
- Designing/creating needed supports.
- Making ideas a reality over time by working together.

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Ongoing Planning

Learning about the person's life now:

- My story
- My day now
- Places where I spend time
- People in my life
- Choices
- Likes/dislikes
- Communication
- What works/doesn't
- My current life roles
- My hopes and dreams
- My fears, concerns, worries

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Ongoing Planning

A future that makes sense:

- My home
- my ideal day
- for fun I would..
- Places I'd go
- people and associations
- job/career:
  - ✓ preferences
  - ✓ conditions
  - ✓ activities

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Ongoing Planning

How do we define a desirable future?

A Service Life

- Residential services
- Vocational services
- Recreation therapy
- Socialization skills training
- Retirement programs
- IHPs, ISPs
- Active treatment

A community life

- A home
- A job
- Fun
- Friends
- Chances to learn
- Help as necessary
- Personal involvement

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Ongoing Planning

Action Plan: Making Ideas a Reality

- What do we need to learn about…
- Who do we need to contact
- What are the opportunities
- What are the barriers
- Identify person(s) responsible, what is to be accomplished, how and by when
- When will we meet again to review progress and determine next steps

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Ongoing Planning

Designing/Creating Supports

- To be successful, I'd need..
- To find this job, I need...
- To be a homeowner I need…
- To become a member of the Optimists…
- What concerns or worries me about this job is...

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Ongoing Planning

Designing Supports

Activities of life	Support or assistance	Possible responses	Explore & decide

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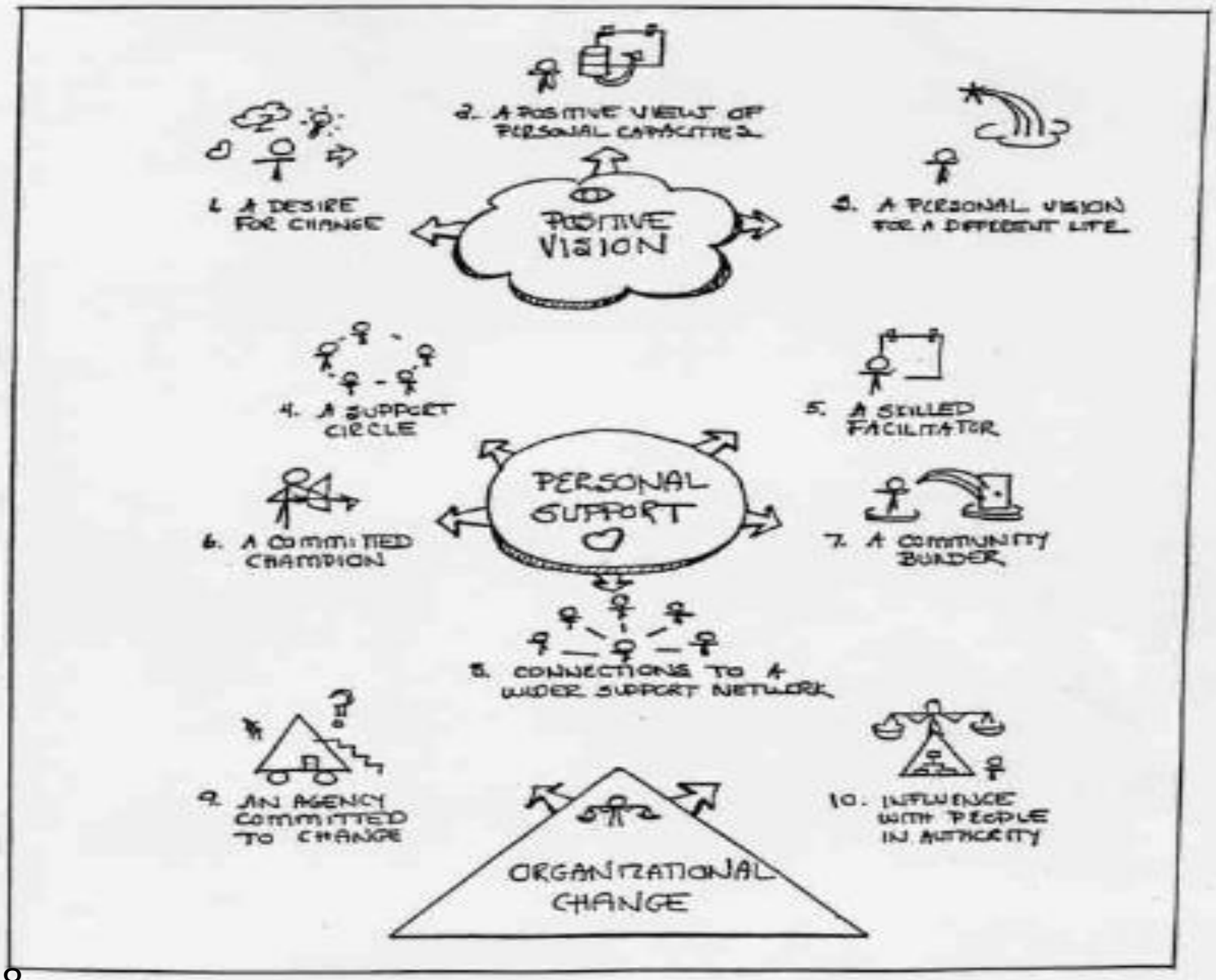
POSITIVE CHANGE IS MORE LIKELY UNDER THESE CONDITIONS



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Incorporating Person-centered Values and Practices

Planning Practices

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Aging and Disability Resource Center of Northwest Missouri

Planning Practices

What are the qualities of good planning?

Planning practices

- Tailored to each person.
- Builds and sustains relationships.
- Seeks a more desirable future.
- Results in action and outcomes.
- People work together to solve problems.

Outcomes of planning

- It's clearly the focus person's plan.
- Focus person has a strong & vital network.
- Everyone has a clear picture of a life that makes sense.
- Real changes are occurring for the focus person.
- Real change is occurring in communities and support organizations.

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Incorporating Person-centered Values and Practices

Person-centered Planning and ADRC Functions

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Person-centered Planning & ADRC Functions

Implications for ADRC Staff

- Person Centered Planning is a way of thinking and interacting with people.

- **A "world view"**

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Person-centered Planning & ADRC Functions

Interaction between PCP Principles & ADRC Functions

- Principles of person-centered work:
  - ✓ View individuals from a community & capacity perspective.
  - ✓ Plan and support a vision of the future rather than “placing” people.
  - ✓ Honor choice and self determination.
  - ✓ Facilitate community partnerships.
  - ✓ Promote policy that supports people

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Person-centered Planning & ADRC Functions

Interaction between PCP Principles & ADRC Functions

- Key functions of the ADRC
  - ✓ Public education
  - ✓ Provision of information & referral
  - ✓ Options consulting

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Person-centered Planning & ADRC Functions

Seeing People from a Capacity & Community Perspective

Public education	Information & referral	Options consulting

Person-centered Planning & ADRC Functions

Seeing People from a Capacity & Community Perspective

Public education	Information & referral	Options consulting
Materials use people first language Emphasize individuals, rather than classes of people Stress value of individuals gifts and talents to others	Take time to get the story Seek to learn about people's interests gifts and talents Community is for all	Work with the individual to design a planning process that works for them Assist in helping the person identify allies who can participate and support Assure the person remains the focus of the planning Focus on capacities rather than deficiencies

Person-centered Planning & ADRC Functions

Planning as Vision & Opportunity

Public education	Information & referral	Options consulting

Person-centered Planning & ADRC Functions

Planning as Vision & Opportunity

Public education	Information & referral	Options consulting
Emphasize tailoring resources and supports around the individual Strengths and capacities of the community Strength in diversity	Determine the kind of life the person wants Help them figure out the support they need Identify and suggest community resources available	Be sure options are a good fit for the individual; i.e., are consistent with what we know about them Create a clear picture of a desirable future Don't let planners concerns about needed support get in the way, i.e., first the what, then the how

Person-centered Planning & ADRC Functions

Honoring Choice and Self Determination

Public education	Information & referral	Options consulting

Person-centered Planning & ADRC Functions

Honoring Choice and Self Determination

Public education	Information & referral	Options consulting
Emphasize that ADRC functions as a service; ultimate decisions belong to individuals Information is power—ADRC empowers people	Offer suggestions and resources, but know it is the individual who must make the decision Seek to simplify and make understandable complexities that people may be faced with Relate advantages and disadvantages of particular options	Check in with the person about ideas and actions before, after and during planning sessions-what's working/ what isn't. Develop strategies for engaging the individual in the planning process; this is especially important when the person may have negative images or an undesirable reputation

Person-centered Planning & ADRC Functions

Facilitating Community Partnerships

Public education	Information & referral	Options consulting

Person-centered Planning & ADRC Functions

Facilitating Community Partnerships

Public education	Information & referral	Options consulting
Relate how ADRC's work with other community agencies and state agencies Relate and give examples of natural support and collaborative assistance	Explore sources of natural support Explore possible generic community support and resources Build and create partnerships with other potential sources of support and assistance (housing, volunteer opportunities, in-home assistance, personal assistance services)	Emphasize that in grassroots planning, the planners are the doers. Involve supporters in the work to be done Encourage supporters to spend time Invite new people into the planning process as ideas emerge Make meetings an opportunity for review and progress as well as fellowship/ camaraderie. Celebrate accomplishments

Person-centered Planning & ADRC Functions

Policy that Supports People

Public education	Information & referral	Options consulting

Person-centered Planning & ADRC Functions

Policy that Supports People

Public education	Information & referral	Options consulting
Explain impact of rules, regulations and policies; be familiar with eligibility criteria Explain how to navigate systems Provide examples of strategies that enable people to get what they want	Have an understanding of rules regulations and policies Recognize when a policy or procedure is a barrier Advocate as appropriate Suggest self-advocacy strategies	Recognize policy barriers (we have never done that before) Develop and propose strategies for seeking support from key people in authority Encourage development of “experiments in innovation.” Look for champions for change

Person-centered Planning & ADRC Functions

Policy that Supports People: What is our image of human services?

Machine

Living system

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Person-centered Planning & ADRC Functions

Policy that Supports People

Mechanistic Model

- Recipients of service and support are merely widgets in the system's machinery.
- People are inputs, and "better people" are the outputs.
- Human service workers have functions in the assembly process

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Person-centered Planning & ADRC Functions

Policy that Supports People

Living Systems Model

- Seeks to see the whole person in relation to others and to environments.
- Appreciates the complexity of interaction across community roles.
- Recognizes that peoples' planning circles, human service organizations and communities are all interrelated parts of a living system.

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Person-centered Planning & ADRC Functions

"You can't do person centered planning in a system centered way."

– Beth Mount, 1992

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