

New Hampshire Aging and Disability Resource Center Options Counseling and Assistance Program

January 7, 2014

ACL Grant Award Number: 90OC0004

Project Period: 09/30/2010-09/29/2013

Reporting Period: 09/30/2010-09/29/2013

Final Reporting Period: 09/30/2010-09/29/2013

ACL Program Officer: Eric Weakly

ACL Grants Specialist: Christine Ramirez

Prepared by

University of New Hampshire Institute for Health Policy and Practice
Durham, NH 03824

Report Author

Laura Davie

laura.davie@unh.edu

603.862.3682

Principal Investigator

Ned Helms

Table of Contents

Title Page	1
Table of Contents	2
I. Executive Summary	3
II. Introduction	4
III. Activities and Accomplishments	
Q1	7
Q2	50
Q3	51
Q4	52
Q5	53
IV. Appendix	
A. Evaluation Plan	54
B. SLRC Presentation Fall 2011	64
C. SLRC Presentation Aug-Sept 2013	87
D. Summary of Conversations/Comments SLRC Presentation 2013. .	102
E. Evaluation of Peer Supervision with Dr. Rene Bergeron	108
F. Action Plan Examples	124
G. Interview Reference Guide	127
H. SLRC Options Counseling Brochure	164

I. Executive Summary

In September 2010, the University of New Hampshire (UNH) received the Aging and Disability Resource Center (ADRC) Options Counseling and Assistance Program grant from the US Administration for Community Living (ACL). Building on ongoing collaborative work between the Institute for Health Policy and Practice (IHPP), NH Bureau of Elderly and Adult Services (BEAS) in the New Hampshire Department of Health and Human Services (NH DHHS), and the ServiceLink Aging and Disability Resource Centers (SLRC), this project had two major goals: (1) Standardize the delivery of options counseling statewide and (2) Actively participate in the development of National Standards for Options Counseling.

There were several objectives and activities for the 2010 Options Counseling and Assistance project, which are described in detail in this report. The work of this project has provided a strong foundation for the continuing work under the 2012 Enhanced Options Counseling award. Key areas New Hampshire will continue to build upon include evaluation metrics for the delivery of options counseling, peer supervision sessions across all SLRC positions, refining tools to aid options counselors' performance, and meeting options counseling delivery standards.

A specific impact the project achieved was to develop, articulate, and disseminate the basic philosophy of options counseling, not only to SLRC staff but to partners in the aging and disability 'system'. A major lesson learned under this project was that follow up to training is essential. This will be applied to all training in the future. From a policy perspective, the work of the 2010 Options Counseling and Assistance project is being integrated into further work within the State of New Hampshire through the 2012 Part A ARDC Enhanced Options Counseling grant, the Money Follows the Person program and the Balancing Incentive Program.

II. Introduction

In September 2010, the University of New Hampshire (UNH) received the Aging and Disability Resource Center (ADRC) Options Counseling and Assistance Programs grant from the US Administration for Community Living (ACL). Building on ongoing collaborative work between the Institute for Health Policy and Practice (IHPP), NH Bureau of Elderly and Adult Services (BEAS) in the New Hampshire Department of Health and Human Services (NH DHHS), and the ServiceLink Aging and Disability Resource Centers (SLRC), this project had two major goals: (1) Standardize the delivery of options counseling statewide and (2) Actively participate in the development of National Standards for Options Counseling.

New Hampshire has been an ADRC grantee state since 2003 and operates a statewide, fully-functioning ADRC model. BEAS contracts with locally-based SLRCs to deliver services under the ADRC model and utilizes an ADRC Advisory Board to provide guidance for the program, with representation from community based organizations, multiple NH DHHS departments, and consumers. New Hampshire has been delivering Options Counseling since the ADRC program began in 2003. Each of the SLRC sites employs a Long Term Support Counselor (LTSC), who provides options counseling. Through work funded prior to 2010 by previous ADRC and Systems Transformation grants, New Hampshire had focused on developing a set of LTSC professional standards, skills, and competencies. Since fall 2009, all SLRCs have used the standard set of LTSC Competencies, Standards, and Job Description for the purpose of hiring, training, and evaluating the performance of the LTSC position. These documents highlight education and work experience expectations for LTSCs, and describe the standards of practice expected by the LTSC that align with the six core components of options counseling established by ACL.

In addition to the LTSC positions and the formal incorporation of options counseling into that role, other programs integrated into the SLRCs utilize options counseling components. The New Hampshire Family Caregiver Support Program (NHFCSP), funded by AoA; the state-funded Alzheimer's Disease and Related Disorders (ADRD) respite grant program for caregivers; and the Transitions in Caregiving Project (TIC), a demonstration grant also funded by AoA; are delivered by the SLRCs through a person-centered, consumer-directed model. In addition, each SLRC works with a staff member assigned from the Division of Family Assistance (DFA), who determines financial eligibility for Medicaid and a long-term care nurse who determines clinical eligibility for services. The statewide SLRC Network also delivers the New Hampshire State Health Insurance Assistance Program (SHIP) at the community level. The primary mission of SHIP is to provide information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage including such topics as Medicare coverage, Medicare Prescription Drug Benefit, Medicare Supplemental Plans, and long term care insurance to Medicare eligible persons, their families and caregivers. In addition to NHFCSP, ADRD, and SHIP, New Hampshire's Senior Medicare Patrol Project (SMP) is delivered at the community level through the SLRCs. In all of these SLRC-based programs, elements of options counseling have been incorporated; however, currently, there is not a formal set of professional standards, skills, and competencies related to options counseling for those positions, as exists for the LTSCs.

Several efforts prior to 2010 promoted the use of person-centered options counseling and the standardization of the LTSC position across the SLRC network in New Hampshire. However, there was not a standardized approach to delivering options counseling among the LTSC or the partner programs (such as NHFCSP, ADRD, TIC). In recognition of these areas for

improvement, New Hampshire proposed to build upon the history of options counseling delivery and New Hampshire's extensive training on person-centered planning to achieve the two major goals of the 2010 Options Counseling and Assistance project.

To achieve the first goal of standardizing the delivery of options counseling statewide, this grant project had five major objectives: (1) Develop a standardized operational protocol for ADRC Options Counseling throughout the SLRC Network; (2) Implement options counseling standards defined by the operational protocol; (3) Develop and define the role of LTSCs in BEAS's quality improvement process for the SLRC Network; (4) Develop processes to include other SLRC staff in the training, tracking, and use of outreach materials for options counseling; and (5) Develop an evaluation plan for options counseling standards. Activities and accomplishments related to these five objectives are provided in Section III.

The second major goal of the project, to actively participate in the development of National Standards for Options Counseling, included two major objectives: Inform the process for development of national standards for options counseling, and incorporate thinking from national best practice development into New Hampshire standards. Activities and accomplishments related to this goal and related objectives are provided in Section III.

III. Activities and Accomplishments

New Hampshire submitted an evaluation plan for options counseling as a major deliverable to ACL under the Options Counseling and Assistance grant in August of 2011. The plan described short and long term goals for evaluating options counseling in New Hampshire both at the system and client level (per ACL guidelines). The full evaluation plan can be found in Appendix A. ACL acknowledged the long term view of the plan and that all aspects of the evaluation plan would not be conducted under this grant period. What follows are the activities

and accomplishments outlined in New Hampshire's grant proposal for the Options Counseling and Assistance Programs, with the corresponding evaluation outcomes and indicators from the full evaluation plan.

1. What measurable outcomes did you establish for this project and what indicators did you use to measure performance? To what extent did your project achieve the outcomes?

For *Goal 1: Standardize the delivery of options counseling statewide*, five major objectives were established. Each objective had outcomes and indicators to measure performance, as outlined in the evaluation plan. The sections that follow summarize each objective's activity (or activities), including the outcomes, indicators, and performance.

Objective 1: Develop a standardized operational protocol for ADRC Options Counseling throughout the SLRC Network

Overview & Summary: Goal 1, Major Objective 1

New Hampshire has several components that combine to make up the Options Counseling operational protocol, as described in submissions through the Semi Annual Reporting Tool over the course of the grant. These include the New Hampshire definition of options counseling, Refer7 User Manual, Options Counseling Tip Sheet, options counseling training curriculum, and job descriptions for all SLRC positions. These components comprise the operational protocol, and were built using the national definition of options counseling and informed by the national workgroup calls. They outline the standards for options counseling and how they are operationalized across all positions within the SLRC. In addition, the Refer 7 User Manual provides the protocol for options counseling follow up for LTSC, an issue raised for New Hampshire during the most recent evaluation of the states ADRC fully-functioning status.

**Objective 2: Implement options counseling standards defined
by the operational protocol**

Overview & Summary: Goal 1, Major Objective 2

To achieve objective 2, a series of trainings were developed to educate and train SLRC staff on the standards and provide ongoing support (Peer Supervision). Trainings were designed to provide an overview of the Options Counseling standards and the context for the standards from the federal and state perspective and train staff on using the options counseling tool in Refer7, which was developed as part of this project to assist staff in delivery of options counseling and capture metrics for quality assurance. The second type of training was a Peer Supervision Program aimed specifically at LTSC to provide ongoing support.

Education and Training Series on Options Counseling

Table 1 provides a listing of the trainings that were offered over the course of the grant period focused on the definition, components, competencies (e.g., person-centered planning), and documentation of delivery of effective and consistent Options Counseling across the statewide SLRC (ADRC) Network.

Table 1: Options Counseling Trainings

OPTIONS COUNSELING TRAININGS			
Presentation and Date	Trainers	Target Audience	Comments
<i>Orientation to Federal and State Initiatives</i> (“Roadshow”) September - October 2011	Susan Fox Laura Davie Mary Maggioncalda Wendi Aultman Cathy Creapaux	All SLRC Staff; Presenters traveled to each office around the state	Presentation is included in Appendix B
<i>Options Counseling in New Hampshire: The Nuts and Bolts of Standards Implementation</i> November 30, 2011	Wendi Aultman Susan Fox Laura Davie	- Long Term Support Counselors - Center Managers	Introduction to options counseling concepts and plans for New Hampshire adoption

New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

<i>Enhancing the Delivery of Options Counseling: Implementation Techniques and Tools</i> January 31, 2012	Wendi Aultman Susan Fox Laura Davie Marguerite Corvini Melissa Mandrell	- Long Term Support Counselors - Center Managers	Group work on development of implementation manual and role play of options counseling provision
<i>Introduction to the OC Tool, Action Plan, and Triggers; plus Refer7 Refresher</i> April 2012	Wendi Aultman Becky May Marguerite Corvini Melissa Mandrell	All SLRC Staff	Three different sessions offered
<i>Adult Family Conflict Resolution Training</i> May 1, 2012	Elder Decisions	- Long Term Support Counselors - Caregiver Specialists	Provided by outside trainers from Massachusetts
<i>Implementation Review & Update Webinar</i> June 2012	Wendi Aultman Marguerite Corvini	All SLRC Staff	
<i>Options Counseling: Past, Present, and Future</i> (“Roadshow Revisited”) August-September 2013	Laura Davie Melissa Mandrell	All SLRC Staff; Presenters traveled to each office around the state	Summary report is included in Appendix D

Most trainings (except for the two” roadshows” and the implementation review webinar) were evaluated by participants. Trainings and evaluation results are described below.

Orientation to Federal and State Initiatives, September through October 2011

In Fall 2011, representatives of the NH DHHS, BEAS and the UNH Center on Aging and Community Living visited all ten SLRC offices to present information about federal and state initiatives that had implications for the operations of the SLRC program. The goals of the presentation included describing the federal and state policy driving current long term care system changes; developing a shared understanding of what “Person-Centered” approaches across systems and programs; discussing the various programs and initiatives currently underway within the SLRC network; and engaging in a dialogue about SLRC perspective, insights, and needs of the programs and initiatives.

The presentation emphasized the importance of person-centeredness in the delivery of ADRC services and the federal and state focus on expansion of the SLRC roles in their community.

New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

Initiatives active in New Hampshire at that time included Care Transitions, Caregiver programs, VD-HCBS, Money Follows the Person, and the primary focus of the presentation, Options Counseling. The presenters described the plan for rolling out Options Counseling including trainings that would be offered and planned changes to Refer7. This presentation allowed all SLRC staff to learn about the current activities at federal, state and local levels and to make recommendations about how to implement changes on the local level.

Given the overview nature of the presentation and discussion, there was no formal evaluation of this session.

Options Counseling in New Hampshire: The Nuts and Bolts of Standards Implementation,
November 30, 2011

This training focused on the introduction of Options Counseling concepts and standards and to help staff incorporate these standards into their everyday work. There were a total of 24 participants from across the SLRC sites: 54% were Long Term Support Counselors and 38% were their supervisors (Center Managers). The remaining participants were site supervisors and other NH DHHS staff. To evaluate the effectiveness of the training and their understanding of options counseling standards, participants were given a pre-test/post-test questionnaire to evaluate the knowledge change; in addition, quality of the trainers was evaluated.

Charts 1-9 provide the participants' levels of knowledge before and after the training on several aspects of options counseling.

Chart 1: Knowledge of Current Standards for Options Counseling

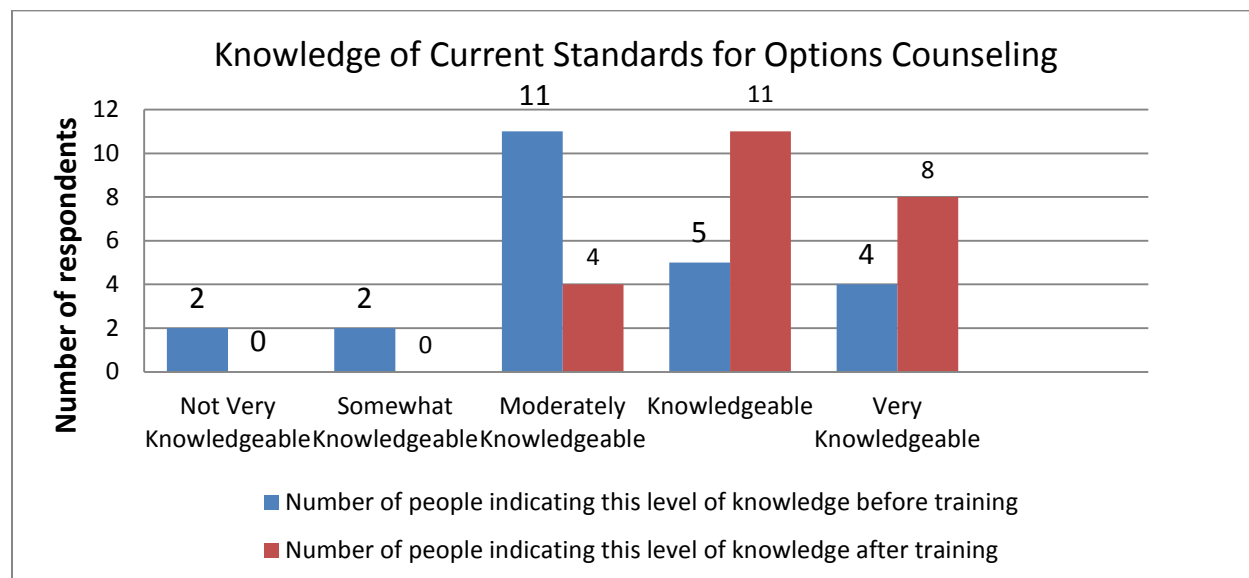


Chart 2: Understanding of Role of All SLRC Staff in the Provision of Options Counseling

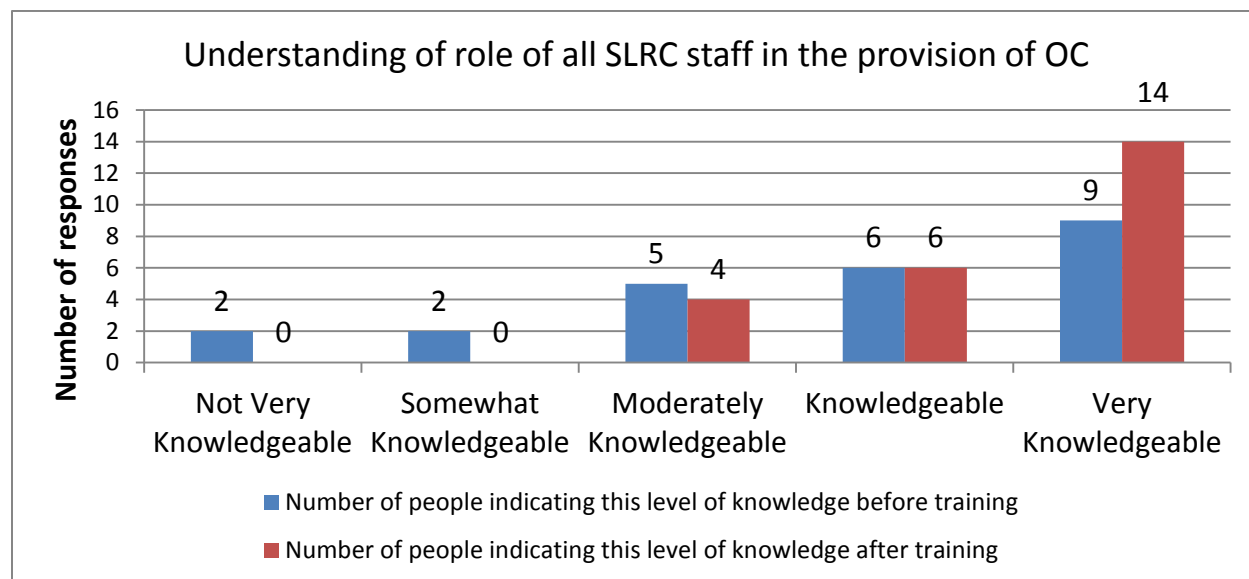


Chart 3: Understanding of the Essential Elements of Options Counseling

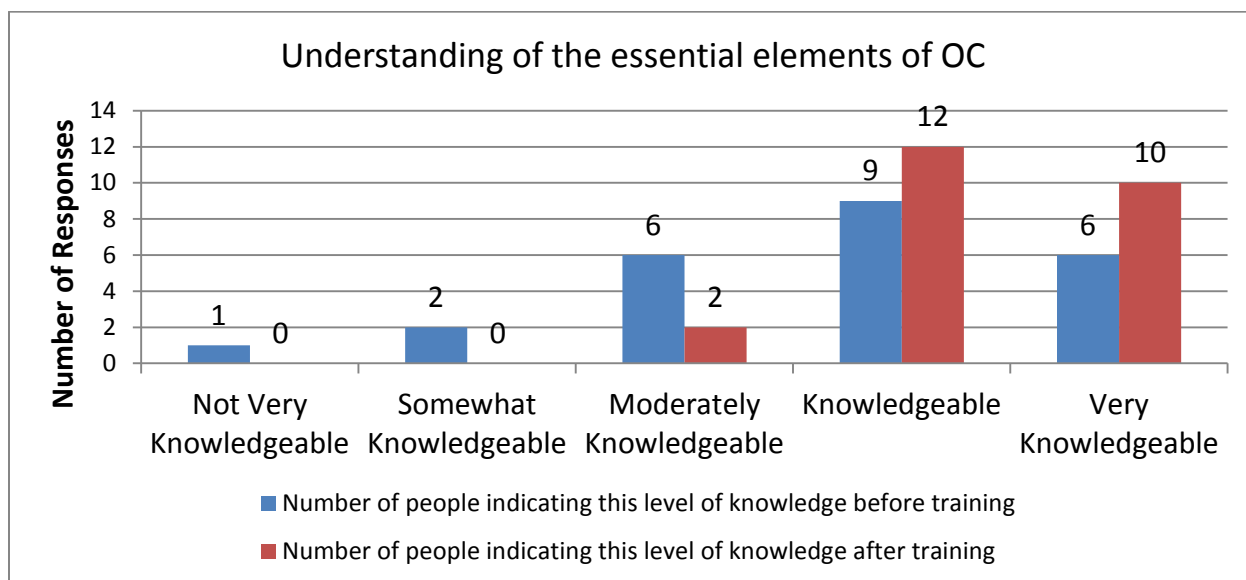


Chart 4: Knowledge of Difference between Options Counseling and Other Services Provided by SLRC

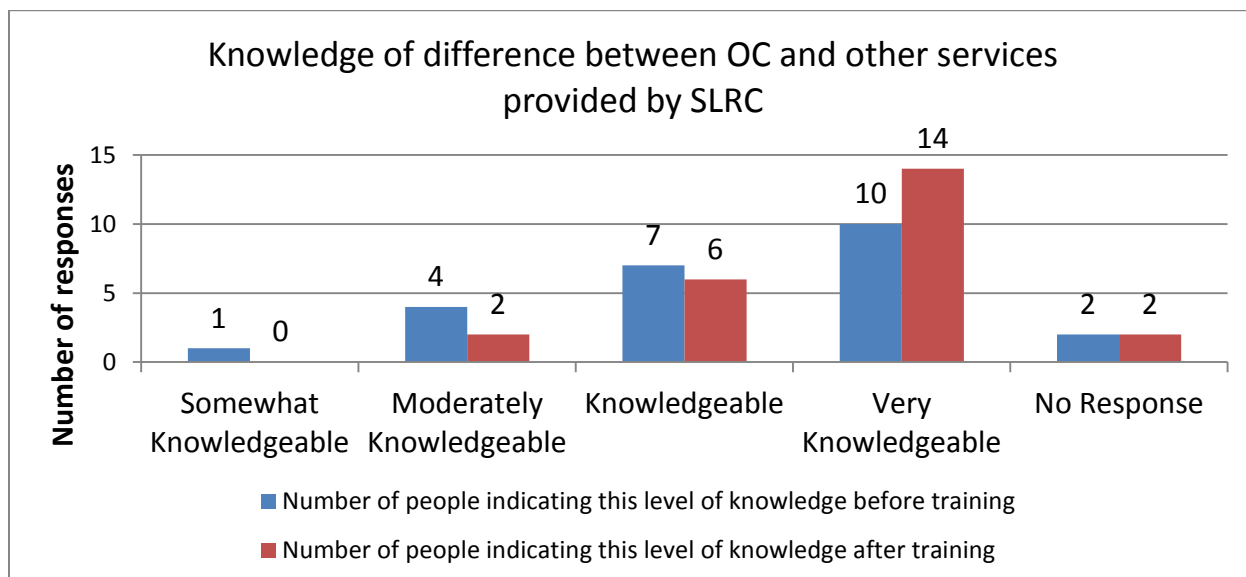


Chart 5: Knowledge of Essential Elements of Decision Support

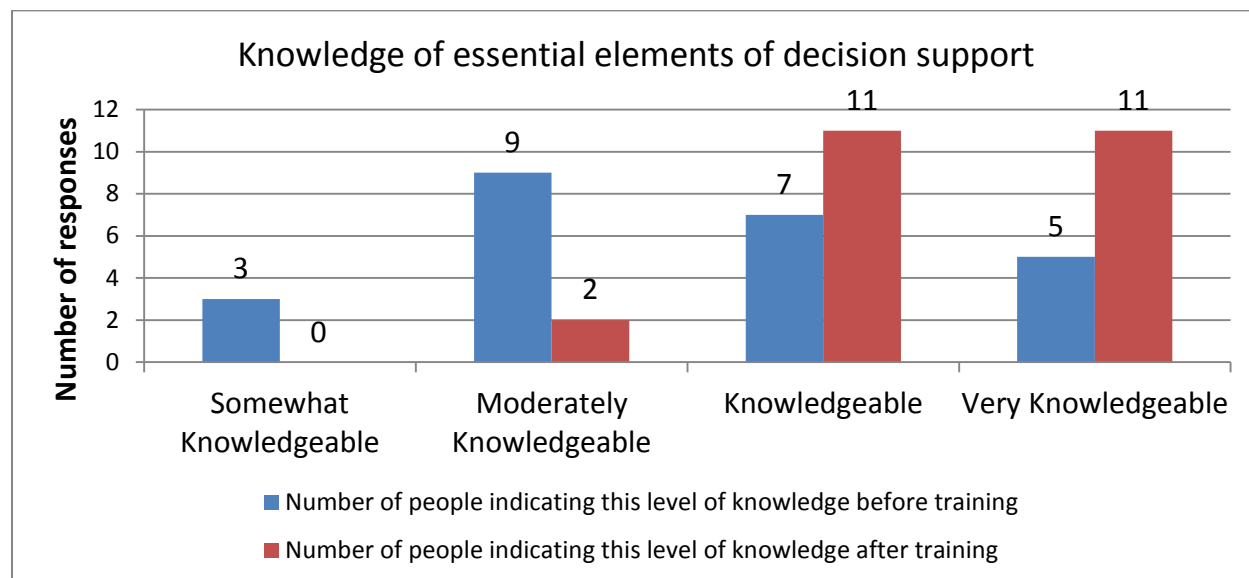


Chart 6: Knowledge of Skills Needed for Successful Options Counseling



Chart 7: Ability to Learn About Person's Values, Preferences, Concerns During Interview

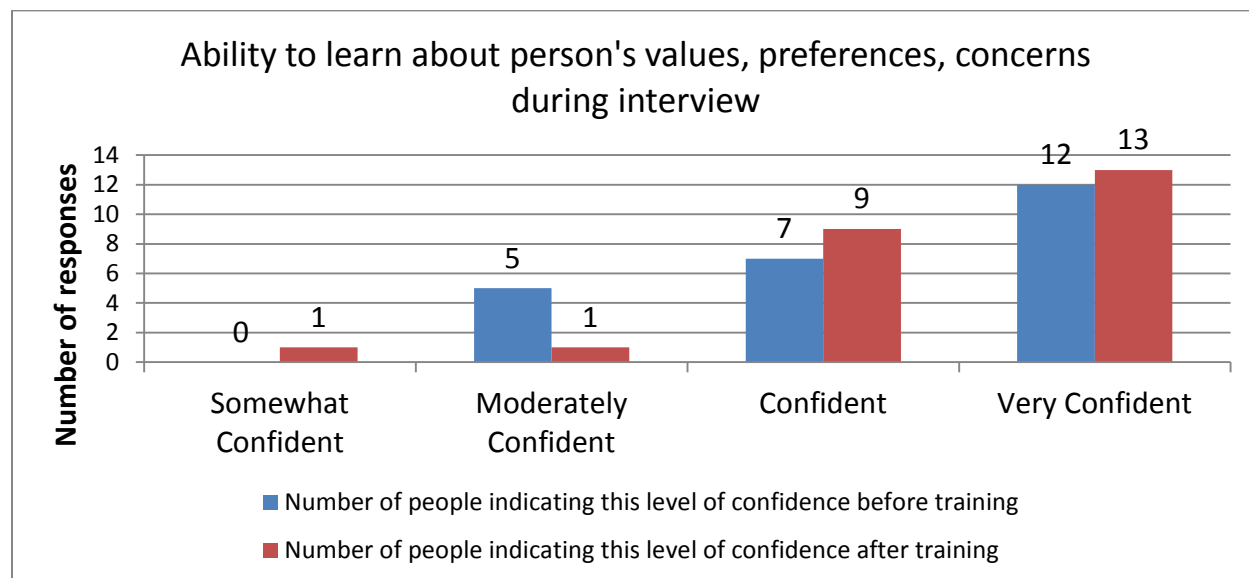


Chart 8: Ability to Evaluate a Person's Decision-Making

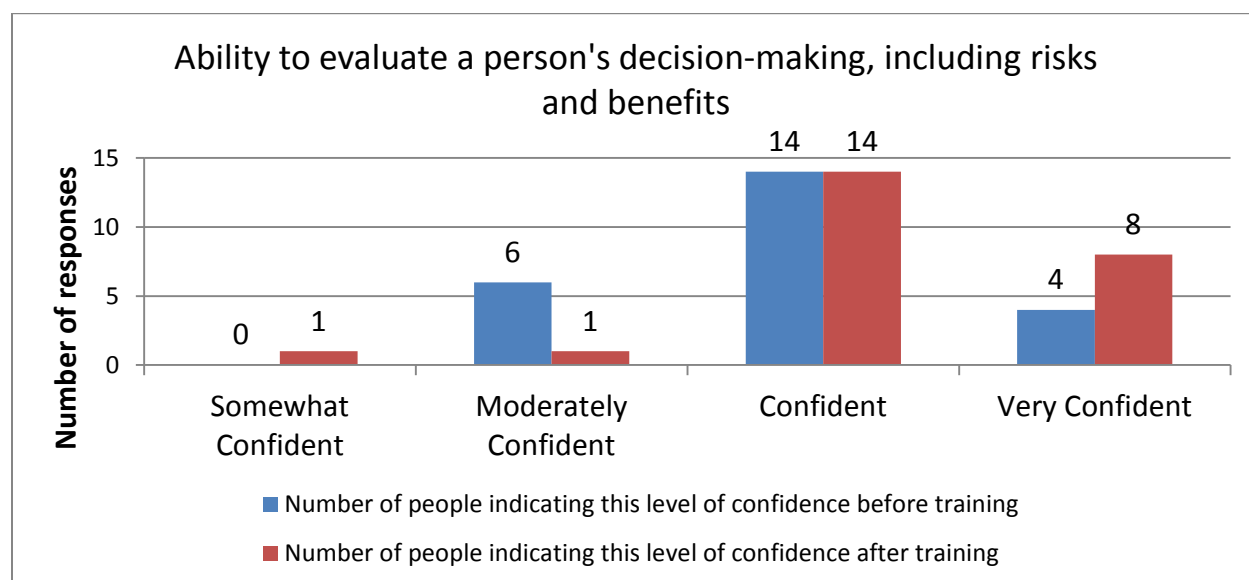
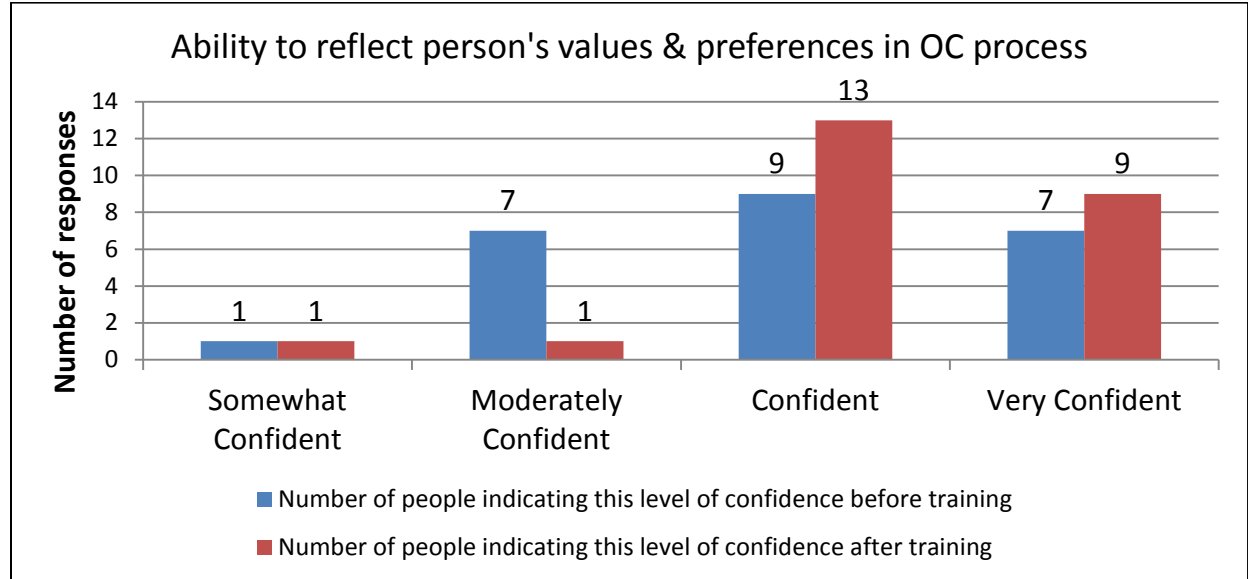


Chart 9: Ability to Reflect Person's Values and Preferences



In general, trainees were mostly confident or at least moderately confident of their understanding of options counseling and their ability to implement options counseling. The training increased their confidence in their skills and ability.

Enhancing the Delivery of Options Counseling: Implementation Techniques and Tools, January 31, 2012

This training was presented in two parts. The first half of the day was targeted to LTSCs and Center Managers. The afternoon session marked the start of the Peer Supervision training, led by Rene Bergeron, PhD, Associate Professor in the UNH Department of Social Work. In the morning, the focus was on 'how-tos' for providing options counseling. As part of the session, participants reviewed and edited a guide to options counseling, intended to support LTSCs in completing the options counseling tool that was added to Refer7. The OC Tool can be found in Appendix G. Presenters provided a detailed description of how to complete the Options Counseling Tool and the Action Plan which were added to the Refer7 data tracking system. In

addition, scenarios were acted out, with participants giving feedback and advice to the interviewer during the scenario. Sixty-seven percent of the participants found the content of the morning session to be useful. Ninety-one percent indicated overall satisfaction with the morning session.

Charts 10-13 provide pre-test and post-test levels of confidence related to the morning session, completing the Options Counseling Tool and the Action Plan, and in assessing an individual's decisional capacity.

Chart 10: Level of Confidence in Completing Options Counseling Tool

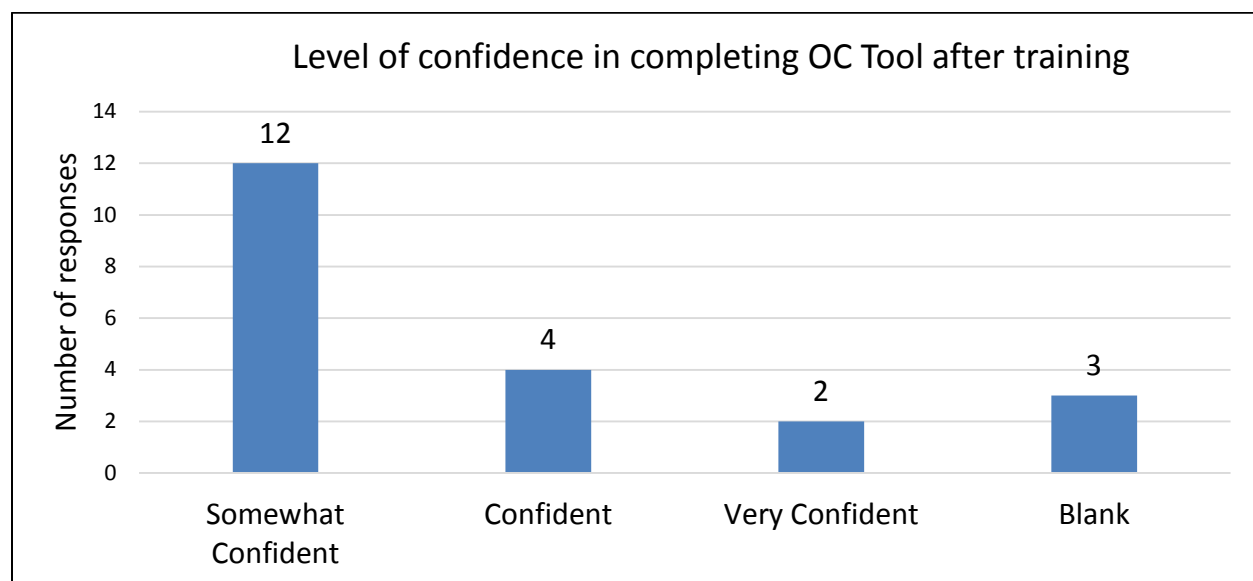


Chart 11: Confidence in Developing a Person-Centered Action Plan

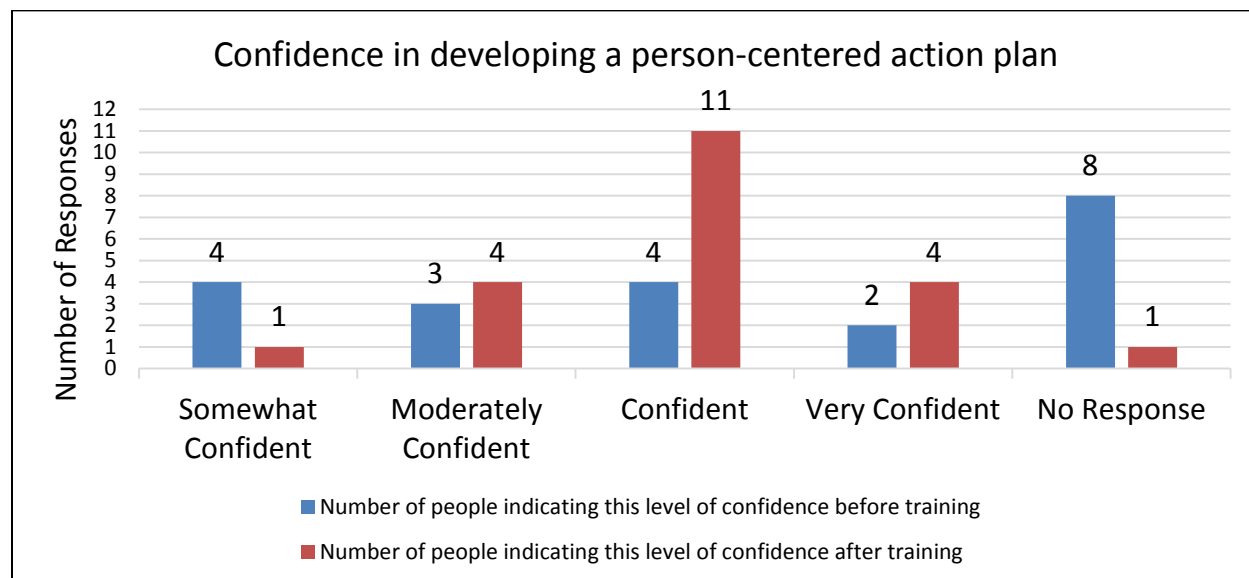


Chart 12: Confidence in Assessing Decisional Capacity

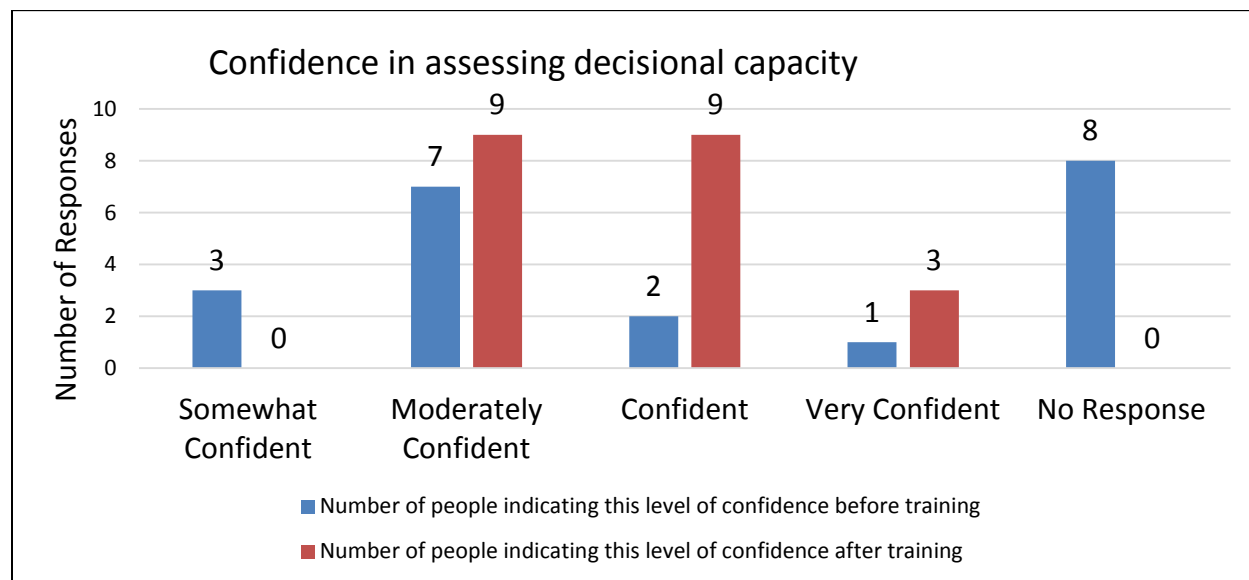


Chart 13: Participants Confidence Level in Managing Ethical Dilemmas



Training in decisional capacity and developing an action plan clearly improved participants' level of confidence. Training increased the participants' confidence in creating a person centered action plan, assessing decisional capability and managing ethical dilemmas. Overall, training increased the participants' confidence in their skills and ability, but further training and support was needed around the use of the new options counseling tools.

For the second half of the day for this training, only LTSCs participated in the session. This session was designed to launch the LTSC peer supervision sessions, led by Dr. Bergeron. Dr. Bergeron's presentation in the afternoon was rated very positively by participants. Ratings of the Peer Supervision Program are located in Dr. Bergeron's full report in Appendix E.

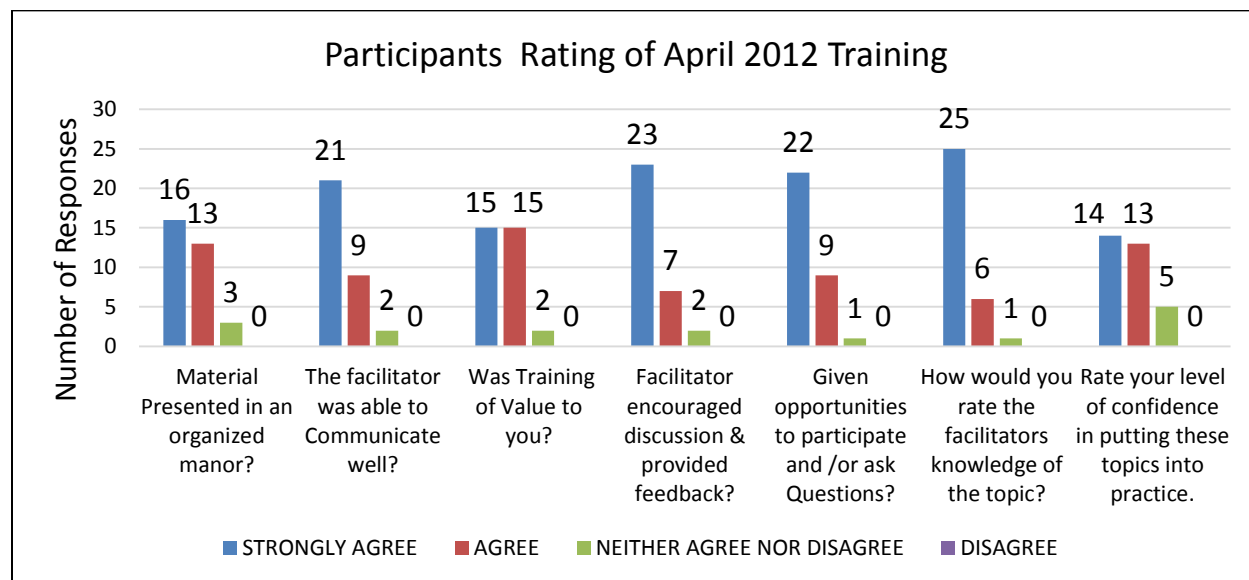
Introduction to the OPTIONS COUNSELING Tool, Action Plan, and Triggers;

plus Refer7 Refresher, April 2012

In April 2012, BEAS and CACL delivered a training to introduce the Options Counseling Tool, the Action Plan, and 'Triggers' for referral to all SLRC staff. In addition, this training reviewed aspects of recording client information in the Refer7 data system. Most SLRC offices

sent all of their staff members to the training, including I&R Specialists, Caregiver Specialists, LTSCs, Center Managers, SHIP, and SMP staff. Chart 14 provides the summary of the participants' rating of the training.

Chart 14: Participants Rating of April 2012 Training



Participants strongly agreed or agreed for the majority of questions. Of particular importance was that the participant's level of confidence in putting the topics into practice (the last question above), had the highest number of responses of "neither agree or disagree" (5 participants). There is an opportunity to develop follow-up trainings to people who continue to have needs to support this issue.

Adult Family Conflict Resolution Training, May 1, 2012

In response to requests for training about conflict resolution from staff delivering options counseling at the local SLRC sites, CACL contracted with Elder Decisions, a Massachusetts-based provider of, and trainer about, mediation services. A total of 26 staff from SLRC's around the state participated, a combination of LTSC (61%) and Caregiver Specialists (35%). Overall, participants indicated that the training session improved their conflict resolution skills, but also

made it clear that this training was not advanced enough for them given the high level of their daily interactions. Charts 15-22 provide the pre-test/posttest results for questions focused on conflict resolution, consensus building, developing options, and moving from options to resolution. Participants indicated their appreciation for the training, but also indicated a need for more advanced training about conflict resolution, specifically focusing on strategies for de-escalating angry individuals and family situations.

Chart 15: Knowledge of Conflict Resolution Techniques

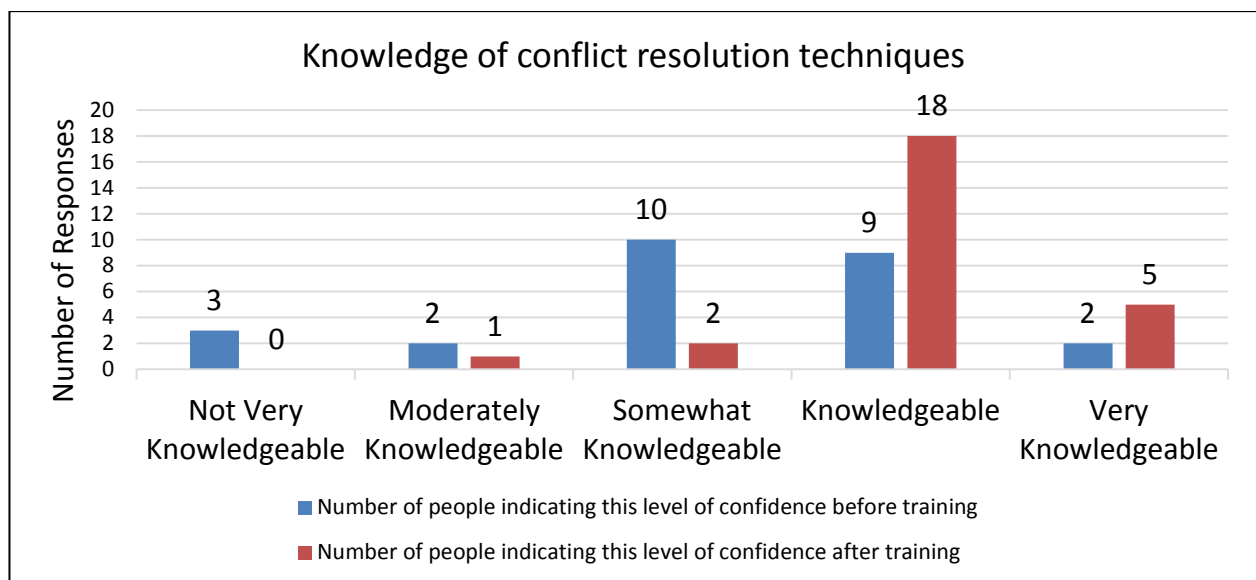


Chart 16: Knowledge of Person Centered Decision Support

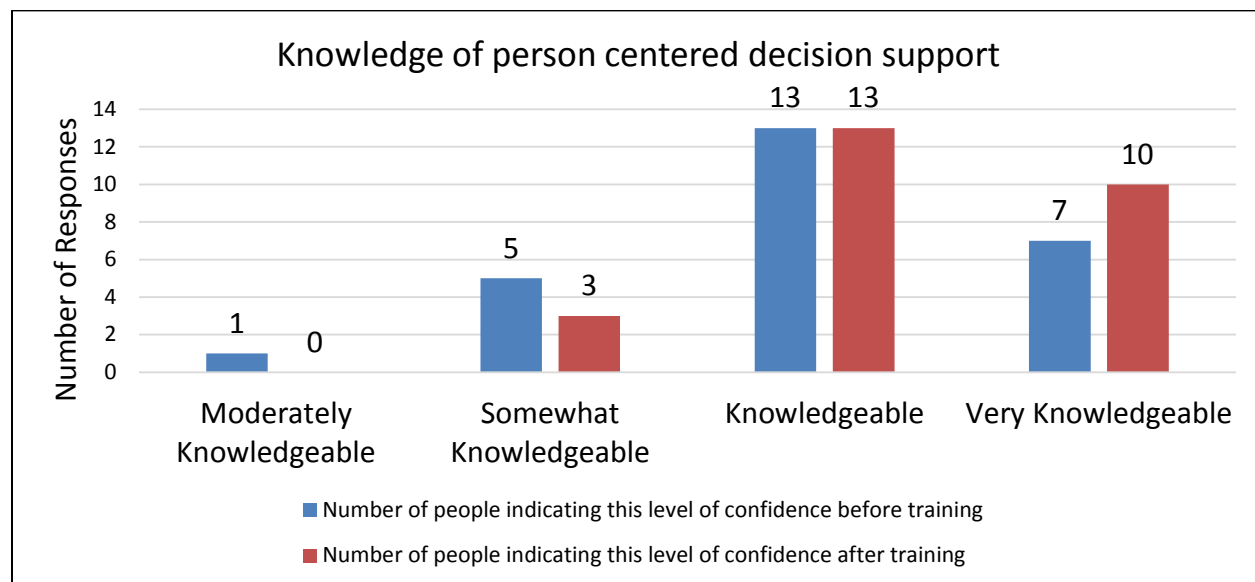


Chart 17: Knowledge of consensus building

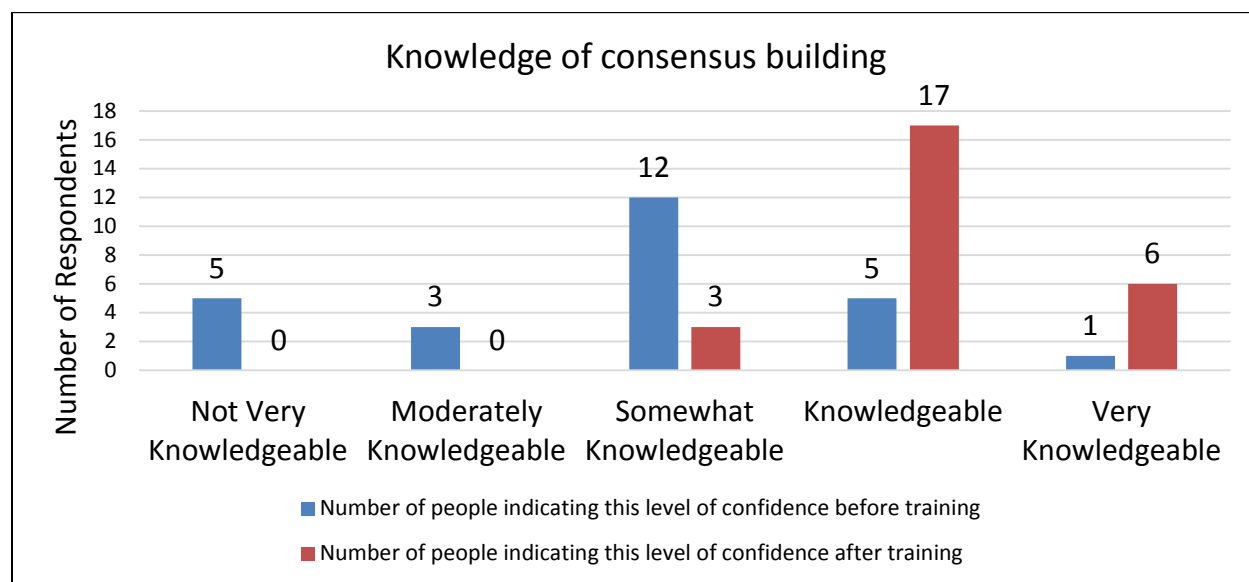


Chart 18: Confidence in Moving from Options to Resolutions

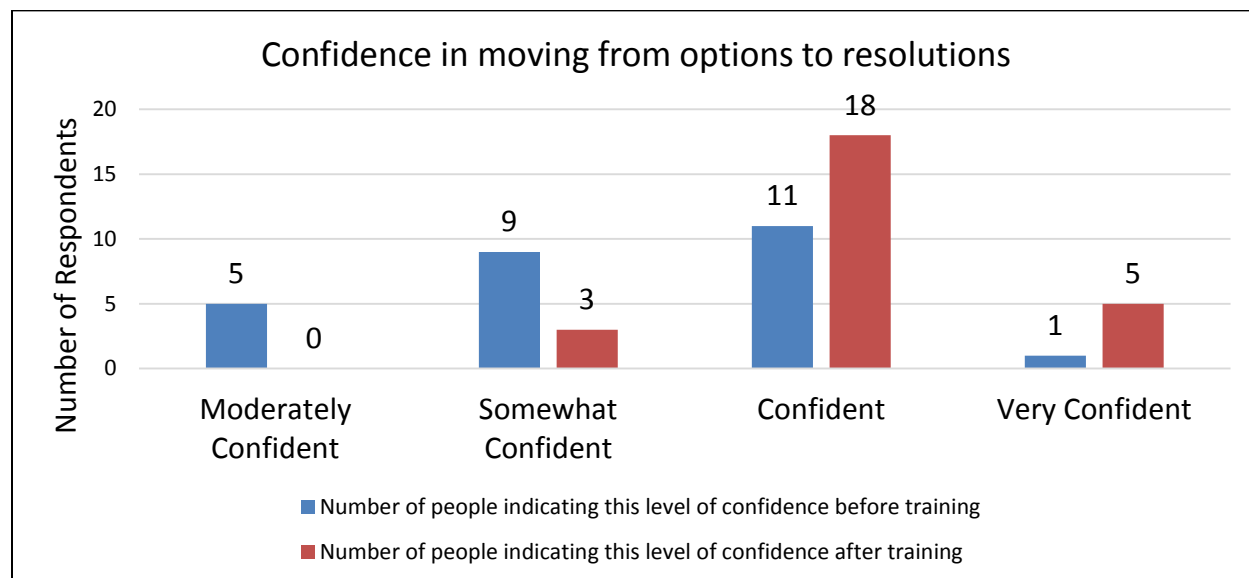


Chart 19: Confidence in Generating Options Based on Interests

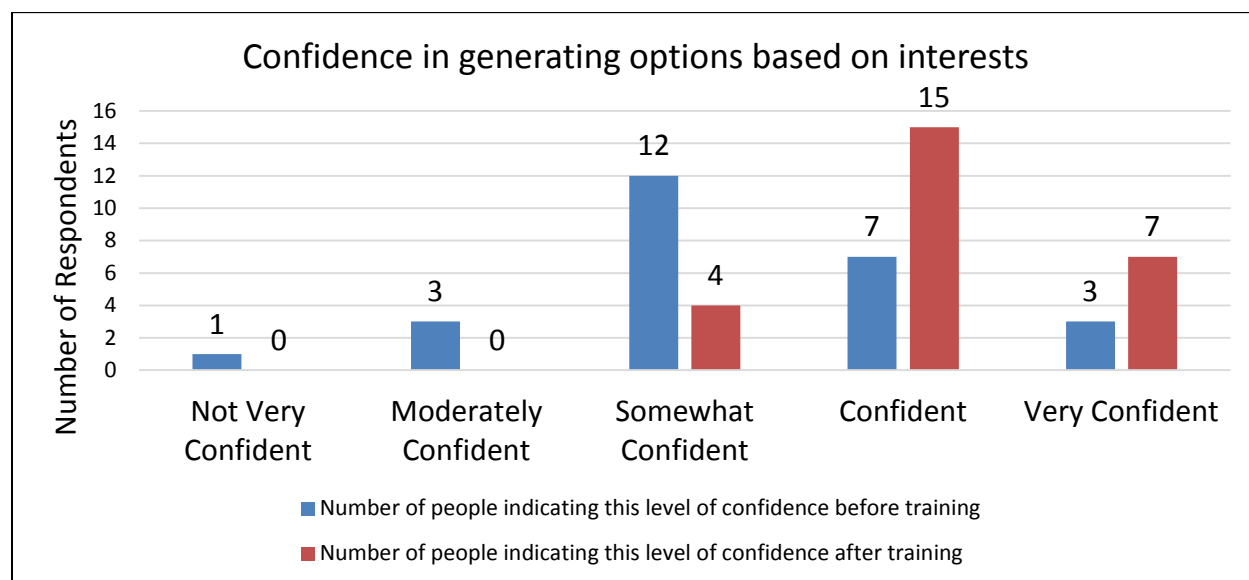


Chart 20: Confidence in Building Consensus

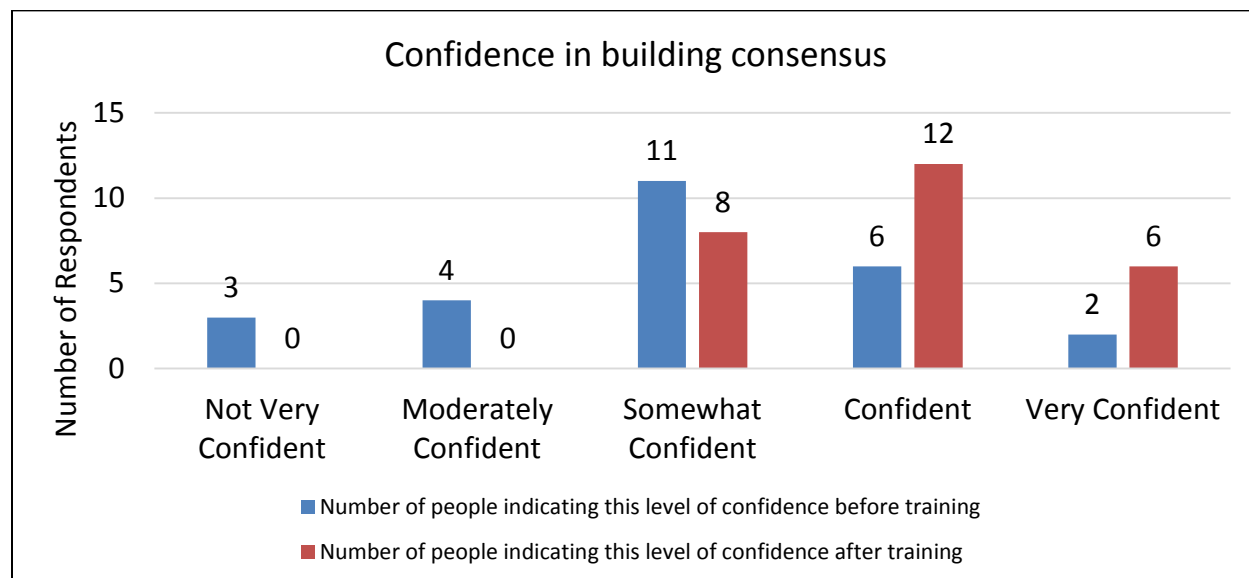


Chart 21: Confidence in Using Interactive Communication Skills

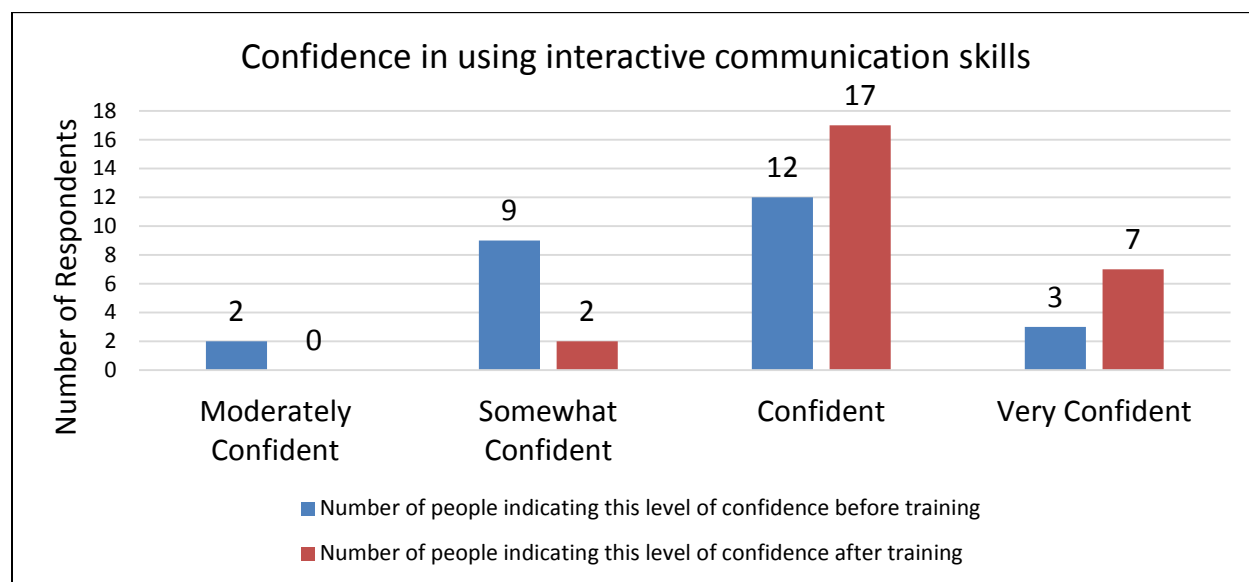
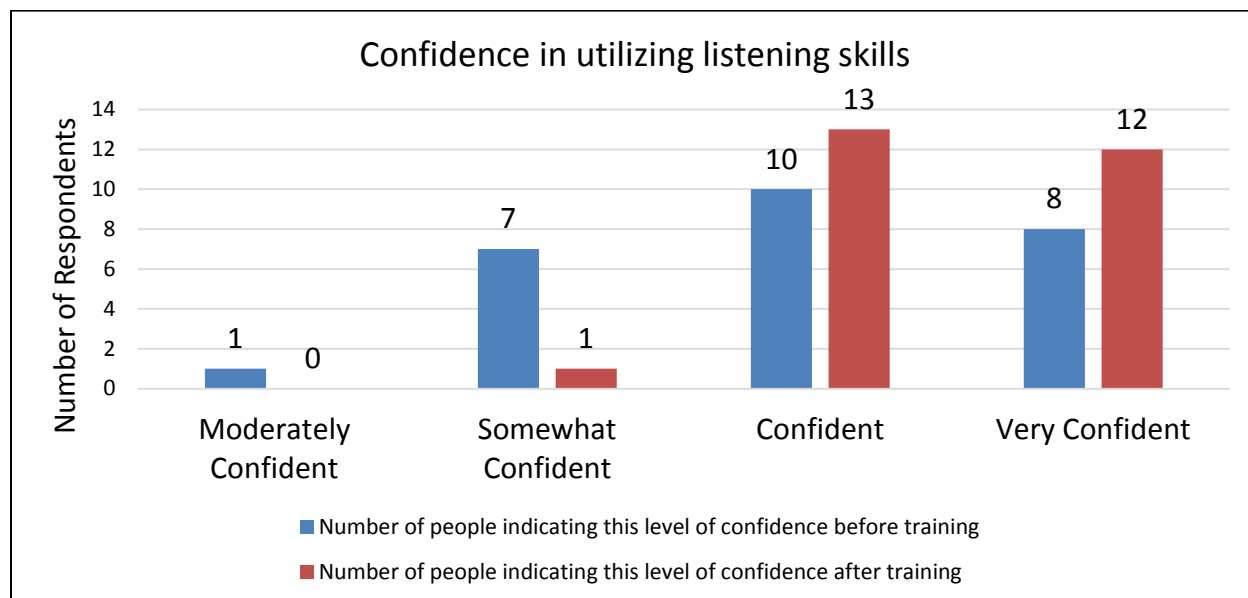


Chart 22: Confidence in Utilizing Listening Skills



Options Counseling: Past, Present and Future, August-September, 2013

In August and September 2013, two CACL staff visited all main SLRC sites to review and receive feedback on the trainings and tools developed through the 2010 Options Counseling and Assistance project. A brief overview of project, a description of the future of Options Counseling from the federal perspective, an outline of how the federal program views options counseling as part of all SLRC roles were provided. This was followed by an open session for discussion of Refer7, the Options Counseling Form and the Action Plan Form, and feedback on training needs. A copy of the presentation is located in Appendix C.

Participants made significant comments regarding training for SLRC staff. Overall, there was a general consensus that there should be consistent, statewide, ongoing training effort that would help to ensure standard delivery of the ADRC model. State-level training should include general SLRC orientation and a tutorial on Refer7. Some commented that it is expensive to send people to training, both from the perspective of having a person go and finding coverage for the

individual while they are out of the office. Peer supervision sessions (discussed in detail later in this report) were seen as useful and desirable for all staff roles, providing assistance with problem solving and coping with emotionally demanding jobs. Others, however, were not sure of the purpose of peer supervision. A suggestion was made to have a point person available to bounce ideas off of for Options Counseling across all positions. A full report with the feedback received is attached in Appendix D. The feedback received during this presentation will be used in future planning for SLRC's, and in designing future training and implementation of the certification process for Person Centered Counseling.

Another component of training for the LTSC focused on person centered planning. UNH offers *Methods, Models & Tools for Facilitated Person-Centered Planning*, an intensive five-day workshop designed to develop the competencies needed to facilitate consumer and family directed career, education, and life planning. This course is offered once per year in early June. A goal of the project was for all LTSCs to take this workshop. Of the fourteen current LTSCs, ten have completed the course. However, three of these individuals are new to their positions as of July, 2013. They started in their positions after the course was offered in 2013. They will likely take the course next June. Thus, ten of the eleven LTSCs in their position as of June 2013, or 91%, have completed the course.

Overall, the trainings gave all SLRC staff an understanding of the definition, components, competencies and documentation of delivery of effective and consistent Options Counseling. One shortcoming of the training program was a lack of follow up training and support with staff other than the LTSCs.

Peer Supervision Program

LTSCs participated in an ongoing Peer Supervision Program during this grant period aimed at achieving objective 2: *Implement options counseling standards defined by the operational protocol*. The program, started in January of 2012, grew out of recognition of the need for consistent education and support across all SLRC sites, specifically around expectations for the LTSC position. The goal of Peer Supervision was to promote professional credibility and integrity through the dissemination and discussion of best practice standards and sharing resource options, which enhanced the management of challenging cases as well as strengthened collaboration across SLRCs.

As previously discussed, Peer Supervision was initially led by Dr. Rene Bergeron, UNH Professor of Social Work. A total of eight workshops were held on a monthly basis for individuals in the role of LTSC at SLRCs. These workshops consisted of a lecture portion and a peer supervision discussion. The lectures consisted of one-and-a-half-hour sessions on topics revolving around ethics and included: Historical Review of Ethics, Client Autonomy and Duty to Protect, The Rights of the Practicing Professional and Ethics of Care, Continuing Ethics of Self-Care and Case Studies, Ethics in Group Work and How to Facilitate a Group, Caregivers Role in Ethical Practice, Ethical Responsibility to Employing Agency and Colleagues and Writing a Proposal /Termination of Group. The peer supervision portion was facilitated by Dr. Bergeron and gave the LTSCs the opportunity to get to know each other, support one another, share cases and solutions and share frustrations and the inherent difficulties of their work.

The final evaluation of Dr. Bergeron's program found that 95% of participants strongly agreed that the content on the topic was useful; 99% of participants believed that it was important to get together as a group; 99% of participants would like to continue to meet as a

group and 99% of participants stated that the instructor was a good facilitator for the group process. These workshops enhanced LTSCs ability to participate, voice their frustrations, present sensitive cases and gain new insights for resolution, which developed new ways of communication with colleagues, clients, and the elder's family. These points make for cultivating stronger workers, with less chance of burn-out, more proficient in use of their time, and better networking abilities because of these face-to-face meetings – which makes for effective and clear communications with their supervisors.

Dr. Bergeron was not available after September 2012 to direct the Peer Supervision Program, so CACL staff took the lead. The program followed a similar pattern to Dr. Bergeron's program, but educational components were chosen by the LTSCs rather than by the group leader.

Overall, the program enhanced professionalism statewide by increasing competence and consistency of implementation of the multiple SLRC programs and projects. The program created and provided an open and confidential environment for discussion of specific, challenging cases, as well as larger discussion of issues around ethical dilemmas and professional integrity. It has encouraged the development of mentoring relationships between new and more experienced LTSCs. LTSCs have indicated that it increased the consistency and effectiveness of their delivery of options counseling.

Table 2 provides the topics of the education components for the Peer Supervision Program and indicates the number of LTSCs that attended each session. Dr. Bergeron's summary evaluation report is included in Appendix E.

Table 2: Long Term Counselor Peer Support Educational Sessions

Long Term Counselor Peer Support Educational Sessions					
Educational Topic	Date	Trainer	# Attend	% of LTSCs*	Results
Ethics: The beginning	1/31/12	Rene Bergeron	18	100	Evaluation summarized all Rene Bergeron sessions. Results were very positive. See attached final summary evaluation for detailed results.
Ethics: Who <i>is</i> the client? Client Autonomy and Duty to Protect	2/24/12	Rene Bergeron	11	79%	As above.
The Rights of the Practicing Professional and Ethics of Care	3/30/12	Rene Bergeron	14	100%	As above.
Continuing Ethics of Self-Care and Case Studies	4/27/12	Rene Bergeron	14	100%	As above.
Ethics in Group Work and how to facilitate a group	6/22/12	Rene Bergeron	13	93%	As above.
Review of Previous Workshops, Caregivers Role in Ethical Practice, More on Peer-Led Groups	7/27/12	Rene Bergeron	8	57%	As above.
What is My Ethical Responsibility to my Employing Agency and to my Colleagues?	8/24/12	Rene Bergeron	6	43%	As above.
Termination. How to write a proposal	9/21/12	Rene Bergeron	12	86%	As above.
Discussion of continuing peer support and proposal development	11/2012	Melissa Mandrell	12	86%	Participants developed a proposal for continued peer supervision.

New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

Long Term Counselor Peer Support Educational Sessions					
Educational Topic	Date	Trainer	# Attend	% of LTSCs*	Results
Confidentiality and Communication: HIPAA and beyond	1/18/13	Nancy Sauter	9	64%	Group satisfied with information presented; useful in their everyday work.
Overview of Organizational Structure	2/22/13	Laura Davie	12	86%	Group very satisfied with presentation content and presenter.
Emotional Contagion	3/22/13	Nancy Sauter	11	79%	Group satisfied with presentation, but wanted more substantive topics covered
E-Studio Review & Training	4/26/13	Wendi Aultman	10	71%	Overall average satisfaction; Appreciative of content, but wanted clearer answers
Can't We All Just Get Along?: Conflict Resolution Training	5/24/13	Kate Crary	9	64%	No evaluation
Presumptive Eligibility Training	6/28/13	Mickie Grimes	14	100%	No evaluation
Strategies for Self Care	7/2013	Marty Fuller	10	71%	Overall low satisfaction with presenter and content: 25% highly satisfied, 50% somewhat satisfied, 25% not at all satisfied
Veteran's Benefits Process	9/2013	Peter Higginbotham Veterans Service Officer	11	79%	Very successful: 100% highly satisfied with presentation and presenter.

* Percentage based on average of 14 Long Term Support Counselors in SLRC Network. Turnover and absence due to medical leave changes number of LTSCs at any given time and vacation/illness affected attendance at any given session. However, percentages don't reflect this variation.

Objective 3: Develop and define the role of LTSC in BEAS's quality improvement process for the SLRC Network.

Overview & Summary: Goal 1, Major Objective 3

Over the course of the Options Counseling and Assistance grant project, BEAS utilized the options counseling protocol, the options counseling standards, and the training developed to inform the quality improvement process for the SLRC Network. This ultimately resulted in updating the SLRC ADRC contracts. Starting January 2014, each SLRC site will track and report to DHHS demographic information, including information on age and type of disability. SLRC sites will also provide data indicating 1) options counseling enabled people to make informed, cost-effective decisions about LTSS; 2) the number of individuals diverted from nursing home/institutional settings; and 3) the number of individuals successfully transitioning from institutional settings (i.e., number of people assisted through formal coordinated or evidence-based transitions programs). Under the 2012 Part A Enhanced Options Counseling grant, a goal will be to developing standardized approaches to collecting and reporting this data. Training and assistance will be given to local SLRC sites as needed to support this effort.

Objective 4: Develop process for including other SLRC staff in the training, tracking, and use of outreach materials for options counseling

Overview & Summary: Goal 1, Major Objective 4

The work for Objective 4 has been addressed as part of several other activities. As contracts have been developed for SLRC by BEAS, options counseling, including person centered approaches to services, have been part of the requirements outlined for all job duties. This includes activities that cover the 'full range' of options counseling, such as consideration of

long term care options, support for family caregivers, Medicare Part D assistance, and information and referral.

To achieve this objective, three trainings, listed in Table 2, were offered to all SLRC staff: *Orientation to Federal and State Initiatives (“Roadshow”); Introduction to the OC Tool, Action Plan, and Triggers plus Refer7 Refresher; and Options Counseling: Past, Present, and Future (“Roadshow Revisited”)*. Each of these trainings provided the context of options counseling as part of a fully functioning ADRC.

While several trainings were developed and the options counseling tracking and tools were available to all SLRC staff, one training area that was delayed in implementation was the complementary peer supervision sessions for staff other than LTSC. As this 2010 Options Counseling and Assistance grant started into its final year, ACL released the 2012 ADRC Enhanced Options Counseling grant opportunity, which New Hampshire received. Under this new project, ACL is working towards national certification for options counseling. Further development of state based trainings, including the expansion of peer supervision, is on hold until national certification is defined.

Objective 5: Develop an evaluation plan for options counseling standards

Overview & Summary: Goal 1, Major Objective 5

New Hampshire submitted an evaluation plan for options counseling as a major deliverable to ACL under the Options Counseling and Assistance grant in August of 2011. The plan described short and long term goals for evaluating options counseling in New Hampshire both at the system and client level per deliverable guidelines. The full evaluation plan can be found in Appendix A. ACL acknowledged the long-term view of the plan, and that all aspects of the

evaluation plan would not be conducted under this grant period. Provided in this section is the baseline data collected under the evaluation plan. The process of collecting, lessons learned, and baseline data will be used to continue to evaluate and improve the evaluation of options counseling under the 2012 ADRC Enhanced Options Counseling grant.

Evaluation of the changes in the Refer7 database and the action plan tool

Two tools, the *Options Counseling Tool* and the *Action Plan*, were designed in consultation with LTSC and Center Managers, to assist in the standard delivery of options counseling across all sites. In addition to the tools, an Interview Guide was created to suggest approaches to asking questions, important considerations, and other tips. (Interview Reference Guide is attached in Appendix G. OC Tool and Action Plan forms can be found on pages 26 and 33 respectively of the Guide.)

SLRC staff members were introduced to the specific elements of options counseling in the April 2012 training session. As part of the training, ‘triggers’ for referring someone for more in depth options counseling were discussed, and training was provided to all SLRC staff on the Options Counseling Tool and the Action Plan. Staff were encouraged to use any part of the Options Counseling Tool that seemed appropriate for a particular individual or family. In addition, staff was encouraged to develop Action Plans in conjunction with the people they were working with, assigning tasks to both staff and the individuals. Ideally, staff would print out copies of the completed Action Plan for people to take with them, and could use the plan as a starting point for follow up calls and discussions.

The evaluation plan for options counseling includes evaluating the completion and quality of the Options Counseling Tool and utilization of the Action Plan. Metrics for these outcomes are still in development. Even though there was poor utilization of the OC Tool and Action Plan during the grant period, during the August/ September 2013 sessions at the local SLRC sites,

CACL staff received significant feedback on the utility of Refer7, the OC Tool, the Action Plan, the identified ‘triggers,’ and training on these items. The information collected during these sessions will be used in refining the tools used to document options counseling. Baseline results for the use of the OC Tool and Action Plan are discussed below.

Baseline demographic data

Charts 23-28 provide information from all the SLRC sites for contacts made between February 1, 2012 and September 28, 2013. This information provides the baseline data that the evaluation plan aimed to collect. From this baseline data, the evaluation plan will be re-evaluated under the 2012 Part A Enhanced Options Counseling grant. The following metrics were compiled using the SLRC Refer7 Database. SLRC Staff, including LTSCs, use the Refer7 database to track all calls and contacts. In general, information in the database pertains to the nature of the request and any follow-up, including referred services, made on behalf of the client.

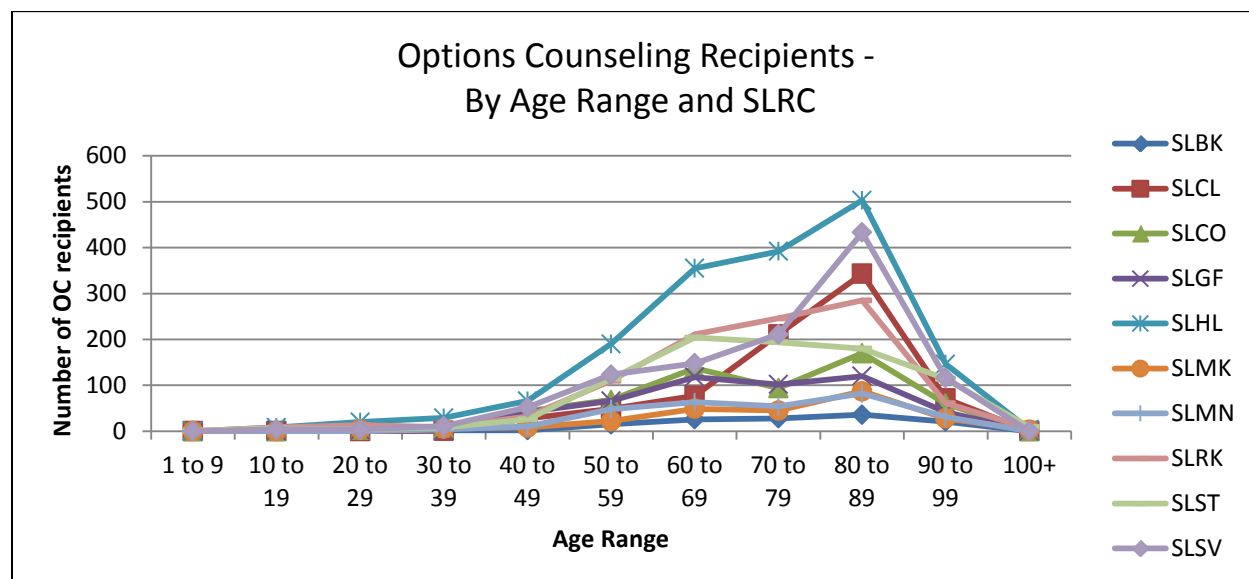
Older adults were the largest population to receive options counseling across New Hampshire. Generally, data shows a trend that options counseling services increased as age increased. Beginning at age 35 and continuing until age 89, the amount of options counseling steadily rose to accommodate the older population seeking services. After age 89, options counseling recipients decreased dramatically. ServiceLink of Hillsborough County (SLHL in chart 23) served the most options counseling recipients ($n = 503$), within the age range of 79 to 89. Similarly, ServiceLink of Sullivan County (SLSV) ($n = 433$), ServiceLink of Carroll County (SLCL) ($n = 343$) and ServiceLink of Rockingham County (SLRK) ($n = 285$) served the most individuals in options counseling in the 79 to 89 age range.

Table 3 provides a key to abbreviations for ServiceLink sites used in charts 23-35 below.

Table 3: SLRC Abbreviations

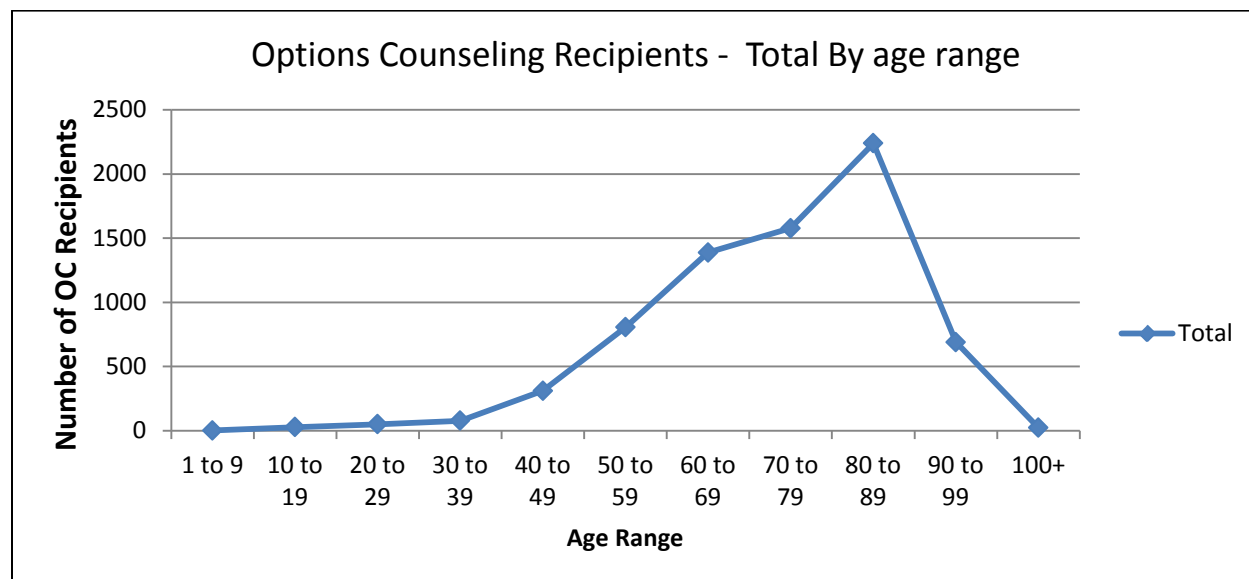
SLRC Abbreviations	
SLBK	ServiceLink of Belknap County
SLCL	ServiceLink of Carroll County
SLCO	ServiceLink of Coos County
SLGF	ServiceLink of Grafton County
SLHL	ServiceLink of Hillsboro County
SLMK	ServiceLink of Merrimack County
SLMN	ServiceLink of Monadnock Region
SLRK	ServiceLink of Rockingham County
SLST	ServiceLink of Strafford County
SLSV	ServiceLink of Sullivan County

Chart 23: Options Counseling Recipients by Age Range and SLRC Site



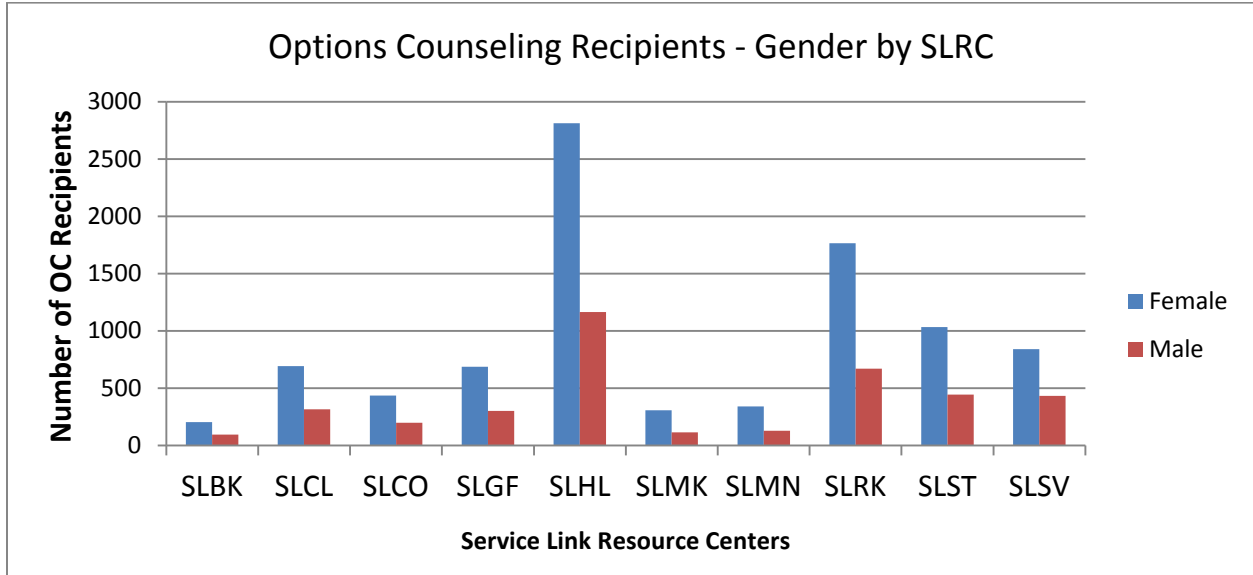
With all counties combined, Chart 24, results show that the older adult population received the highest amount of options counseling. The largest age range to receive options counseling was the 80-89 population ($n = 2,239$). Data showed that as individual's age increased the more services they accessed, equaling a higher likelihood that they received options counseling. Furthermore, after age 89, the number of recipients receiving options counseling drastically declines.

Chart 24: Options Counseling Recipients-Total by Age Range



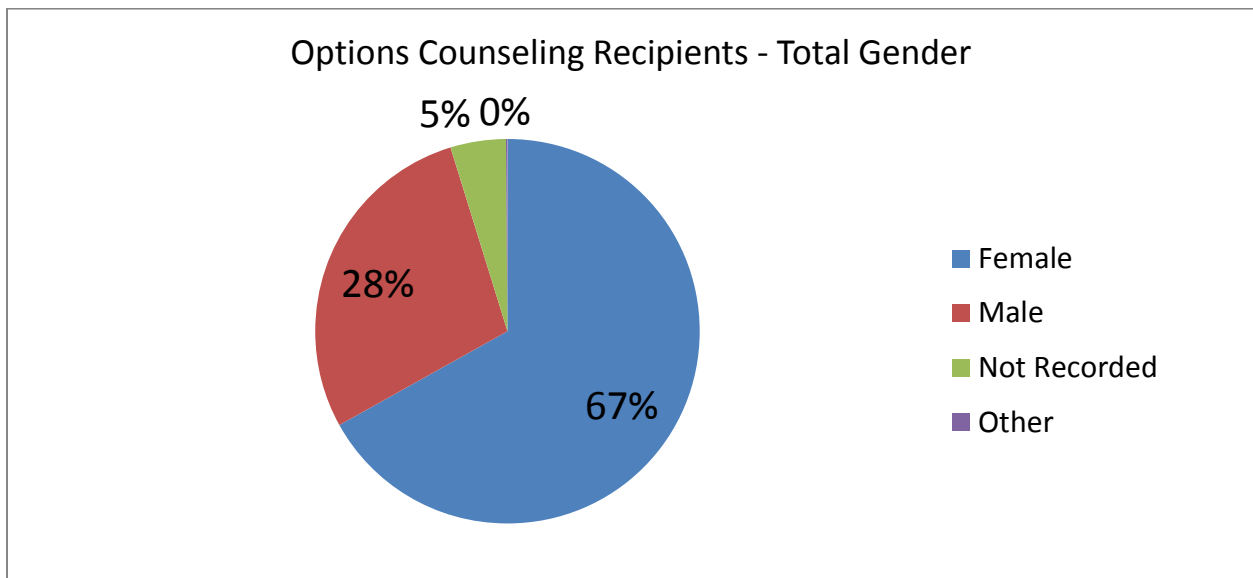
Data demonstrates that more women than men received options counseling. At ServiceLink of Hillsborough County, (SLHL in chart 25) 2,813 females were recipients of options counseling, as compared to 1,165 males. At ServiceLink of Rockingham County (SLRK), 1,766 females were served, compared to 670 males. Other counties showed similar discrepancies on a smaller scale. This could be due to a number of reasons, including that women live longer than men, and that women are more likely to seek supports than men.

Chart 25: Options Counseling Recipients- Gender by SLRC



Looking at all counties combined in chart 26, data reiterates that 67% of individuals that received options counseling were female, as compared to 28% that received options counseling were male. Data was not recorded for 5% of individuals who received options counseling.

Chart 26: Options Counseling Recipients- Total Gender



The most common primary insurance type reported by individuals seeking options counseling is Medicare (Chart 27) followed by Medicaid. Collecting insurance type is encouraged in the local SLRC sites, however it is not mandated. In line with interests expressed by ACL and CMS, SLRCs in New Hampshire are voluntarily collecting insurance type in order to understand the possible insurers to whom options counseling services may be billable in the future.

Chart 27: Options Counseling Recipients- Insurance by SLRC

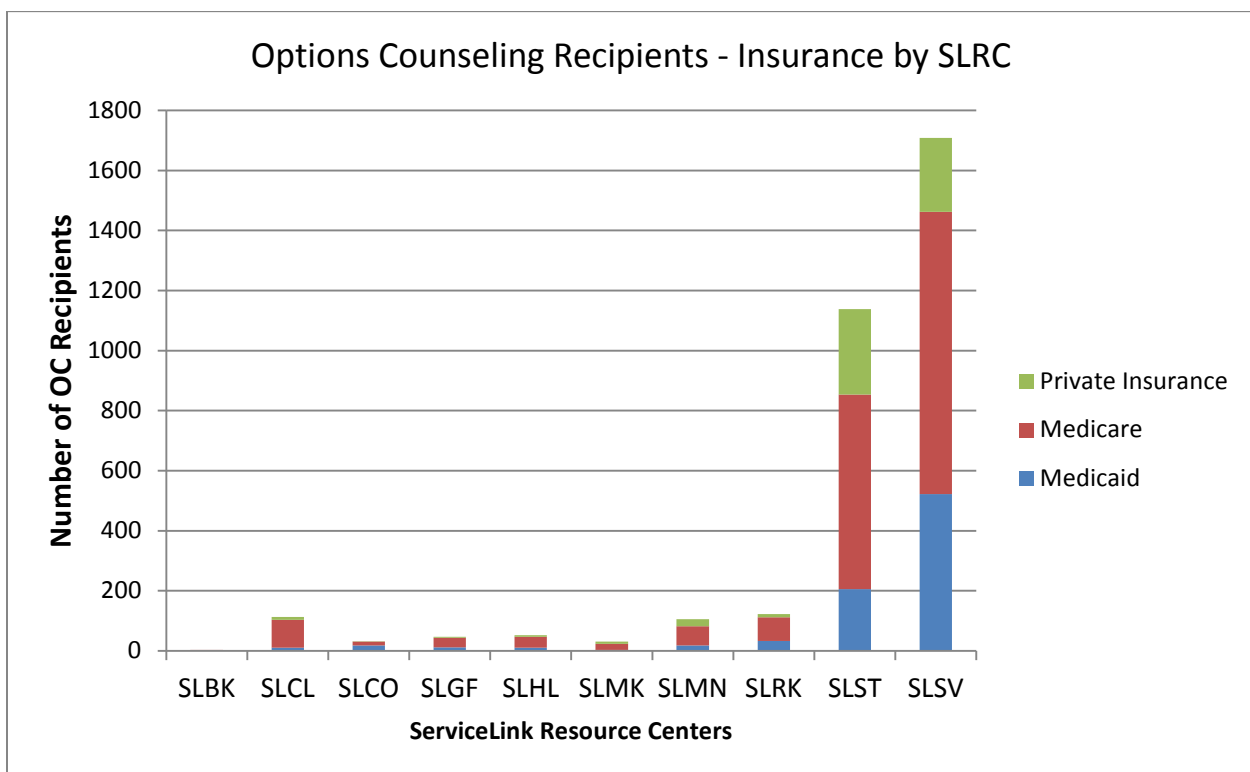
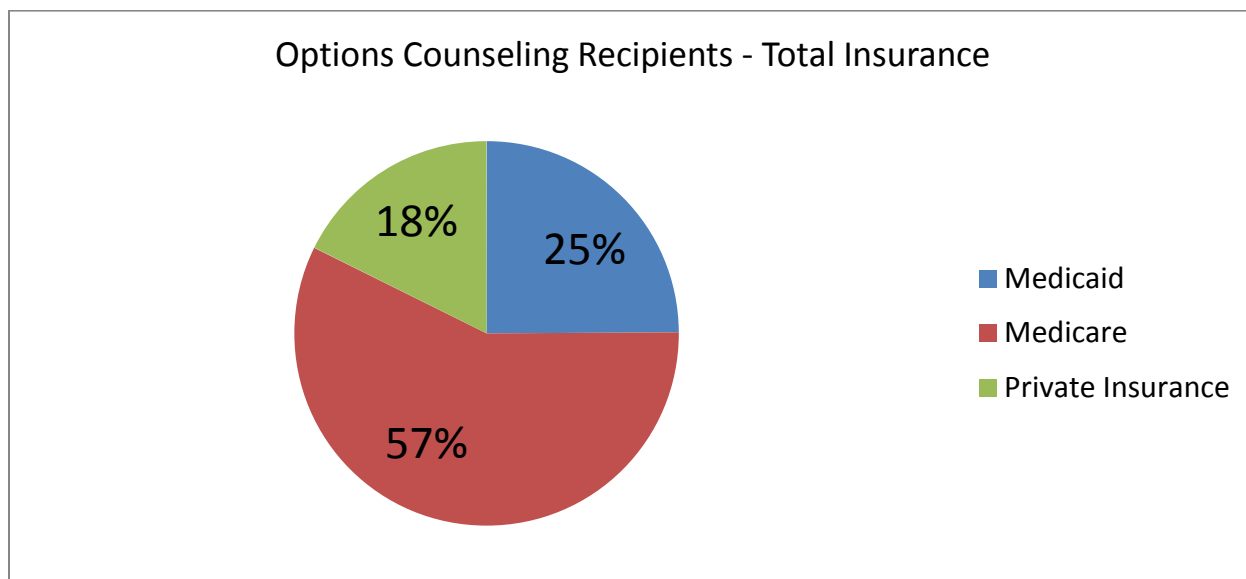


Chart 28 shows with all counties combined 57% of the individuals who received options counseling had Medicare. Further, 25% of recipients were covered by Medicaid and 18% had private insurance.

Chart 28: Options Counseling Recipients-Total Insurance



Based on zip code, data presented in table 4 demonstrates that ServiceLink of Hillsborough County ($n = 3,713$) and ServiceLink of Rockingham County ($n = 2,380$) provided the most options counseling. ServiceLink of Belknap County ($n = 324$) and ServiceLink of Monadnock ($n = 424$) provided the least options counseling. When compared to county population, the variation would be controlled. Overall, data shows that 12,754 options counseling recipients are residents of New Hampshire, while 280 options counseling recipients came from out of state.

Table 4: Number Receiving Options Counseling by Zip Code

ServiceLink Resource Center	Number receiving Options Counseling by Zip Code
Belknap County	324
Carroll County	990
Monadnock (Cheshire County)	424
Coos County	663
Grafton County	940
Hillsborough County	3713
Merrimack County	674
Rockingham County	2380
Strafford County	1471
Sullivan County	1175

New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

Out of State	
MA	173
CT	2
ME	59
VT	41
RI	5

Evaluate the Long Term Support Counselors' Delivery of Options Counseling.

Tables 5-8 and Charts 29-38 provide summary measures of options counseling delivery, based on information from the SLRC Refer7 Database. SLRC staff, including LTSCs, use the Refer7 database to track all calls and contacts. In general, information in the database pertains to the nature of the request and any follow-up, including referred services, made on behalf of the client. The tables and charts reflect contacts made between February 1, 2012 and September 28, 2013.

Results showed that six main areas often triggered referrals to long term support counselors including: inquiring about Choices for Independence waiver and nursing facility applications (CFI/NF), State Plan Medicaid (CFI/NF/Medicaid), concerns about care, long-term support needs, potential future care and a drastic change in circumstances. Individuals sought LTSCs 27% of the time regarding CFI/NF and 24% of the time when they needed long-term support services. Twenty-one percent of the time individuals sought help due to planning for the future and 20% of the time about concerns for care. Individuals only sought help 7% of the time when circumstances had dramatically changed and only 1% of the time for CFI/NF/Medicaid.

Chart 29: Trigger Referrals to Long Term Support Counselors- Total

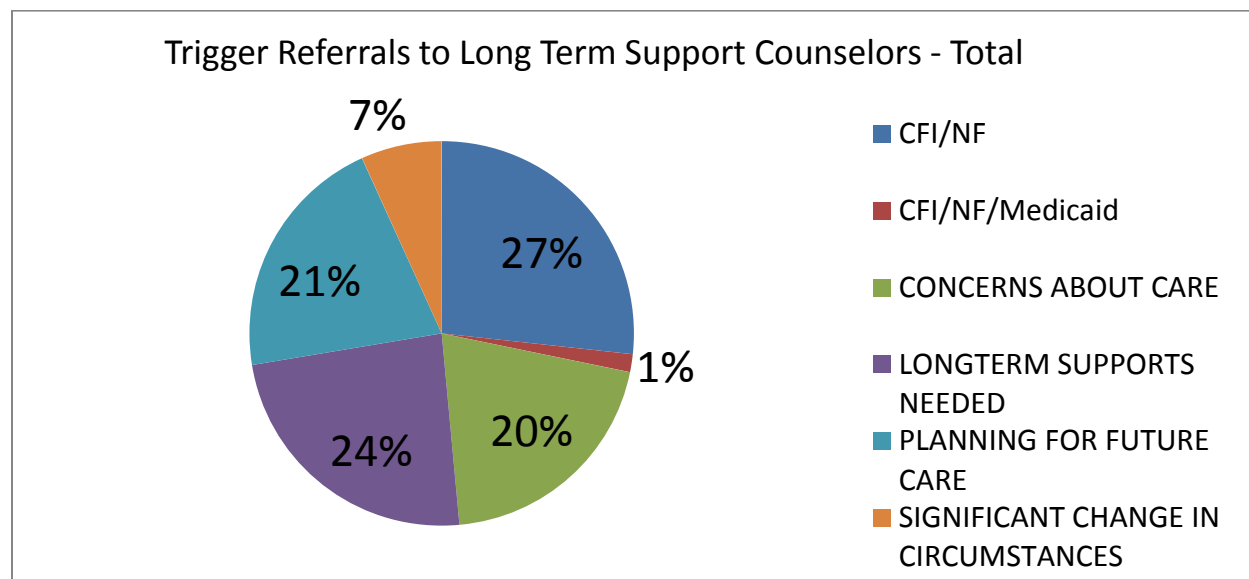


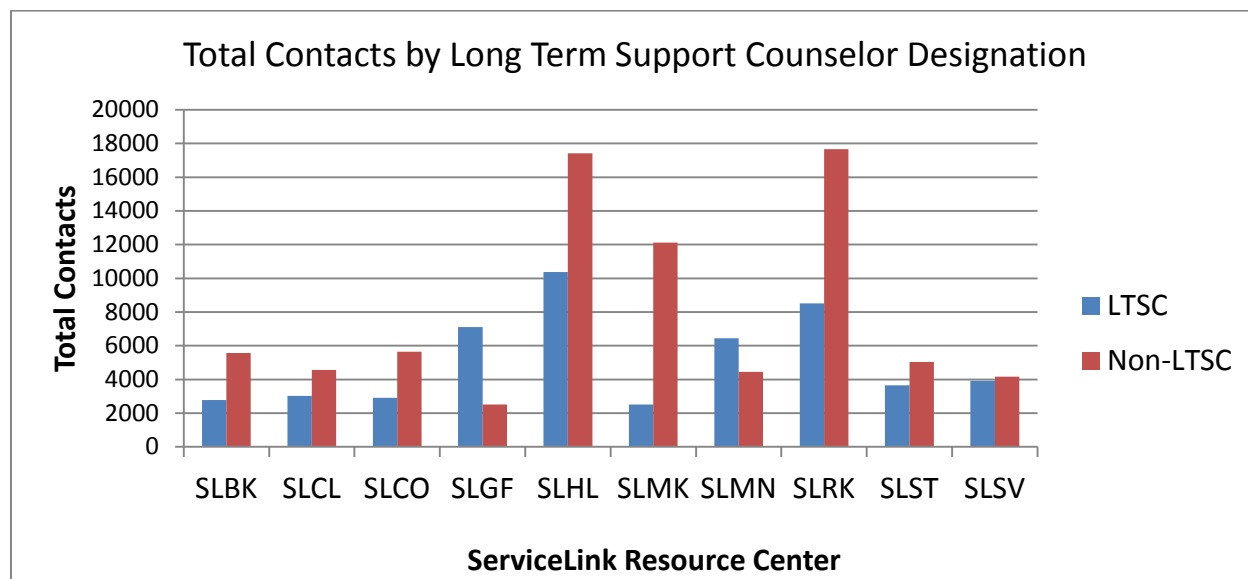
Table 5 indicates that more phone contacts are made than in-person contacts and the LTSCs represented fewer contacts than the other SLRC representatives .

Table 5: Number of In-Person Contacts and Phone Contacts by Long Term Support Counselor Designation

Number of In-Person Contacts and Phone Contacts by Long Term Support Counselor Designation											
ServiceLink Resource Center	SLBK	SLCL	SLCO	SLGF	SLHL	SLMK	SLMN	SLRK	SLST	SLSV	TOTAL
LTSC											
In Person Contact	524	580	255	1,825	862	202	1,789	1,295	857	1,259	9,448
Phone Contact	2,257	2,435	2,653	5,281	9,514	2,309	4,653	7,218	2,798	2,656	41,774
Non LTSC											
In Person Contact	854	1,070	1,230	870	1,788	1,431	1,472	2,339	1,290	1,332	13,676
Phone Contact	4,721	3,482	4,405	1,637	15,619	10,684	2,974	15,322	3,752	2,836	65,432
TOTAL	8,356	7,567	8,543	9,613	27,783	14,626	10,888	26,174	8,697	8,083	130,330

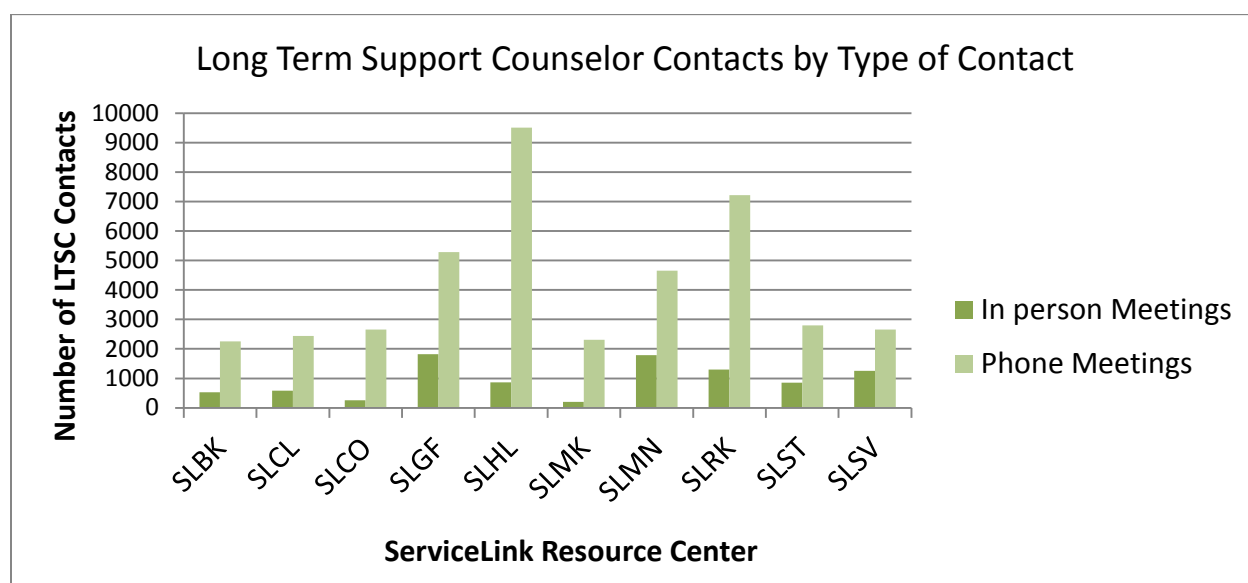
The majority of contacts are made by the SLRC representatives not designated as LTSCs, except in ServiceLink of Grafton County (SLGF) and Monadnock ServiceLink (SLMN), Chart 30. In those SLRCs, a larger percentage of the staff is trained as LTSCs.

Chart 30: Total Contacts by Long Term Support Counselor Designation



Focusing specifically in the contacts made by the LTSCs, there are many more phone meetings than in-person meetings, Chart 31. This result mirrors the type of contacts seen across all SLRC representatives.

Chart 31: Long Term Support Counselor Contacts by Type of Contact



New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

The Refer7 database not only tracks the contact made by SLRC representatives, but also maintains a database of state-funded and home and community based services and information sources. A SLRC representative can refer a client to services already entered into the database or services outside of the database. Table 6 shows the total number of referrals for in-database and out-of-database services. The vast majority of referrals are made for services within the database. Looking specifically at the out-of-database referrals, most are made by a non-LTSC. Again in the Grafton County and Monadnock ServiceLinks, the referrals made to LTSCs are greater due to a larger percentage of the staff being trained as LTSCs.

Table 6: Total Number of In-Database and Out-of-Database Referrals by Long Term Support Counselor Designation

Total number of In-Database and Out-of-Database referrals by Long Term Support Counselor Designation											
<u>ServiceLink</u> <u>Resource Center</u>	<u>SLBK</u>	<u>SLCL</u>	<u>SLCO</u>	<u>SLGF</u>	<u>SLHL</u>	<u>SLMK</u>	<u>SLMN</u>	<u>SLRK</u>	<u>SLST</u>	<u>SLSV</u>	<u>TOTAL</u>
Out-of-Database Referrals											
LTSC	28	79	9	301	23	92	51	78	7	36	704
Non-LTSC	149	143	111	5	98	367	41	195	87	80	1,276
In-Database Referrals											
LTSC	1,518	3,597	1,116	7,174	8,402	1,879	5,376	5,741	3,445	5,258	43,506
Non-LTSC	4,645	5,305	5,227	3,090	17,786	10,257	4,278	12,047	5,656	4,548	72,839
TOTAL	6,340	9,124	6,463	10,570	26,309	12,595	9,746	18,061	9,195	9,922	118,325

The Action Plan is used by SLRC staff to assist with follow-up post options counseling. Table 7 shows the number of unique clients with an action plan, as well as the total number of action plan interactions. The interactions are tracked when any action plan is created, updated, or saved. Of the total number of Action Plan interactions, 1182, 84% (995) were done by an LTSC. Two examples of completed Action Plans can be found in Appendix F.

Table 7: Number of Unique Individuals with Action Plan and Total Interactions

ServiceLink Resource Center	Number of unique individuals with an action plan	Total number of Action Plan interactions (creations, updates, saves)
SLBK	1	9
SLCL	2	25
SLCO	1	55
SLGF	7	89
SLHL	18	330
SLMK	4	19
SLMN	12	101
SLRK	8	51
SLST	28	216
SLSV	19	287

In addition to the Action Plan, the Options Counseling Tool is used to help the counselor understand and record a client's current needs and preferences. Table 8 shows the total number of unique individuals who have an OC Tool, as well as the number of OC Tool interactions. Of the total number of interactions, 47% (1638) were done by an LTSC. Also important to note is that the number of individuals with OC tools are significantly lower than the number of individuals who had received Options Counseling during the evaluation time frame.

Table 8: Number of Unique Individuals with OC Tool and Number of OC Tool Interactions

ServiceLink Resource Center	Total Number of unique individuals with an OC Tool	Total Number of OC Tool Interactions (Creation, modification, Saves)
SLBK	0	0
SLCL	1	9
SLCO	3	53
SLGF	4	21
SLHL	3	7
SLMK	38	144
SLMN	35	231

New Hampshire Options Counseling and Assistance Program
Final Report ~ January 7, 2014

SLRK	89	1968
SLST	69	418
SLSV	71	623

Several custom questions were added at the end of the OC tool. A relatively small number of unique individuals with OC tools completed those questions, particularly the ServiceLink of Belknap County and ServiceLink of Carroll County where there were zero responses. However, for those who answered the questions, there is an indication of an overall level of understanding and empowerment to make ongoing care and services choices, as shown in Charts 32-36.

Chart 32: Can the Person Make and Express their Choices?

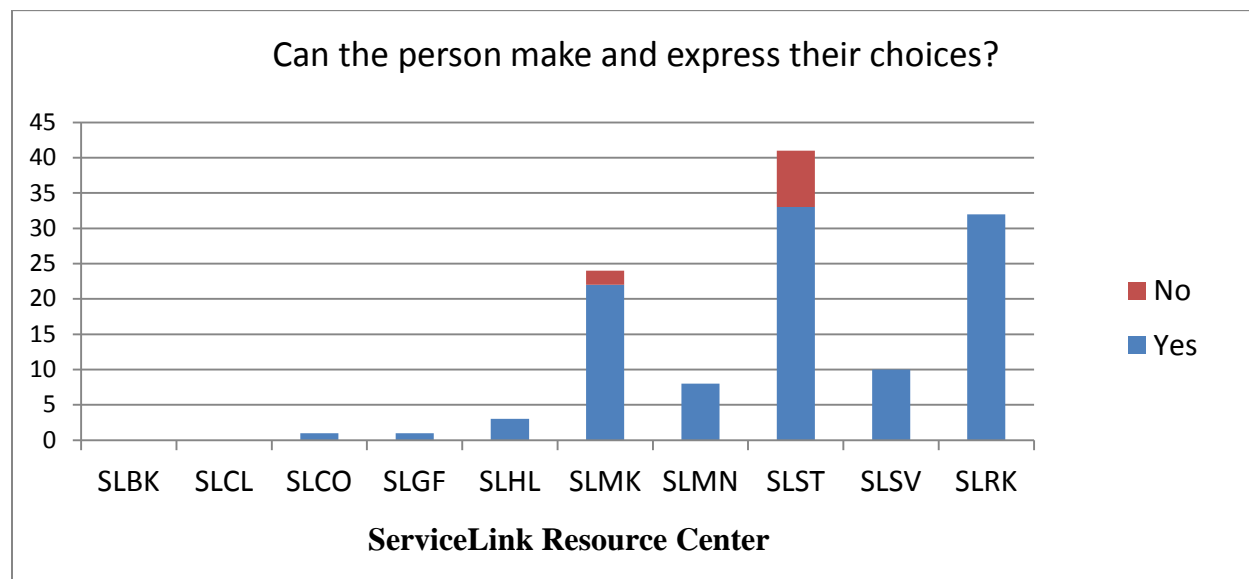


Chart 33: Can the Person Give Reasons for their Choices?

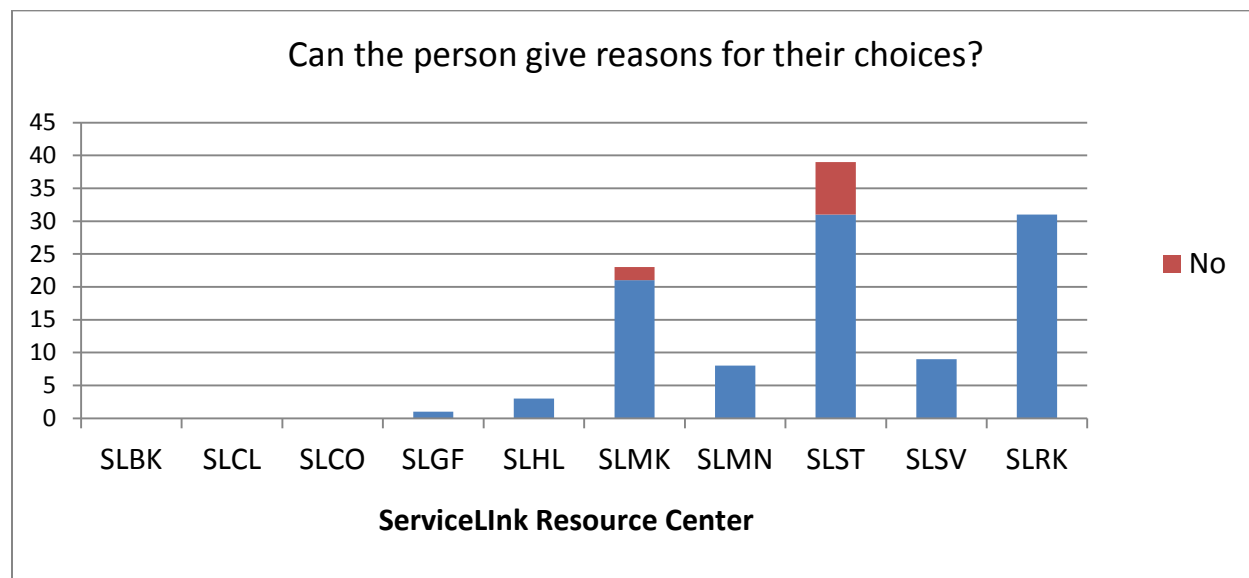


Chart 34: Does the Person Have Factual Understanding of the Concerns?

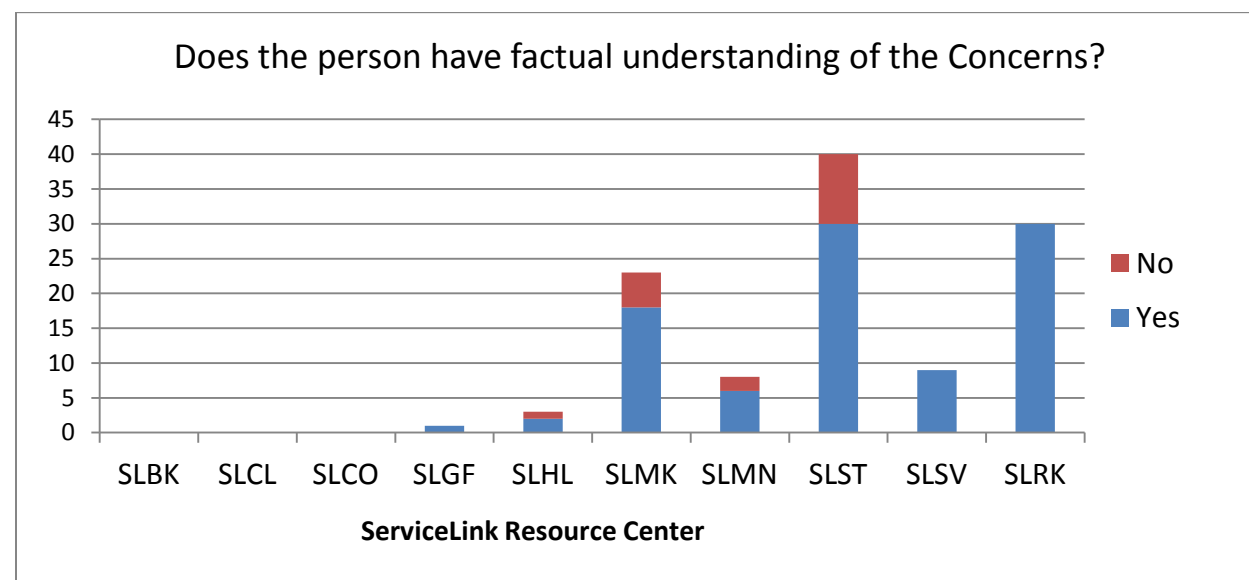


Chart 35: Does the Person Understand the Risks and Consequences of the Decisions?

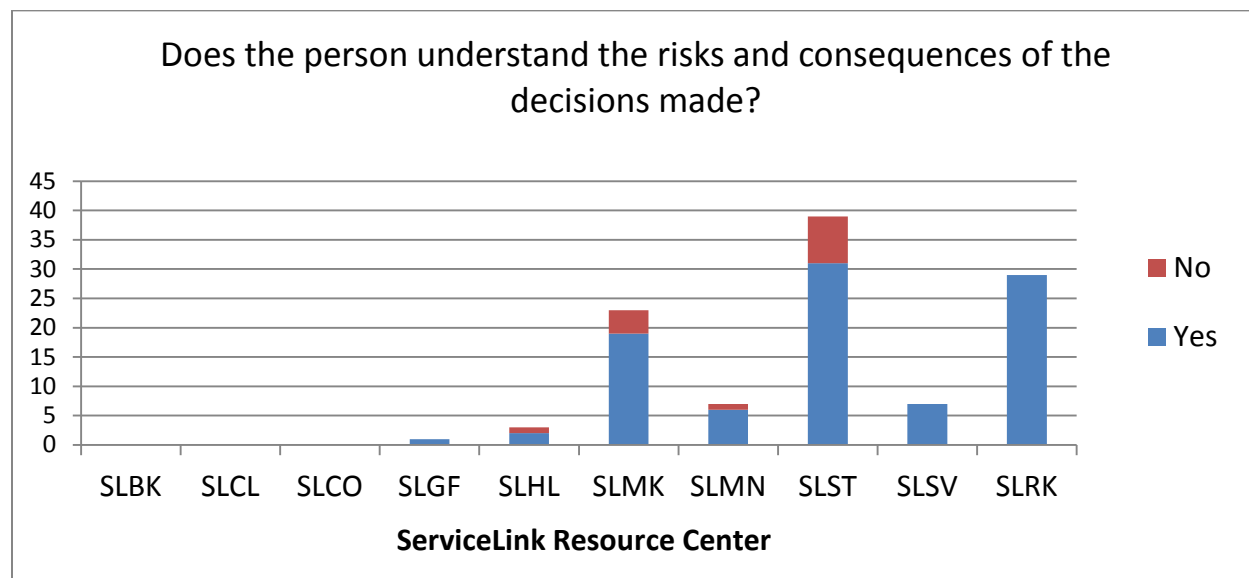
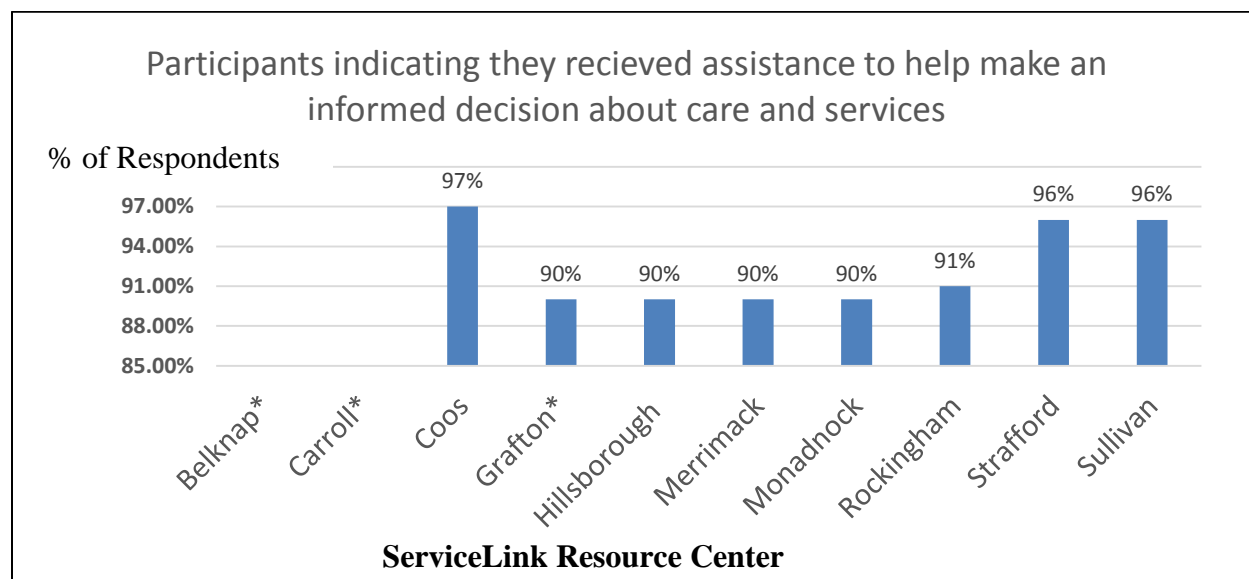


Chart 36: Participants Indicating They Received Assistance to Help Make an Informed Decision about Care and Services



The last portion of New Hampshire's baseline evaluation data for the delivery of options counseling is from the consumer satisfaction surveys. Eight of the ten counties, Coos, Grafton, Hillsborough, Merrimack, Monadnock, Rockingham, Strafford and Sullivan, submitted their satisfaction data. As shown in Charts 37 and 38, the majority of participants strongly or somewhat agreed that they were overall satisfied with their SLRC experience.

Chart 37: Total Level of Satisfaction with SLRC Experience

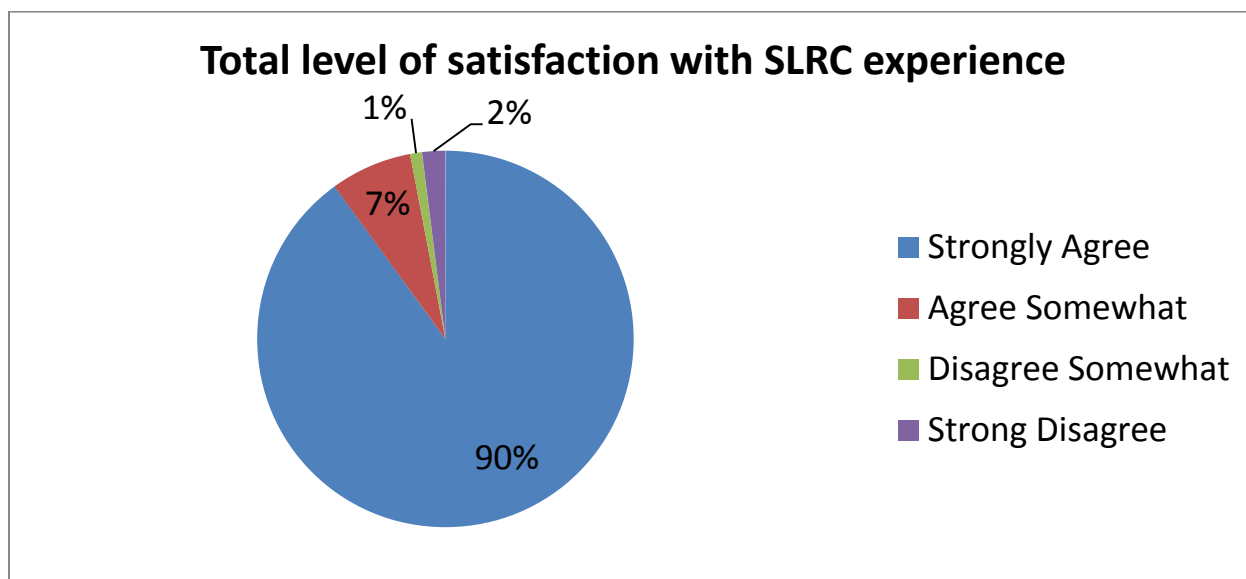
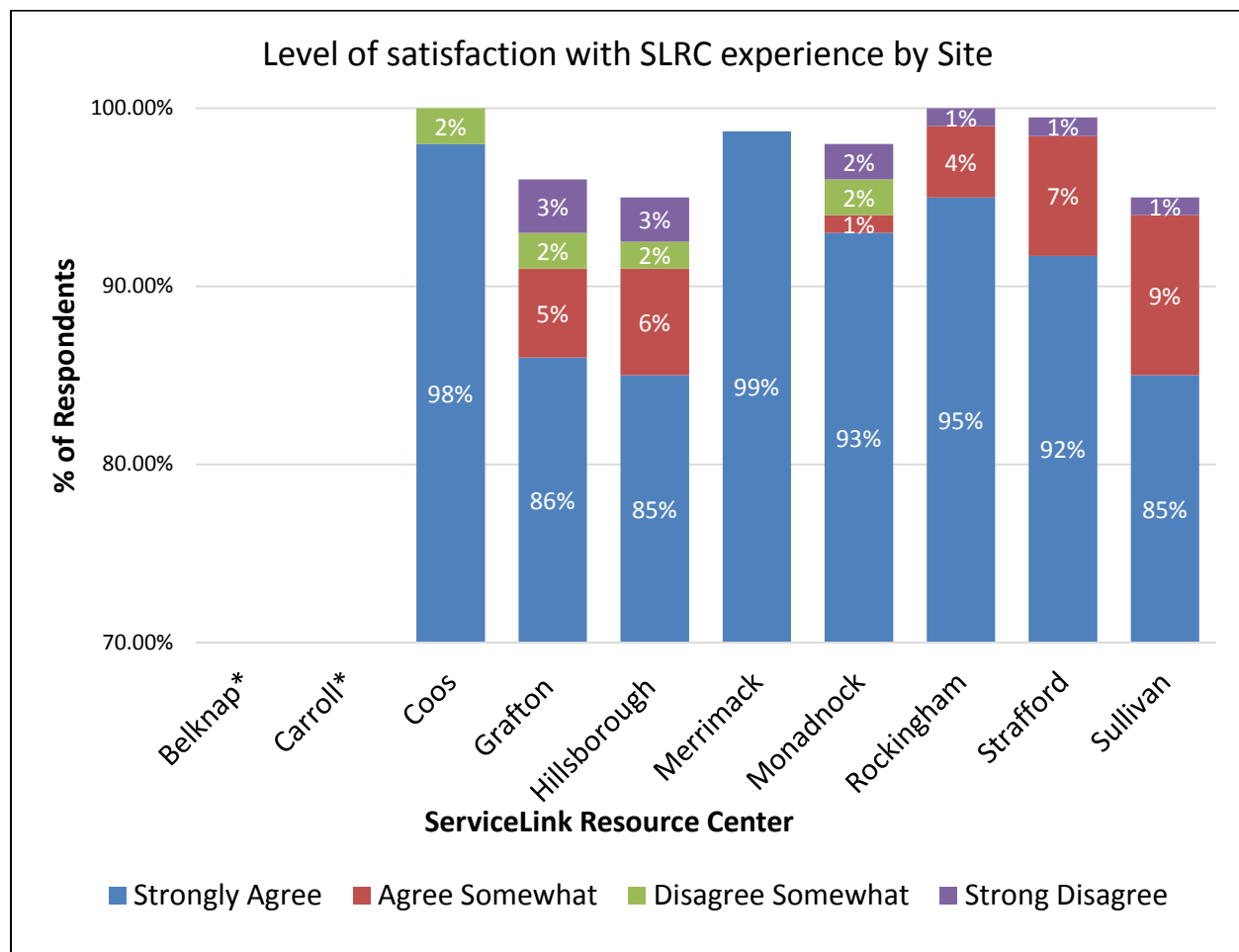


Chart 38: Level of Satisfaction with SLRC Experiences by Site



*indicates that data was not received by these counties.

Second Goal: Actively participate in the development of National Standards for Options Counseling.

Objective 1: Inform the process for development of national standards for options counseling

Overview & Summary: Goal 2, Major Objective 1

New Hampshire representatives provided feedback on drafts of the national options counseling standards through multiple mechanisms. Raelene Shippee-Rice, UNH professor of

nursing, and Wendi Aultman, BEAS SLRC Director, participated in the ACL options counseling standards national advisory group calls. New Hampshire was one of six grantee states to participate in these calls. Several representatives from New Hampshire's ADRC program, including two LTSCs, participated in the larger national grantee calls and attended the national grantee meetings in 2011 and 2012.

In addition to the national calls and meetings to inform the national standards, New Hampshire was one of only a few states to pilot six client-level evaluation questions developed by the OC Project Evaluation Committee in December 2011 and January 2012. LTSCs identified individuals with whom they had done some options counseling during December 2011 and whom the LTSCs thought were likely to be willing to participate. LTSCs provided names of individuals (with the permission of the individuals) to project staff. The LTSCs told the individuals that they would be participating in a national evaluation on the type of services that they had received. Participants were called, explained the survey, and asked the five questions. A summary of the pilot and results were submitted to ACL.

Objective 2: Incorporate thinking from national best practice development into NH standards

Overview & Summary: Goal 2, Major Objective 2

New Hampshire established a workgroup for the Options Counseling and Assistance grant that included two LTSCs, BEAS, and UNH staff. This workgroup examined the national standards as they were developed and made sure they aligned with New Hampshire standards. These state standards were submitted to ACL and approved. BEAS then incorporated the national standards into the statement of work for SLRC ADRC contracts. BEAS also utilized the

standards as the framework for performance measures, core competencies, and job duties and skills required to perform options counseling in New Hampshire.

2. What, if any, challenges did you face during the project and what actions did you take to address these challenges?

The New Hampshire Options Counseling and Assistance project faced several challenges in achieving its objectives. A major challenge is related to difficulties in using the information and referral tool, Refer7, as the primary data collection system utilized by the SLRC program. The information collected in Refer7 is useful to SLRC staff in providing support and information to their customers. Staff has developed processes and systems to note down information they need, including history, clinical status, insurance status, etc. However, the systems they have developed are idiosyncratic and particular to each office. This makes evaluating the data across offices difficult, requiring significant time on the part of data analysts to obtain and clean the data. It is clear that, although there are specific standards for data entry in Refer7 that have been established at the state level, these have not been reiterated to staff on a regular basis, and thus the data collected is not always standardized. Considerable training, refreshers, and trouble shooting is needed, but this is difficult given that there is significant staff turnover at SLRC sites, and limited availability for training both at the local level and at the state level due to resource constraints.

At the state level, there were some technical complications that delayed the development of contracts with the SLRC offices in early 2013. Interim contracts were put in place, but this left SLRCs in limbo for over a year, because it was not clear what policy and funding changes might be implemented in new contracts. This uncertainty caused turnover at some SLRC sites, which

further complicated the implementation of options counseling data tracking. The contract situation has recently been rectified (after the end of this project period).

3. What impact do you think this project has had to date? What are the lessons you learned from undertaking this project?

Overall, this project has supported New Hampshire in moving toward the implementation of options counseling approaches and standards statewide, and has positioned the SLRC Network well to implement national options counseling certification. In addition, other initiatives that New Hampshire DHHS is involved in will complement the implementation of options counseling, including the State Innovations Model (SIM) and the Balancing Incentive Program (BIP). The SLRCs are also well positioned to support New Hampshire in the positive changes that are being implemented in the state's long term care system through SIM, BIP, and other efforts.

A specific impact the Options Counseling and Assistance project was to develop, articulate, and disseminate the basic philosophy of options counseling, not only to SLRC staff but to partners in the aging and disability 'system'. The premise for this project was that all staff interactions should be person-centered, and the approach is not limited to sessions officially labeled as options counseling, but includes every contact in an SLRC site. The philosophy was that options counseling is synonymous with person-centered planning. All SLRC staff are committed to supporting their customers, and overall believes that standardization and tracking of data will improve services. Staffs are looking forward to achieving certification as 'person-centered counselors.' This project created the opportunity to involve all staff in the process of developing standards for their work.

A major lesson learned under this project was that follow up to training is essential. After introducing the Options Counseling Tool and Action Plan, participants should have been invited back together to discuss the success and challenges of applying the tools in their daily work. This process helps to bridge the gap between learning and applying a new skill or tool, an element missing from our training under this project. For the 2012 Part A ADRC Enhancement Grant, follow up to training will be planned.

4. What will happen to the project after this grant has ended? Will project activities be sustained? Will project activities be replicated? If the project will be sustained or replicated what other funding sources will allow this to occur? Please note your significant partners in this project and if/how you will continue to work on this activity.

New Hampshire has been successful integrating the 2010 ADRC Options Counseling and Assistance grant activities into ongoing initiatives, most specifically the 2012 ADRC Part A Enhanced Options Counseling grant and the Balancing Incentive Project. In addition, the work under this grant aligns with the Money Follows the Person project, particularly the Section Q initiative.

The New Hampshire DHHS recently completed the State Innovation Model planning grant and submitted to CMS a model design proposal. The proposal aligns with the ADRC No Wrong Door vision and incorporates options counseling (or person-centered counseling) in the planning for long term service needs.

The Options Counseling and Assistance grant partnered specifically with the UNH Social Work Department for assistance with Peer Supervision, the UNH Survey Center on evaluation, the SLRC Network for creation of tools and trainings, ADRC Advisory Committee for oversight

and guidance. The ADRC Part A Enhanced Options Counseling has expanded these partnership under BEAS leadership to include Balancing Incentive Program staff, and Behavioral Health and disability stakeholders.

5. Over the entire project period, what were the key publications and communications activities? How were they disseminated or communicated? Products and communications activities may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, and other informational resources.

A brochure was developed to provide information about options counseling to the general public (Appendix H). This brochure was developed by two LTSCs and BEAS and is disseminated through the local SLRC sites and at state wide events. In addition, as described throughout this final report, the products and communications were specific to developing options counseling standards for New Hampshire with the main audience the SLRC Network staff. These items are included as Appendices to this report.

Appendix A:
Evaluation Plan

**New Hampshire
Institute for Health Policy and Practice**

AoA Research Questions

- 1) Do the revised standards and training enable ADRC Options Counselors to deliver Options Counseling effectively and efficiently?
- 2) Does the Options Counseling action plan tool in Refer7 assist the Options Counselor in providing thorough, person-centered planning with the consumer?
- 3) Are the revised Options Counseling standards sustainable across the ADRC Network in New Hampshire?
- 4) Does Options Counseling help people make informed decisions about their LTSS options?
- 5) Is Options Counseling effective in linking people to home and community based services?

Evaluator

Laura Davie, Institute for Health Policy and Practice, laura.davie@unh.edu, 603-862-3682 and Kimberly Phillips, Institute on Disability, kimberly.phillips@unh.edu

Intervention Detail

Geographic Area:

New Hampshire has an ADRC site in each of the ten counties. Thus, our revised State Options Counseling Standards will be implemented in all our sites statewide.

Specify the demonstration/evaluation timeframe:

Training for the Long Term Support Counselors (LTSC) will begin in September of 2011. Evaluation will be done with all trainings throughout the grant period.

Evaluation of the participant outcomes within the position of the LTSC will start January 2012.

Training and evaluation of standardized practice of the components of Options Counseling among other SLRC positions will start in the summer/fall of 2012.

Target Population:

The target population within the first iteration of the implementation of standards (September 1, 2011- August 31, 2012) is the delivery of Options Counseling by Long Term Support Counselors (existing position in NH) to persons 60 and over, adults over the age of 18 who are chronically, physically ill or have a disability and who may need long term care supports, family members, caregivers, advocates, providers, and any person who requests or requires current long term support services and/or persons who are planning for the future regarding long term support services without regard to income or assets.

During the summer and fall of 2012, the standardization of Options Counseling will expand across other ADRC positions (caregiver support, Medicaid Counseling, etc) to persons 60 and over, adults over the age of 18 who are chronically, physically ill or have a disability and who

Options B: NH ADRC Options Counseling Standards Grantees Evaluation Plan

may need long term care supports, family members, caregivers, advocates, providers, and any person who requests or requires current long term support services and/or persons who are planning for the future regarding long term support services without regard to income or assets.

Describe the specific interventions to be evaluated:

- **Evaluate the training on the revised standards/operations of Options Counseling:** New Hampshire is developing a series of trainings which cover the definition, components, competencies (e.g., person-centered planning, adult protection,) and documentation of delivery of effective and consistent Options Counseling across the statewide ADRC Network. The initial focus of the trainings will be the LTSC and their supervisors. The second round of trainings will include other ADRC staff.
- **Evaluate the changes in the Refer7 database and the action plan tool:** New Hampshire is in the process of creating a new page in Refer7 that will provide trigger questions for Options Counselors and assist in gathering information counselors need to serve the consumer. The action plan tool is also in development. This tool will be evaluated to measure its effectiveness in assisting Options Counselors and consumers.
- **Evaluate the delivery of Options Counseling based on the training and tools:** New Hampshire will deliver Options Counseling across the statewide network primarily in the position of the LTSC through the training and tools developed. In addition, other ADRC positions will be trained in some or all components of Options Counseling. A team of LTSC will develop, implement and participate in a peer support forum to insure quality delivery and increase professionalism across the Network.

Indicate below which, if any, of the following categories your interventions fall into (check all that apply):

- ☒ training programs or requirements
- ☐ staffing requirements
- ☐ service mode or setting of options counseling delivery
- ☒ service protocols or tools
- ☐ target populations
- ☐ outreach strategies
- ☐ partnerships
- ☒ documentation, tracking strategies

Evaluation methodology

The primary goals of the SLRC Options Counseling Standards established in New Hampshire's grant application are to 1) evaluate and adapt the existing role of SLRC Long Term Support Counselors to meet the new Options Counseling decision support and person-centered planning focus of the standards, 2) establish an effective person-centered and decision support training protocol for SLRC Options Counselors and 3) redefine and evaluate the role of SLRC

Options B: NH ADRC Options Counseling Standards Grantees Evaluation Plan

LTSC within the scope of Options Counseling. The evaluation approach presented here, aims to answer these questions.

Our evaluation hypotheses are:

- LTSC's find value in a standardized approach to the delivery of Options Counseling.
- LTSC's can benefit from training on the revised Options Counseling standards.
- The development and implementation of Refer7 changes and an action tool facilitates effective delivery of Options Counseling.
- When LTSC's are trained about Options Counseling it improves the delivery of the service.
- Delivery of Options Counseling after training in the standards and competencies improves outcomes for people who seek long term care support.

We have divided our evaluation into three areas:

- Evaluate the revised standards/operations of Options Counseling
 - Metrics include: Number of referrals for services made by Options Counselors; demographics of those who receive Options Counseling; use of Options Counseling action plan tool; percent of Options Counselors trained in person-centered planning; number of referrals from other ADRC staff to Options Counseling after receiving training on triggers; documentation of changes in Refer 7 for tracking.
- Evaluate the training on the standards/operations for Options Counseling
 - Metrics include: Number of trainings delivered; percent of Options Counselors participating/completing; knowledge pre/post of standards and person-centered approach; competency of Options Counselors in Refer7 documentation.
- Evaluate the Long Term Support Counselors' delivery of Options Counseling
 - Metrics include: Number of in-person meetings and phone meetings; degree of completion of action plan in Refer7; follow up on action plan; recipients' satisfaction with Options Counseling; recipients' ability to make informed decisions; recipients' perception of care plans utility.

The evaluation tools will be implemented in several ways; pre and post assessments of the trainings will be administered to assess knowledge of the standards and capacity to deliver the standards. This will encompass understanding, documentation skills, and person-centered planning skills. The Options Counselors will utilize the Refer7 database to track all participants, populate and distribute the action plan, and document all referrals. Refer7 database will be used to track referral source to Options Counseling. Participant surveys will be sent out monthly as per current SLRC satisfaction survey protocol. The provider survey will be distributed annually per current ADRC evaluation protocol.

Evaluation Challenges Anticipated

The achievement of a successful transition to the new Options Counseling standards will be dependent upon current SLRC LTSC adapting to the new training tools during the training process, performing consistent data entry into the Refer7 database, utilizing the new OC Screening/Assessment tool and upon participant completion of the satisfaction surveys. In addition, long term funding for evaluation activities beyond this grant period will need to be secured. State funding will not support this type of extensive evaluation.

Options B: NH ADRC Options Counseling Standards Grantees Evaluation Plan

Problems	Activities/ Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
<p>1. A need for more consistent/ standardized delivery of Options Counseling include:</p> <ul style="list-style-type: none"> • Service definition and design • CQI, evaluation, and outcomes • Tools, training and documentation <p>2. A need to ensure consumer receives info to make informed decisions.</p> <p>3. A need to ensure that individuals are linked to the services that best meet their individual needs and preferences.</p>	<p><u>Activity 1:</u> Implement OC standards in the following areas:</p> <ul style="list-style-type: none"> • Quality assurance components including documentation tracking, training, and peer support structure is developed and documented. • Training of LTSC and supervisor in a) conducting personal interview (in person or on the phone); b) exploring options with individuals; c) person-centered planning d) client follow up during process (typically 1-3 months in NH); e) utilization of action plan. <p><u>Output 1:</u></p> <ul style="list-style-type: none"> • Documentation of LTSC and supervisor training completed and evaluated. <p><u>Activity 2:</u> Training and tools for informed decision making:</p> <ul style="list-style-type: none"> • Training in a) exploring options with individuals; b) providing decision support; c) client follow up during process. • Action plan development and training in its use. <p><u>Output 2:</u></p> <ul style="list-style-type: none"> • Documentation of completion of informed decision making training and evaluation of training 	<ul style="list-style-type: none"> • Knowledge and delivery of Options Counseling is consistent across the ADRC Network through the position of LTSC. • Skills/competence in the delivery of Options Counseling is consistent across the ADRC Network in the position of LTSC. • Accurate information about available services is provided on the website and is consistently updated for both public and LTSC use. • LTSC use person-centered decision-support techniques, tools and processes in the delivery of Options Counseling. • A plan is developed for the expansion of Options Counseling standards and appropriate components to the other ADRC positions. 	<ul style="list-style-type: none"> • Training is completed and knowledge of the delivery of Options Counseling is consistent across the ADRC Network in the position of the LTSC. • Skills/competence in the delivery of Options Counseling is consistent across all positions in the ADRC Network. • Options Counseling delivery which is: Person-centered; streamlined; complete; accurate; timely; accessible. • Consumers are satisfied with the delivery of Options Counseling. • Complete documentation/ record-keeping in Refer7 by all ADRC staff. • Data from Refer7 and evaluations are used to inform and improve Options Counseling program. • State funding is maintained to assure the delivery of Options Counseling statewide. • Resources are secured for ongoing 	<ul style="list-style-type: none"> • Options counseling or its components are used by all ADRC staff. • A sense of professionalism among Options Counseling staff is established and maintained. • Data (Refer7 and evaluations) is used by the ADRC Network, policy makers and other stakeholders to identify effectiveness of Options Counseling and build capacity across the long-term care system. • Options Counseling is sustained at the community level. • Participants utilize action plans to make informed decisions and to link to services. • Participants receive referrals to identified services. • Participants remain in their desired setting.

Options B: NH ADRC Options Counseling Standards Grantees Evaluation Plan

	<p>results.</p> <p><u>Activity 3:</u> Ensure individual's needs and preferences are met.</p> <ul style="list-style-type: none">• Training LTSC in person-centered approach and tools. <p><u>Output 3:</u></p> <ul style="list-style-type: none">• Use Refer7 to track referrals and use of action plan. Customer satisfaction survey results obtained and shared. <p><u>Activity 4:</u> A plan is developed and implemented for training other ADRC staff in Options Counseling standards and components utilizing activities listed above.</p>		evaluation and training for Options Counseling.	
--	---	--	---	--

System Level

Options B: NH ADRC Options Counseling Standards Grantees Evaluation Plan

Client Level

Problem	Activities/ Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
<p>1. The long term care system is complex and confusing</p> <p>2. Making choices about long term care and services can be frustrating and disempowering</p> <p>3. Individuals and families need support:</p> <ul style="list-style-type: none"> • Navigating long term care systems • Learning about their options. • Making informed choices about their long term care needs and services. • Developing an action plan that accounts for their needs and preferences. 	<p><u>Activity:</u> Support individuals/families to consider long term care options and make decisions by standardization and training staff in the delivery of Options Counseling:</p> <ul style="list-style-type: none"> • Other ADRC staff are aware of what triggers an appropriate referral for Options Counseling. • Options Counseling interview is conducted in a series of in-person and/or phone calls. • Individual concerns and needs are identified. • Individual choices are explored and identified. • Participants are assisted with the development of individual action plan. • Referrals are made to services when appropriate. • Follow-up is completed. 	<ul style="list-style-type: none"> • Participants in Options Counseling are knowledgeable of their long term care options. • Participants in Options Counseling have the information/tools needed to make informed decisions. • Participants in Options Counseling develop and utilize an action plan in partnership with their counselor. • The referrals participants receive result in their needs being met. • Accurate information about available services is provided on the website and is consistently updated for both public and LTSC use. 	<ul style="list-style-type: none"> • Participants in Options Counseling receive the information they need to make long term care decisions. • All Options Counseling participants receive a personalized action plan. 	<ul style="list-style-type: none"> • There is an awareness of the long term support options available in community. • Information is readily accessible about the long term care system. • Individuals and family are empowered to navigate the long term care system.

Data Source/Data Collection Instrument	Relevant Data Included/Collected	Collection Intervals
Primary Data Source: Training survey of ADRC staff <ul style="list-style-type: none"> Pre and post test training surveys for staff (in development) Person-centered planning assessment post 6 months of training (complete) 	Independent variables: <ul style="list-style-type: none"> Prior level of knowledge and skill Outcome variables: <ul style="list-style-type: none"> Staff knowledge and ability to deliver Options Counseling. Staff knowledge and ability to complete Refer7 information and use of action plan with consumers. Staff knowledge and use of person-centered planning. 	Pre and post training
Primary Data Source: ADRC Consumer Satisfaction Survey <ul style="list-style-type: none"> Monthly randomly generated sample of individuals who receive ADRC surveys stratified by those who received long term care planning (Options Counseling under the long-term support counselor role). Written, mail survey 	Independent variables: <ul style="list-style-type: none"> Participants in long term planning services at ADRC Participants in other ADRC programs Outcome variables: <ul style="list-style-type: none"> Satisfaction with long term planning support Ability to make informed decisions about care and services Satisfaction with referrals Perception of referrals meeting consumer needs Perception of needs and preferences taken into account during long term planning process 	Monthly
Secondary Data: ADRC Client Tracking system <ul style="list-style-type: none"> Refer7 database 	Variables: <ul style="list-style-type: none"> Average age of participant Zip code Current living situation Number of individual contacts per Options Counseling process (including in-person/phone) Referrals to other ADRC services Referrals to community services 	Aggregate service data analyzed every quarter throughout standards demonstration period
Secondary Data: ADRC Client Tracking system <ul style="list-style-type: none"> Action Plan 	Variables: <ul style="list-style-type: none"> Degree of completion of action plan 	Random sample of plans every quarter throughout standards demonstration period.

Description of Attached Data Collection Instruments:

- Consumer Satisfaction Survey (current survey attached- some minor revisions may be made prior to Jan 1, 2012 implementation)
- Pre and Post Training Survey examples (current person-centered planning training evaluation tool attached. Other training surveys to be developed)
- Screen shots of Refer7 data collection instrument (draft version attached)
- Screen shot of new OC screening/assessment tool (draft version attached)

Appendix B:
SLRC Presentation Fall 2011

ServiceLink Resource Center • Bureau of Elderly & Adult Services • Center on Aging and Community Living

Partners building behind the scenes to improve
the long term care system

Goals for today

- Understand the federal and state policy driving current long term care system changes.
- Develop a shared understanding of what we mean by Person-Centered approaches across systems and programs.
- Discuss the various programs and initiatives currently underway within the SLRC network.
- Engage in a dialogue about SLRC perspective, insights, needs of the programs and initiatives.

Center on Aging and Community Living



CENTER ON AGING AND
COMMUNITY LIVING

A Collaboration Between



INSTITUTE ON DISABILITY / UCED
A University Center for Excellence on Disability



UNIVERSITY
of NEW HAMPSHIRE

New Hampshire Institute for
Health Policy and Practice

Federal Policy Context

- L.C. vs. Olmstead (1999)
- Bush Administration's New Freedom Initiative (2001)
- Real Choice Systems Change Grants (2001 – 2011)
- AoA Community Living Act (2006)
- Patient Protection and Affordable Care Act (Health Care Reform) (2010)

Person-Centered Services

NH Policy History

- Shaping Tomorrows Choices (1998)
- SB 409 Long Term Care Reform (1998)
- SB 324 Consumer Directed Personal Care (2000)
- Real Choice Grants (2001 - 2011)
- NH Long Term Care Statute, RSA 151-E:4 (2007)
- AoA Funding for ADRC's, Community Living Program, Care Transitions, Options Counseling....
- Health Care Reform (2010 and beyond)

Person-Centered Approaches Across Systems

- Developmental Disabilities (Intellectual Disabilities)
 - ▣ Self Determination
 - ▣ Person-Centered Planning
 - ▣ Individual/Family Direction
- Mental Health
 - ▣ Recovery
- Physical Disabilities
 - ▣ Self Direction
- Medical
 - ▣ Informed Consent
 - ▣ Informed Decision Making/Shared Decision Making
 - ▣ Slow Medicine
 - ▣ Hospice
- Aging
 - ▣ Person-Centered Planning
 - ▣ Participant Directed Services (Self Direction/Consumer Direction/etc)
 - ▣ Options Counseling

Applying PCP Across Roles

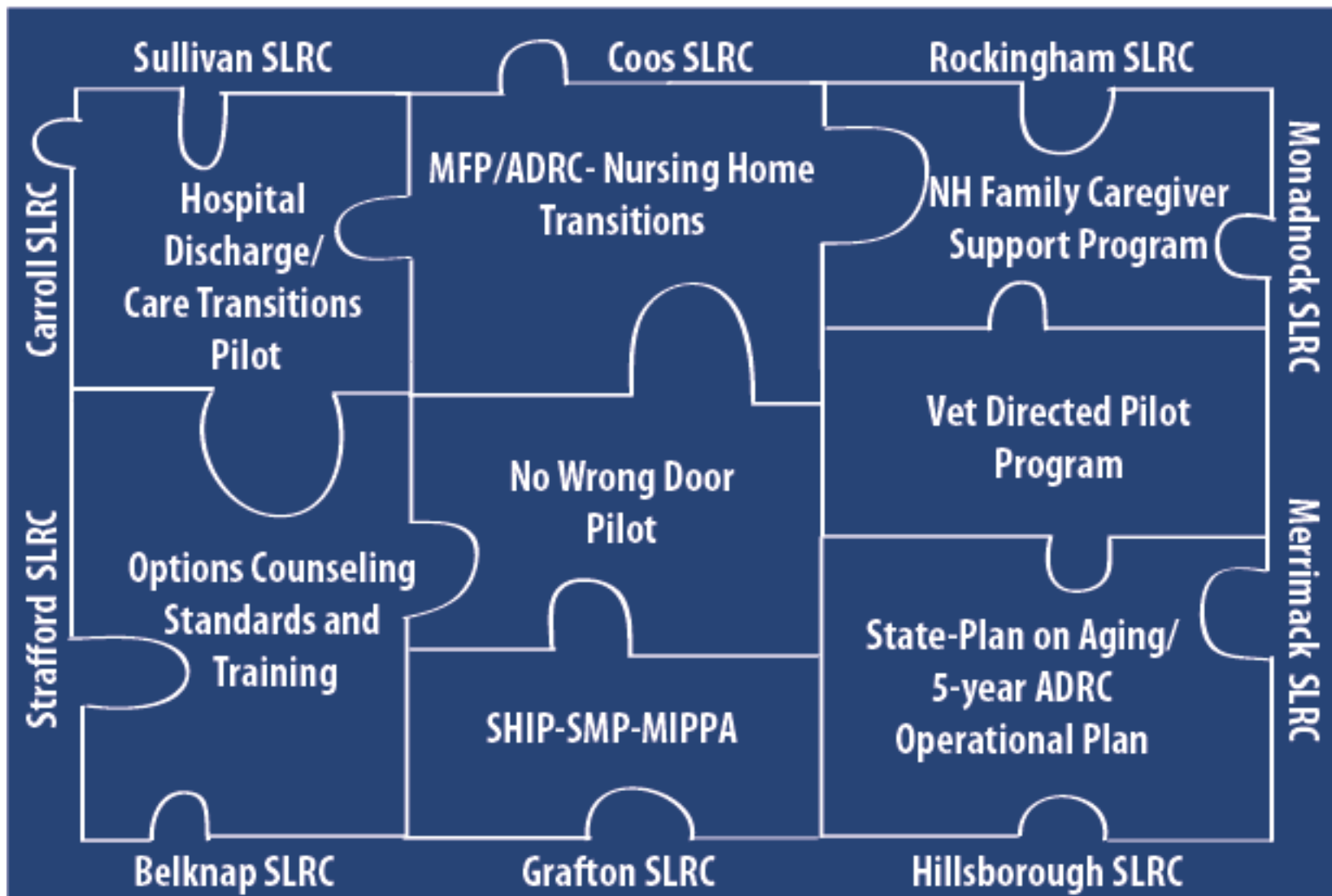
7

Function/ Role	Information and Referral Specialist	Assessment Specialist Nurse Long Term Support Counselor	Options Counseling	Service Planning	Ongoing care coordination
Person Centered Approach	Person- Centered Approach and Questioning	Person- Centered Inquiry (Use inquiry PCP tools as appropriate)	Informed Decision Making (Use decision making PCP tools as appropriate)	Person- Centered Goals and Strategies (Person's goals, not professional's or service system's goals)	Ongoing assessment of needs, quality of services, monitoring, and refinement

AoA's perspective:

Maturity, Growth, & Expansion of ADRCs

- **The federal ADRC initiative began with three core functions**
 - ▣ Awareness, Assistance, and Access
- **The set of core expectations has grown over time**
 - ▣ Information, referral, and awareness
 - ▣ Options counseling, advice, and assistance
 - ▣ Streamlined eligibility determinations for public programs
 - ▣ Person-centered transitions
 - ▣ Quality assurance and continuous improvement
- **AoA and CMS are viewing ADRCs as the platform to:**
 - ▣ Intervene during care transitions
 - ▣ Promote self direction
 - ▣ Implement new initiatives (e.g., Veteran Directed Home and Community Based Services)
 - ▣ Catalyze broader systems change
- **Health reform adds new fuel to the fire (a lot of fuel!)**



NH Family Caregiver Support Program

- Person-centered, consumer-directed model
- The AOA, ArchRespite, Family Caregiver Alliance have partnered to address caregiver supports across the lifespan
 - ▣ Lifespan Respite Care Act
 - ▣ Vision for the ADRC's
- Exploring linkages with family caregivers and Care Transitions
- Weinberg Foundation Grant- Coos, Grafton, Monadnock, Sullivan

Veteran Directed/HCBS



- Expand caregiver support model to Veterans via the VD-HCBS program
- Current pilot in Belknap

Care Transitions are a New Core Commitment for AoA

- **Care Transitions added to the ADRC Fully Functional Criteria by AoA (nursing home and hospital based)**
- **Nationally about 15 ADRCs are implementing evidence-based care transitions models**
- **ADRCs are being encouraged to be more involved in Money Follows the Person grants in their states**
 - **MFP (AKA: NH Community Passport) is a CMS-sponsored program to help transition consumers from nursing facilities to community-based long-term care settings.**

MFP/ADRC- Nursing Home

- Project goals:
 - To strengthen the partnership of MFP/ADRC in NH
 - Improve and strengthen rebalancing efforts in NH's long term care system.
- Part of the larger care transitions spectrum
- Statewide implementation (Jean Crouch)
- SLRC role:
 - Inform the development of protocols and educational/training sessions on the protocols.
 - Be the local contact agency for MDS 3.0 Section Q

<http://chhs.unh.edu/nhihpp/communityliving.html>

ADRC Person-Centered Care Transitions Projects, Part 1

2009 ADRC Enhancement Grant: develop a person-centered hospital discharge planning model (Monadnock SLRC and CMC/DH- Keene; Carroll SLRC and Memorial Hospital)

- ▶ Formalize how hospitals refer to SLRC's and train hospital and community providers in person-centered approach

<http://chhs.unh.edu/nhihpp/Care+Transitions+Project.html>

ADRC Person-Centered Care Transitions Projects, Part 2

15

2010 ADRC Option D Grant: implement and/or enhance evidence-based models for care transitions.

- The Better Outcomes for Older Adults through Safe Transitions (BOOST) model Lakes Region General Hospital and Belknap SLRC.
- The Care Transition Intervention (CTI) model Cheshire Medical Center- CMC-DHK and Monadnock SLRC; and Memorial Hospital and Carroll County SLRC.

Options Counseling

- OC project is one of the four ADRC grants awarded in 2010
- All SLRC staff are part of Options Counseling
- Builds on 2009-10 job description activities with UNH/Raelene Shippee-Rice
- Part of ongoing evolution of SLRC operations: 'SLRC 4.0'
- Project provides tools to demonstrate value of ADRCs/SLRCs

Definition

Options Counseling is a relationship-centered (person-centered), interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices **in the context of their own preferences, strengths, and values.**

Person-Centered Planning = Options Counseling

18

- ▶ RSA 151-E:4 (2007): *“The person shall have the right to have their individual support plan developed through a Person-Centered Planning process regardless of age, disability, or residential setting.”* (New Hampshire)
- ▶ Person-centered planning means a process to develop an individual support plan that is directed by the participant and/or their representative and is intended **to identify their preferences, strengths, capacities, needs, and desired outcomes or goals.**

Federal View

Options Counseling is an umbrella process that includes the following functions:

- Identification of the person's strengths, values, needs and preferences
- Service plan development
- Enrollment in consumer directed programs
- Enrollment in publicly funded programs
- Service initiation
- Ongoing assistance and follow-up

NH's Description

Options Counseling may include the following components at the direction of the individual:

- ❑ Conducting a needs assessment
- ❑ Providing information on and educating about long term support options
- ❑ Weighing pros/cons and potential implications of various options
- ❑ Collaborating to develop a long term support plan
- ❑ Facilitating enrollment in participant directed services
- ❑ Assisting with enrollment in publicly funded services
- ❑ Assisting in connecting to privately purchased and/or informal supports
- ❑ Following-up with the individual.

Five elements in DRAFT Options Counseling Standards

- **Service Definition**
- **Continuous Quality Improvement, Evaluation and Outcomes**
- **Service Design**
- **Partnerships**
- **Staffing**

State Implementation

- Training, preparation
 - ▣ Standards – November 30
 - ▣ Person-Centered Planning
 - ▣ Other possible trainings:
 - Motivational Interviewing
 - Mediation skills
 - ▣ Other areas that you would like to see?
- Refer7 updates- streamlining reporting
- Starting with LTSC- but tools, trainings, support for all staff, including managers
- Peer support/supervision
- What else would be helpful?

Appendix C:
SLRC Presentation Aug-Sept 2013

OPTIONS COUNSELING

PAST, PRESENT, AND FUTURE

Goals for Today

- Options Counseling- past, present, future
- Review/Feedback on OC Form & Action Plan
- CACL – Technical Assistance and Project Management Entity

Options Counseling

- ADRC 2010 OC Grant
 - ▣ CACL is grantee as agent of the state
 - ▣ Bunch of states (40?)
 - ▣ Worked with ACL on national standards
 - ▣ Implemented standards statewide
 - ▣ Developed Action Plan, Refer7 OC tool
 - Handbook and training

The Future of Options Counseling

- ADRC 2012 Enhanced OC Grant (EOC)
 - ▣ BEAS is grantee/ CACL TA contractor
 - ▣ Goals:
 - OC Certification including Person Centered Thinking training
 - Quality Assurance including tracking/data
 - Veterans directed and care transitions both go statewide
 - ▣ OC across other partners— (federally/ NWD)
 - ▣ OC Workgroup on training and certification; faculty calls

Definition

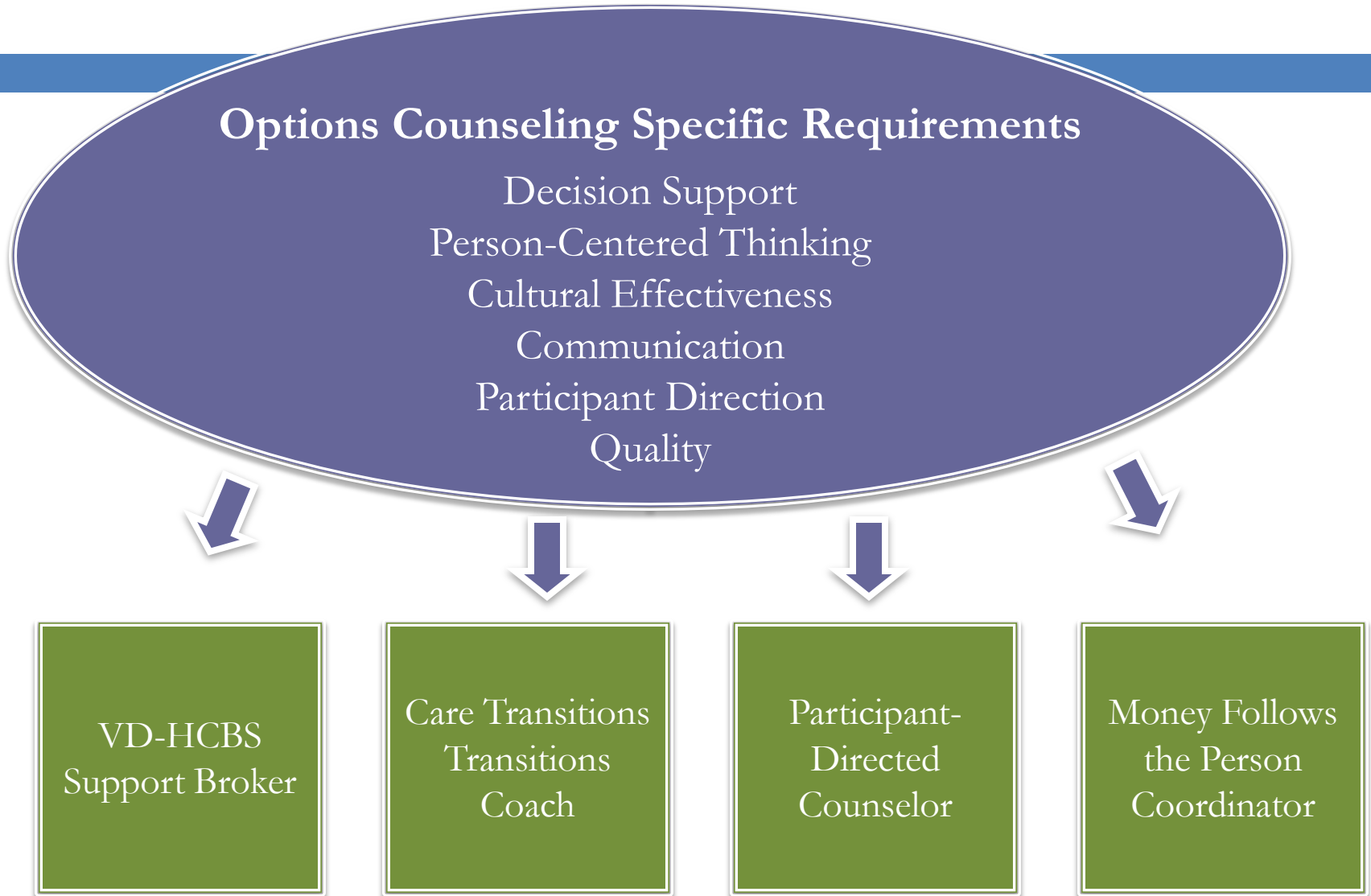
Options Counseling is a relationship-centered (person-centered), interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices **in the context of their own preferences, strengths, and values.**

Foundations of Options Counseling

- Options Counseling as a key component of Aging and Disability Resource Centers (ADRCs)
- Providing individuals support they need to make informed decisions about LTC to prevent or delay unnecessary institutionalization
- ACL/CMS National Vision for ADRCs
 - ▣ In every community
 - ▣ Key to success of MFP, MDS Section Q, Care Transitions, Community Living Program, VD-HCBS and other Participant-Directed programs



ACL Vision for Role of Options Counseling



Options Counseling v Options Counselor



Options Counseling & SLRC Staff

Person-Centered Approach

Function/ Role	Information and Referral Specialist	Long Term Support Counselor	Caregiver Specialist	SHIP	Care Transitions Specialist	Manager
ADRC/ACL Job Duties	Conduct Person Centered Interview	Conduct Person Centered Interview	Conduct Person Centered Interview	Conduct Person Centered Interview	Conduct Person Centered Interview	Conduct Person Centered Interview
		Develop Person Centered Plan	Develop Person Centered Plan		Develop Person Centered Plan	
		Facilitate Access to Services & Support	Facilitate Access to Services & Support	Facilitate Access to Services & Support	Facilitate Access to Services & Support	
	Follow up and Documentation	Follow up and Documentation	Follow up and Documentation	Follow up and Documentation	Follow up and Documentation	Follow up and Documentation

Person-Centered Approach

ADRC's – Big Picture

- **The federal ADRC initiative began with three core functions**
 - ▣ Awareness, Assistance, and Access
- **The set of core expectations has grown over time**
 - ▣ Information, referral, and awareness
 - ▣ Options counseling, advice, and assistance
 - ▣ Streamlined eligibility determinations for public programs
 - ▣ Person-centered transitions
 - ▣ Quality assurance and continuous improvement
- **ACL and CMS are viewing ADRCs as the platform to:**
 - ▣ Intervene during care transitions
 - ▣ Promote self direction
 - ▣ Implement new initiatives (e.g., Veteran Directed Home and Community Based Services)
 - ▣ Catalyze broader systems change
- **Affordable Care Act- “only thing that survived is ADRC”**

Refer7 Features

11

- Identifying OC triggers
- Options Counseling Form
- Action Plan
- Client data

*Goal of the Refer7 features is to allow **all staff** to pull in the important elements of Options Counseling*

Options Counseling Triggers

12

Triggers that are currently listed in Refer7

- CFI/NF
- Concerns about care
- Long Term Supports Needed
- Planning for future care
- Significant change in circumstances

Are there others that should be added to Refer7?

Training

13

- ☐ Internal
- ☐ External
- ☐ Certification
- ☐ Peer Supervision
- ☐ Wish List.....

CACL contracts with DHHS

14

- ADRC Enhanced Options Counseling TA
 - ▣ STAFF:
 - Laura Davie (laura.davie@unh.edu)
 - Marguerite Corvini (marguerite.corvini@unh.edu)
 - Jean Crouch (jean.crouch@unh.edu)
 - Melissa Mandrell (melissa.mandrell@unh.edu)
- Balancing Incentive Program: CACL is Project Management Entity
- Money Follows the Person
 - ▣ Staffing for NH Community Passport
 - ▣ ADRC Section Q

Appendix D:
Summary of Conversations/Comments SLRC Presentation 2013

**Road Show Revisited:
A Summary of Comments and Conversations with ServiceLink Staff
During August and September 2013**

**Prepared by: UNH Center on Aging and Community Living
New Hampshire ADRC Option B:
Options Counseling and Assistance Program Grant
October 2013**

Introduction

In August and September 2013, two CACL staff visited several ServiceLinks to present new federal initiative information, as well as review and receive feedback on previous initiatives implemented by SLRCs. All ten counties, (ten of the thirteen offices) were visited.

CACL staff gave an informal presentation, which consisted of a brief overview of the Aging and Disabilities Resource Center 2010 Options Counseling Grant, the future of Options Counseling from the federal perspective, an outline of how the federal program views options counseling as part of all SLRC roles, the 'big picture' and then opened up the presentation for commenting on Refer7, the Options Counseling Form, the Action Plan and the Refer7 tool, and training.

What follows is the feedback generated from discussions with staff at each of the SLRCs. CACL staff took notes during each session and synthesized the notes. After reviewing the notes, the following comment categories were identified: Gathering and Documenting Information; Refer7 and Beyond; Future Staff Training; and The Future of SLRCs.

Gathering and Documenting Information: Refer7 and Beyond

Notes/Data collection forms

General consensus was that there is not consistency in whether and how information is recorded in Refer7. Many staff report that they use the 'notes' section in Refer rather than a specific form and have their own style for recording information. Many use the 'SOAP' formulation—(subjective, objective, assessment, and plan). Some use the Options Counseling form located in Refer, but there are questions and concerns regarding this (see below). Many of the participants commented that there is a need to develop a best practice for all ServiceLinks for recording information. Once this is established, there needs to be training on the standardized practice, and enforcement of the practice. Many staff noted that they record the majority of relevant information in the notes section. They are used to working this way and wonder why they need to use a tool. Some comments:

- Use of the tool with the person makes conversation awkward
- We don't put a lot of details in the record because it might be subpoenaed or the individual about whom the data is taken may ask to read it
- I know where my stuff is in my notes
- How do we show that we're doing all that is needed when not everyone needs everything (for quality tracking purposes)

- Other programs/agencies may track the same information and we could get data from them
- How do we recognize that the OC tool has been previously used by other staff with a consumer when the consumer calls back?

Another concern mentioned was how the Refer7 forms/system will relate to the Core Standardized Assessment (CSA) that is being developed under Balancing Incentive Program (BIP). Below are some questions and thoughts about the relationship:

- Core standardized assessment will guide who we should collect information on, and what kind of information
- Getting all the info/facts to link person to services is the purpose of Refer7 and the CSA
- BIP will have its own assessment
- The OC form and CSA should be one and the same
- The information collected is “not related to waiver” and should be

General Refer7 Comments

Comments specifically about Refer7 included requests for changes to Refer, such as being able to have two windows open at the same time, having reports show on the initial screen, have the ability to find information about other states' programs (SHIP has this already). On the other hand, there was a strong request from some participants, “DON'T CHANGE Refer7!”

General comments about OC Tool and Action Plan

Comments about specific tools included concerns around the usefulness of the information collected, that the forms asked for too much information and are cumbersome to use, that staff don't know when to use specific tools, and there isn't a requirement to use the tools. There were also concerns about history, showing that the form has been completed, and tracking the changes to forms over time as a situation changes for individuals.

Action Plan

For the Action Plan, one participant stated that there is no way to show that you've completed an action plan, so other staff don't know to look at it and another commented that there is always a plan made with each person who contacts ServiceLink, even if it isn't recorded.

Options Counseling Tool

One participant stated that the OC tool is useful for people who ‘fall through the cracks’ to figure out how they can be helped. In addition, some staff felt that it empowered the person to think about how they will make things better. Some participants expressed concerns around the historical aspects of OC forms—where are they stored? What happens to the history? How does one see the progression over time, the way you can in the notes? One suggestion was to be able to fill out more than one form for an individual to show changes. In addition, other comments included:

What doesn't work:

- Don't know when to use OC form
- Too long- Labor intensive
- Location of tool needs to be in a better location (too many clicks)
- Date/follow up-- Significant change tied to dates (as life changes over time)
- Not enough distinction among categories
- Cumbersome, doesn't flow
- Info supplier report not used
- Cover it without form
- Use in hospital/not in office
- Useful but I don't enter it in Refer
- New assessment to see if needs have been met
- More like a HCBC assessment
- I want to be talking to person, not looking at computer and not filling out a form
- All this information goes into the notes section
- This asks more information than we need to know
- Staff person refers to OC form in narrative in notes and doesn't use Action Plan
- ADLs are too detailed... doing the nurse's job
- Staff need to know why they are doing it
- Tool doesn't replace highly skilled person
- On the OC form, who is the information about?
- Don't need all this detail
- Don't like that it is in first person
- Doesn't fit with our role
- Under environmental—add driving, guns in house
- The ADLs and IADLs information could be shared with the nurse doing the MEA

What could work:

- Ability to see what has been done so you can build
- Just scroll to forms, rather than clicking on separate forms
- Auto populate information from other screens
- SOAP notes form on note page
- Summary section
 - Integrate goal into timeline
 - Informed choice
 - Being able to check off that a goal is met

Triggers

Most people indicated that they did not find the triggers useful and/or they were not sure how to use them. Comments included a request for training on how to use triggers, that they emphasized deficits rather than strengths and encouraged staff to think in silos rather than looking at the whole person. Comments about the trigger options indicated

that they are slanted toward long-term care concerns and focus on the details that are involved in program implementation. Another comment was that triggers stay with a call, not with a person, which limits their usefulness for follow ups. One person suggested that a good core standardized assessment would show triggers to assist in follow up. Several ideas for new triggers were suggested:

- Recent move
- From out of state
- Loss of benefit
- Unemployment
- Fuel assistance
- Money from another state
- What about insurance?
- Caregiver concerns
- Loss of income
- Loss of housing
- Retirement age
- Medicare eligible
- Disability
- Now/stage
- Section Q “yes”
- Recent hospitalization
- New caregiver
- ADLS – help with two or more ADLS
- Long term supports needed
- Put subs
- What kind of ADLS vs. Title 20
- Need to move out of home
- CFI
- “getting worse”
- Last 3 triggers are all the same
- “Other”
- “More info needed”

Future Staff Training Suggestions

Participants made significant comments regarding training for SLRC staff. Overall, there was a general consensus that there should be consistent, statewide training offered that would help to make SLRCs standard across the board. State level training should include general SLRC orientation and a tutorial on Refer7. Some commented that it is expensive to send people to training, both from the perspective of having a person go and due to finding coverage for the individual. Peer supervision was seen as useful and desirable for all staff roles, providing assistance with problem solving and coping with emotionally demanding jobs. Some, however, were not sure of the purpose of peer supervision. A suggestion was made to have a point person available to bounce ideas off of for Options Counseling—this could be

one specific person or people could be partnered with each other.

Specific training topics suggested:

- Judge/Guardian ad litem
 - Guardianship from their perspective
 - What we look at to give guardianship
 - Process of public guardian appointment
- Update on adult foster care - Tracey Tarr
- MFP: What is status
- GSIL
- Housing specialists: What do they do?

The Future of SLRC—Staff Roles and More...

A discussion of staff roles occurred in response to the graphic used to represent the information that was contained in the report requested by ACL regarding who performs specific elements ACL identified of Options Counseling Job Duties (Conduct Person-centered Interview, Develop Person-Centered Plan, Facilitate Access to Services and Support, Follow up and Documentation). Most agreed that all staff did some, if not all, elements of the Options Counseling Job Duties.

Other participants asked how the evolution of Options Counseling and the OC tool might affect other positions—are we doing the work of others (such as taking over for nurses who do functional assessments for Medicaid eligibility)?

What is the vision for SLRCs? Some participants commented that they that they would appreciate receiving more frequent updates on the direction of SLRCs, as it seems to be an evolving entity.

Several SLRCs expressed concern around the large staff turnover at SLRCs. This creates frustration, lack of communication, and lack of continuity for ServiceLinks.

Some participants suggested that as the future of ServiceLink is discussed, we need to be aware of differences and therefore needs of the various sizes and locations.

Next Steps:

- Disseminate to SLRC Network.
- Review the findings with BEAS and the NH Enhanced Options Counseling Training and Certification workgroup.
- Modify the OC tool in Refer7 based on feedback for Roadshow, Refer7 functionality, and other rising initiatives as needed.
- Develop training and follow up technical assistance.

Appendix E:
Evaluation of Peer Supervision with Dr. Rene Bergeron

To: Center on Aging & Community Living

From: L. Rene Bergeron, MSW, PhD
Facilitator

Date: October 24, 2012

Clinical and Peer Support for Option Counselors Final Report

This is a summation of the work completed by Dr. Bergeron as contracted by the Center on Aging & Community Living (CACL), see attached proposal. This report is compiled and written by Dr. Bergeron herein referred to in the personal noun) with the exception of the evaluations of the workshop. The evaluations were computed by an independent source, including the summary of comments.

Workshop Structure

A total of eight workshops were held in the conference room at CACL offices, Concord, N.H. The workshops were held on the third Friday of every month from approximately 9:30 a.m. – 12:30p.m. The structure of each workshop was to first have a “lecture/discussion” period from 9:30 – 10:55 where I would present my knowledge on the selected topic revolving around ethics. After the lecture the group would break for five minutes and then reconvene from 11:00-12:30 in a group format, which I facilitated. The group format was structured for the option counselors (also referred to in this report as practitioners) to get-to-know each other, share cases and solutions, and to share frustrations with their work and the interfacing difficulties with several referring agencies. All of these discussions were professionally guided by me when necessary, e.g., when it stayed negative with no change focus. CACL provided

continental breakfasts, meeting space, necessary equipment for presentations, and salary to the presenter, Dr. Bergeron. This allowed participants to attend the workshop series for “no-cost”. The “no- cost” for participants included their employing agency agreeing to the workshop “time off”, providing office coverage, and reimbursement for mileage and tolls. This is an important point because, according to the participants, there is little money set aside for continuing education for their role as option counselors, little agency supervision (1:1), and great isolation due to the nature of their “business” and being the sole provider of that particular service. In fact, those points may be the reason this group was so eager to begin, positive about using their time for learning, and easy for me to engage. At the initial meeting all but one of the original members stated that these workshops provided the necessary peer-support and training so important for the quality of their work and prevention of burnout.

The Participants

The participants were all very different in education, professional affiliation, and the agency of employment, but their jobs were the same: providing information and referrals to clients calling the ServiceLink Program. Demographics on the participants are in the Summary Evaluation section.

The Workshop Structure and Summary

I began the development of the eight workshops by referencing the Association of Social Work Boards: Guide to Social Work Ethics Course Development. I knew that the participants related to social work field by virtue of their work, but not all the

participants used that discipline as their sole professional affiliation. Therefore, I used the Guide to help in structuring the first two workshops and pulled-in other disciplines to supplement the Guide. I made a request at the first workshop that participants tell me what was important for them to learn about/ discuss for the remaining sessions. The eight workshops were:

1. **Ethics: The beginning. January 31, 2012.** This gave a global historical view of ethics using medical, health/home care, and social work literature. Several handouts on ethical codes were given to participants (*American Association for Home Care Code of Ethics, National Adult Protective Services Association Code of Ethics, and the National Association of Social Workers Code of Ethics*).
2. **Ethics: Who is the client? Client Autonomy and Duty to Protect. February 24, 2012.** This workshop first covered referral processes which often leave the option counselor confused as to exactly who should be the focus of the intervention: the referring person, the family, the elder person. And second how to maneuver through the two values of autonomy and duty to protect. Several handouts on elder/ family rights: *Ambassadors Caregivers: Elder Rights, VNA Community Healthcare: A Family Bill of Rights, Caregiver.Com: A Caregivers Bill of Rights*.
3. **The Rights of the Practicing Professional and Ethics of Care. March 30, 2012.** This workshop focused on whether we, the practitioner, had any rights within the provision of servicing clients. This was a very passionate discussion among the option counselors and I found little in the professional literature about practitioners having rights. One handout was found in the psychology literature: *Therapists have*

a right to the following... <http://www.therapyhub.com/articles/therapy-tips/client-and-therapist-rights>). In addition a Self-Care Assessment was handed out.

- 4. Continuing Ethics of Self-Care and Case Studies. April 27, 2012.** This workshop required me to continue an intense literature about practitioner's rights in practice. The participants were particularly interested in when and if they could terminate services. Reference to a journal article Conscientious Objection in Social Work: Rights vs. Responsibilities, Sweifach, J.; *Journal of Social Work Values & Ethics*, (2011) was presented by me and gave some ethical ways of critically thinking through this process. Differences among cultures were addressed and how that could also affect intervention, thus termination. A brief handout: *Cultural Diversity and Caregiving* <http://www.apa.org/pi/about/publications/caregivers/faq/cultural-diversity.aspx> was discussed.

Issues of self-care were presented with a review of last week's discussion. A handout: *Self-Care Assessment* was discussed and given to participants.

The participants decided to cancel the May workshop due to most of them being committed to another conference and not having the ability to expend more time out of the office.

- 5. Ethics in Group Work and how to facilitate a group. June 22, 2012.** This workshop gave both ethical and a beginning view on peer-led groups. This workshop was at the request of the group knowing we had three meetings left for workshop meetings. The issue of termination was clearly stressful to the participants and discussions began about keeping the group going. Contract setting was discussed at length. Handout included a *Sample Contract*.

- 6. Review of Previous Workshops, Caregivers Role in Ethical Practice, More on Peer-Led Groups. July 27, 2012.** This group began the process of termination, which was woven into the three remaining topics. The group had arrived at the workshop with an agenda of a proposal development to “keep the group going.” And so while the planned material did get presented, and was heard by them, I needed to be very sensitive to their mounting concern of losing a forum that allowed not only peer support, but peer education and peer-supervision. Much of that was discussed in the group setting following the lecture. Handout: *Holding a Family Meeting. From the Family Caregiver Alliance*. This handout was used for its stated purpose and training but also because the points made in this article could be linked to designing a peer-support group. An exercise was done on why the group should continue. Their recorded answers are attached on the flip chart summary. Termination of my service continued to be discussed.
- 7. What is My Ethical Responsibility to my Employing Agency and to my Colleagues? August 24, 2012.** This workshop addressed the mutual connection that should exist among practitioner, agency, and colleagues both within the agency and outside the agency. Release of Information was discussed with two handouts for examples: *Consent for the Release of Confidential Information* and *The Consent for Release of Information used by Social Security (form OMB No. 0960-0566)*. Termination was fully discussed.
- 8. Termination. How to write a proposal. September 21, 2012.** Termination and its complexities continued to be discussed because of resistance to this series ending. Proposal writing took up most of the workshop which was attended by Nancy

Sauter, UNH, MSW student. This person could be quite valuable and available to assist the group in the proposal phase and perhaps with the peer-led groups. I encouraged their consideration of this, but also reinforced it was their choice. Handouts from the previous sessions were brought in for those who may have missed them.

The Peer-Support Group.

The peer-support groups following the workshops became a critical piece of the workshops. Had these not been structured into the design, I have no doubt that they would have emerged because of the needs of the option counselors. The topics of these groups were whatever the option counselors presented as issues. Usually I used a thumb-up and thumb-down approach at the beginning of each group to see who “needed” to be heard on a particular issue he/she was having. Dialogue was always plentiful, supportive, and informative, with shared humor.

EVALUATION SUMMARIES: WORKSHOP SURVEY RESULTS

I did not compute the following evaluative summaries. This was done by a graduate student trained in research evaluations and used by some faculty for this purpose.

Attendance

In all, eight workshops were held with the following attendance.

Workshop 1 Jan	Workshop 2 Feb	Workshop 3 Mar	Workshop 4 Apr	Workshop 5 June	Workshop 6 July	Workshop 7 Aug	Workshop 8 Sept
18	11	14	14	13	8	6	12

The lowest attendance was in the summer months.

A general survey was conducted when the option counselors first convened, yielding the following background information. All surveys and evaluations were voluntary, therefore some participants did not complete them, either by choice or leaving the workshop a little early due to work commitments.

Demographics

The average age is 53.9 with a range of 39-71. While the group began with one male, he dropped out after the first session. In the second session, another male (covering for a female worker) joined the group and remained until the female worker returned with three groups left. All of the participants were female in the final three evaluations; the opening evaluation had an average age of 50.5, with a range of 35-71. Participants have been working in the field for an average of 13.7 years with a range of less than 2-5 years to 20+ years. The average of years working with this current population is 11.35 years with a range of 1-30 years.

Years in the field

0% (0) of participants had 1-2 years in the field

18.1% (2) of participants had 2-5 years in the field

18.1% (2) of participants had 5-10 years in the field

9.1% (1) of participants had 10-20 years in the field

54.5% (6) of participants had 20+ years in the field

Educational Background

- Responses as to educational background were as follows:
- BSW
- Some College
- Bachelor's (Behavioral Science and Criminal Justice)
- Associates (medical Assistant & Human Services)
- BA, MS

- AS, BS, MS
- Bachelor's, MA
- MSW
- MA (Counseling, Psychology)
- MSW
- BSW, partial MSW, MBA

Continuing Education

63.6% (7) of participants had a fair amount of continuing education related to the elderly

36% (5) of participants had some continuing education related to the elderly

7% (1) of participants had a no continuing education related to the elderly

*2 participants did not answer these questions

Workshop Evaluations

Participants evaluated each workshop, except for one workshop when the facilitator failed to pass out the evaluation sheet. The Evaluations were structured the same, with the same questions for each workshop; evaluations were voluntary, and no names were permitted on the evaluations. The results are reported in the aggregate since the numbers for each workshop were small and the questions were the same. Participants used a Likert Scale with choices from:

Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree.

1. Was the content on the topic useful?

95% strongly agreed it was useful.

5% agreed it was useful.

2. The accommodations for the meetings were comfortable?

86% strongly agreed the large conference room was comfortable.

9% agreed it was comfortable

5% were neutral

Comments concerning the large conference room were:

- A little stuffy to start with
- Cold (2)
- Comfortable (10)

100% of participants strongly disagreed that the small conference room (used once) was comfortable.

Comments concerning the small conference room (used once) were:

- Too small (4)
- Small
- Other room is better
- Too tight
- Too warm (3)
- Hot (2)

3. *The presenter's knowledge on the subject was very good?*

98% strongly agreed the presenter's knowledge was very good.

2% agreed the presenter's knowledge was very good

4. *The presenter's style of teaching made it easy for me to learn about the material?*

98% strongly agreed the presenter's style was very good.

2% agreed the presenter's style was very good

Participants continued using a Likert Scale, but with changed values:

Too fast, Too slow, Just right

5. *How would you rate the pace of the presentation?*

100% agreed it was **just right**.

Participants continued using a Likert Scale, but with changed values:

Above, Below, Just right

6. *Was the workshop above or below your current skill level?*

100% agreed it was **just right**.

From comments the following was computed:

- 96% believed that the presenter was clear and easy to understand
- 94% believed that the PowerPoints were relevant to the material being presented.

- 95% stated that the objectives were clearly stated
- 95% stated that the objectives were met

I wish the presenter had done:

- A little less focus on private practice issues, as they are not relative to our setting (from one workshop)
- Was a very good termination meeting
- Wouldn't do anything different

Other thoughts that participants noted:

- Peer support developing, culture of support, self determination, person centered vs. non-person centered model
- Start with the assumption that experience = knowledge

The final evaluation found that

99% believed that it was important to get together as a group

99% would like to continue to meet as a group

92% stated that the agenda for the group was useful

99% stated that the instructor was a good facilitator for the group process

Areas that participants want to learn more about included:

Topic
Guardianship
Advanced directives/Durable power of attorney
Collaborative Decision Making/Self-Determination

	Critical Thinking Skills and Components of Good Decision Making
	Care giving issues
	Elder abuse, neglect, and FINANCIAL exploitation
	Ethical issues related to elder care in communities
	Elderly and Driving
	Effects of aging on the mind, body, emotions and socialization
	Impact of diversity on decision making (ethnicity, race, geographic location, gender, access to healthcare, cognitive functioning) among the elderly
	Mediation/conflict resolution between families/client/providers
	Negotiated consent and Assisted Autonomy
	Case discussions
	Processing our changing roles; budgeting our time; confronting colleagues who do not “work” during their shift; becoming more

	efficient, but not less effective.	
--	------------------------------------	--

What I liked best:

Good combination of listening, empathy, setting goals
Ability to meet/speak about common counselor concerns
Looking at different codes of ethics, whole presentation was interesting
Group process
Wonderful presenter, articulates well, clearly explains key points, etc
Opportunity to input further trainings
Good combination of listening, empathy, setting goals
Group Discussion, Specific examples or scripts of what you can say to a person when they refuse care
Peer session
Discussing the ethical piece regarding "lesser of 2 evils"
While presenting There was room for discussion and examples
Excellent information. Gave much to think about.
I really value this time. It's important and gives me more strength + knowledge
Open discussion - topic is very apropos
The discussions- most helpful- even in the office staff does not go through what we go through
The ease of relationship
The softness of the presenter (authentic)
Sharing by presenter of personal issues in demonstrating a topic
Group processing
Thank you!
Discussion
Case presentation
Case brainstorming
Case discussion, group discussion
Having Rene
Group discussion; peer support
Time allowed for group discussion guided by the group
All very appropriate
Still thinking about the Monadnock example being a mess, this actually has been rumored as what is said above Monadnock
Pace. Ability to address "case specific" situations to process

Review of group process was informative and useful for practice and for contraction (sp?) of Ole's (sp?) group
Having Rene; thinking about Monadnock; pace-ability to address 'case specifics' situations to process; Review of group process was informative; useful for continuation of this group; group discussion; peer support; time allowed for group discussion guided by the group full group involvement encourages positive discussion, allowing for positive feedback and peer support
The peer-lead group/ethics discussion
Very clear. Liked approach to the group process
Great presenter
Great session
I appreciate having the PPT available ahead of time-maybe a sample proposal
Group participation
Suggestions made about group continuations. Facilitator of group. Ability to help us focus on a topic.
I wish presenter could stay with group.
The discussion within the group.
Group practice workshop; group process
Followed her presentation well; was flexible when needed

99% believed that it was important to get together as a group

99% would like to continue to meet as a group

92% stated that the agenda for the group was useful

99% stated that the instructor was a good facilitator for the group process

Comments:

- Less focused on strict social work philosophy/structure and more focused on options counselor - different from social work
- Group activities
- Better digs
- It could last longer
- I like it as it is
- A limit of time set for each case

- Full group involvement encouraged; positive discussions that allow for positive feedback and peer support; presenter is wonderful
 - Love this time, with these people; helps me get through the month
 - This work/support group needs to continue past Rene's contract
 - Very valuable
 - Great meeting
 - Very supportive environment to process!
 - Would like the group to continue
 - Love this time with these people-gets me through the month; Very supportive environment to process; great meeting; would like the group to continue; this work/support group needs to continue past René's contract.
 - I thought process was great and very helpful
 - Thank you so much; look forward to meeting you
 - I'm concerned with having Carleigh in this group- She does not do options or the same job as us and I don't want to open this up to other staff
 - This has been great-I hope we can continue to meet in this way. This has been something that has been needed for a long time and it is very important that it be continued. The LTSC have a unique job with unique issues and we need to have the peer support and education.
 - It continued on as a resource to LTSC's -This has been a very informative and supportive arena
 - I think the process is fine-it seemed to work well
 - We knew it was going to continue
 - I think this whole series, mentoring, and group process has been fantastic. It has been the most positive experience that I have had at SLRC.
 - Process needs to be incorporated with future peer meetings of LTC
 - I really am glad I was here
 - Very, very valuable gathering
 - Finding both instruction time and discussion time very helpful
- [end]

Final thoughts of Dr. Bergeron:

After my role in facilitating these groups, it is clear that the workshop/peer-groups served not only the participants but the agencies that they worked for in the provision of option counseling. I visual could see the confidence building in several participants who began this process unsure of when and if she should participate. Case presentation showed movement from being unsure how to work with a difficult family or client to creating an action-plan of service. Additionally, evaluations showed

this format to be for a good learning environment. It became clear that just having the option counselors at the workshops enhanced their ability to participate, voice their frustrations, present sensitive cases and gain new insights for resolution, and develop new ways of communication with colleagues, clients, and the elder's family. All of these points make for cultivating strong workers, with less chance of burn-out, more proficient in using their time, and better at networking because of these face-to-face meetings – which makes for effective and clear communications with their supervisors.

It is my professional opinion after reading the evaluations and comments and seeing the growth of the option counselors as a group that this format should continue for them. To not do so, would not only “depress” and “devalue” these practitioners, but would make them less likely to invest such high energy in future endeavors of this kind.

Continuing this format is highly possible if a room location can be secured, if expert speakers can be invited on a voluntary basis, and if agencies would commit to time for option counselors to attend monthly morning or afternoon meetings, mileage for their travel, and validation of its importance. It is actually a low-cost, high-yield method of education and a good format in community building/ meeting accreditation or reaffirmation standards/ meeting Federal and State guidelines.

I thank CACL for this opportunity. Please let me know if I can be of help in the future.

Appendix F:
Action Plan Examples

ServiceLink ADRC Option Counseling Action Plan

Action Plan

Created On: 05/07/2012

Action Plan Title/Goal: Cecille's Pain

TASK LIST:

TASK 1: update DPOA for health/Establish DNR order

WHO IS RESPONSIBLE: Claudette 

WHEN: In the next 2 weeks.

TASK 2: Find out if PT can recertify her so that her hha can continue with her bathing.

WHO IS RESPONSIBLE: Claudette 

WHEN: asap

TASK 3: Contact AV Home care-see if she can qualify for sliding scale/ Check into funding sources- Dorothy's

WHO IS RESPONSIBLE: Claudette

WHEN: asap

TASK 4: Call back Lisa/SLRC to follow up on outcome of her tasks.

TASK 5: Contact Consumer Credit Counselor agency to see if Cecille can consolidate debt/ Budget?

WHO IS RESPONSIBLE: Leo 

WHEN: in process

TASK 6: Coordinate with Leo and Cecille regarding finances/CFIP and Claudette regarding current care

ServiceLink ADRC Option Counseling Action Plan

Action Plan

Created On: 08/21/2012

Action Plan Title/Goal: Ruth's Action Plan

TASK LIST:

TASK 1: Call TD Bank to request 60 months of bank statements.

WHO IS RESPONSIBLE: Ruth

TASK 2: Scan health insurance cards: Medicare, PDP and Mailhandlers

WHO IS RESPONSIBLE: Ruth

TASK 3: Call OPM for Life insurance policy and confirmation that it does not have cash value

WHO IS RESPONSIBLE: Ruth

Appendix G:
Interview Reference Guide



New Hampshire

ServiceLink

Aging and Disability Resource Center

Interview Reference Guide

designed for the Options Counseling Tool in Refer7

TABLE OF CONTENTS

Prepared by Marguerite Corvini and Melissa Mandrell, with assistance from the Options Counseling Project Management Team: Wendi Aultman, Donna Leitner, Joanna Theberge, Laura Davie, and Susan Fox.

In addition, the following staff from ServiceLink Resource Centers provided thoughtful feedback: Nancy Bacon, Lydia Bailey, Tina Bellerose, Jessica Benware, Wayne Blanchard, Jill Burke, Jane Conklin, Susan Deyoe, Georges Djanabia, Amber Fogg, Kristy Hayden-Grace, Carrie Johnson, Pam Koski, Kelly Mann, Becky May, Keith McAllister, Dana Michalovic, Amy Newbury, Lisa Polissack, Paul Robitaille, Jena Rutter, Patty Sargent, Mary-Frances Schoenley, Jennifer Seher, Jeanie Thornton, Shand Wentworth, Connie Young

This document was developed in collaboration with the Administration for Community Living, Bureau of Elderly and Adult Services, Center on Aging and Community Living and the ServiceLink Resource Center Network, with funds under grant number 90OC0004 from the U.S. Department of Health and Human Services, Administration on Aging. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services and readers should not assume endorsement by the Federal government.



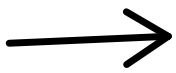
TABLE OF CONTENTS

TABLE OF CONTENTS

KEY

To make this guide easy to navigate, we have created a key to help you are flip through quickly and find specific information.

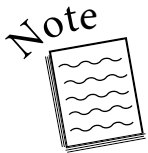
Purpose will indicate the purpose of the particular sections of the OC Tool...



The arrow indicates the specific part of a section being discussed

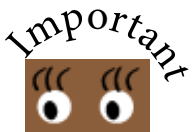


Indicates - “What the aim of the item is”



Note symbol indicates additional information that may be useful to the interviewer

Example questions or conversation starters will be in a bracket just like this one.



Important indicates something the reader should be aware of when executing that particular question/section.

OVERVIEW

The Interview Reference Guide is a resource intended to address and clarify questions when using the Options Counseling Tool in Refer.

Options Counseling Definition

Options Counseling is a relationship-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their **own preferences, strengths, and values.**

Purpose of the Options Counseling Tool:

- To record pertinent assessment information in one location
- Allow for comparison of assessment information supplied by different family members or from different periods of time
- Help standardize the assessment process



The Options Counseling Tool is best used for those information suppliers who are interested in learning about long term care choices as they pertain to themselves, spouses, family members or significant others in their lives. The optimal use of the tool could be an initial assessment for each information supplier (self or someone else regarding a loved one). Subsequent contacts for the same information supplier are worth noting for comparison to the initial assessment if a significant amount of time has passed or the circumstances surrounding that information supplier have altered significantly. Whether the contact is by phone, office, home visit or any other means, the Option Counseling Tool can be utilized to capture the information.

The entire form does not need to be completed for every interview. Depending on the circumstances of the contact (call, home visit, office appointment) some of the items in the assessment may not be appropriate to ask or may not have been observed. Likewise, some of the questions may not be appropriate to that particular contact or at all. There is a comment section after each area that allows for further explanation by the counselor.

BEST USED FOR

- Individuals who are interested in exploring options for long term care for themselves or loved ones
- Assessments of individuals who have experienced a significant change in circumstances

HOW TO USE

This guide lists each question that is on the OC form as well as the answer options that are available in the REFER program. For each section there is also a COMMENT area where notes may be added to clarify/expand answers.



Questions do not need to be asked in any specific order or format. The flow of each interview should be individualized. There is no requirement to ask every question. Only use the questions that are right for a particular situation.

CONTACT

Purpose:

To gather basic information about the manner in which the interview was conducted.



Information Supplier Name: _____

Relationship to Information Supplier: _____

Location of Options Counseling: _____

**Aim**

Who is supplying the information, both their name and their relationship, to the person for whom Long Term Support Options are being explored.

**Note**

The OC tool may be completed separately for each information supplier even when it pertains to the same client.

Example:

Mary Smith, Daughter

John Doe, Spouse

Jane Doe, Self

PHYSICAL HEALTH

Purpose:

It is important to evaluate a person's physical health. Untreated health conditions can affect a person's ability to complete activities of daily living.

**Note**

Each information supplier does not need to be asked all the questions within this category. If during the assessment or conversation concerns are expressed in any one of these areas the interviewer should address this.

Physical:

Consumer stated diagnosis: _____

Understands medical routine: Yes ☐ No ☐

Sees MD regularly: Yes ☐ No ☐

Stated concerns:	eyesight <input type="checkbox"/>	incontinency <input type="checkbox"/>
	hearing <input type="checkbox"/>	physical abuse <input type="checkbox"/>
	speech <input type="checkbox"/>	alcohol abuse <input type="checkbox"/>
	balance <input type="checkbox"/>	med management <input type="checkbox"/>

Comments:

Physical Health Continued...



Consumer stated diagnosis: _____



What is the information supplier stating as the diagnosis (if there is one)?



Please use the exact phrasing given by the information supplier.

Examples:

Jane Doe (self) states she has a sugar problem –*stated diagnosis is “Sugar problem”*

Mary Smith (daughter) states mother is diabetic and insulin dependent –*stated diagnosis is “Insulin dependent diabetic”*



Understands medical routine: Yes ☐ No ☐

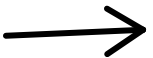


Does the consumer of concern understand and follow a prescribed regimen pertaining to health, medication, therapy or diet?

Examples:

If the person has diabetes, do they understand and follow their routine for testing?

If they have recently had knee surgery, do they understand and follow the physical therapy recommendations?



Sees MD regularly: Yes ☐ No ☐



Does the consumer of concern see a primary care provider or other medical professional on a regular basis? If regular basis is defined by the client as once or twice a year and this routine is being met the response would be yes. If the client states they have not seen their primary care provider in over a year the response would be no.



Start with easier questions, such as, Who is your family doctor?

Physical Health Continued...



Stated concerns:	eyesight	<input type="checkbox"/>	incontinency	<input type="checkbox"/>
	hearing	<input type="checkbox"/>	physical abuse	<input type="checkbox"/>
	speech	<input type="checkbox"/>	alcohol abuse	<input type="checkbox"/>
	balance	<input type="checkbox"/>	med management	<input type="checkbox"/>



Check any of these that the information supplier is relating as a health concern.



You may choose to ask about each of these or to ask generally if the consumer of concern has any health conditions that affect their daily activities.

Comments:



This area is designated for the counselor to post their observations; expand on or clarify any comments.

Examples

- Impressions of the older adult's health
- Energy level or alertness and at what time of day
- How many medications does he or she take
- Evidence of health condition effects (strokes, Parkinsons, etc.)
- Vision and hearing impairment and how the consumer compensates for loss
- If asked to rate their health what would they say?
- Last time they have seen an MD
- Eating patterns and types of meals they may prepare (or not)
- Are MOW untouched
- Evidence of alcohol or medication misuse

PSYCHOLOGICAL/WELL BEING

Purpose:

An individual's psychological and emotional well-being can offer a window into untreated mental health concerns that may impair activities of daily living; forms of abuse that prevent accessing appropriate care (e.g., when services for a particular need are unavailable); and looking at past and present coping abilities to develop strategies for dealing with current concerns



It is important that the interviewer be aware of their own biases and prejudices when talking about this area of the assessment.



Each information supplier does not need to be asked all the questions within this category. If during the assessment or conversation concerns are expressed in any one of these areas the interviewer should address this or refer for appropriate follow up.

Psychological/well being:

Consumer stated diagnosis: _____

Past coping strategies: _____

Expressing suicidal thoughts:

- statement clear with plan ☐
- statement clear but would not ☐
- vague statements ☐
- no evidence of suicidal thoughts ☐

Sees or has seen MH professional: Yes ☐ No ☐

Expressing issues regarding recent losses: Yes ☐ No ☐

Statement concerning emotional abuse: Yes ☐ No ☐

Reduced or infrequent social contact: Yes ☐ No ☐

Feelings of hopelessness or helplessness: Yes ☐ No ☐

Comments:

Psychological Continued...



Consumer stated diagnosis: _____



What is the information supplier stating as the diagnosis? Please use the exact phrasing given by the information supplier. The interviewer may clarify/add information under comments at the end of this section.



Interviewer may want to ask about ‘concerns’ or ‘needs.’

Take what is said and ask leading questions—each interviewer will have their own style. Interviewer should base the discussion on what is pertinent to the particular situation.

Example:

Jane Doe (self)- I get the blues once in awhile –*stated diagnosis is the “blues once in awhile”*

Mary Smith (daughter)- mother suffers from depression for which she is on medication
stated diagnosis is “depression with medication”



Past coping strategies: _____



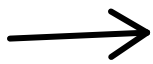
If the individual is going through a difficult time, it may be helpful to ask him/her how they have coped with hard times in the past.

Examples:

- How are you coping with what’s happening in your life?
- You have probably had hard times in the past—how did you deal with them?
- How are you dealing with current problems?
- What about your problem do you see is solvable now?
- How will you know when the problem is solved?
- What future goals do you have beyond resolving this problem?
- Tell me about the times when this problem was not present.



If opportunity permits, using the charts from Methods, Models and Tools training may be a powerful visual for the individual. This gives the interviewer the opportunity to help individuals remember that they have gotten through difficult times previously. It also helps the interviewer understand the person and how they approach decisions.



Expressing suicidal thoughts:

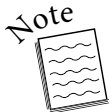
- | | |
|----------------------------------|--------------------------|
| statement clear with plan | <input type="checkbox"/> |
| statement clear but would not | <input type="checkbox"/> |
| vague statements | <input type="checkbox"/> |
| no evidence of suicidal thoughts | <input type="checkbox"/> |



The highest suicide rates of any age group occur among persons aged 65 years and older. One contributing factor is depression that is undiagnosed and untreated. Common suicide risk factors include: mental illness, alcoholism or drug abuse, previous suicide attempts, family history of suicide, terminal illness or chronic pain, recent loss or stressful life event, social isolation, history of trauma or abuse. Additional signs that an older adult may be contemplating suicide: Reading material about death and suicide, disruption of sleep patterns, increased alcohol or prescription drug use, failure to take care of self or follow medical orders, stockpiling medications, sudden interest in firearms, social withdrawal or elaborate good-byes, rush to complete or revise a will.



Has the information supplier themselves or the consumer of concern expressed suicidal thoughts?



The first step is to find out whether someone is in danger of acting on suicidal feelings. Be sensitive, but ask direct questions. Here are some things to ask:

- Are you thinking about suicide?
- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Have you thought about how you would do it?
- Do you know when you would do it?
- Do you have the means to do it?
- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?



It is not necessary to ask all questions--- interviewer has to use their own judgment to guide them and base this on what the interviewer hears from the information supplier.



Asking about suicidal thoughts or feelings won't push someone into doing something self-destructive. In fact, offering an opportunity to talk about feelings may reduce the risk of acting on suicidal feelings.



If you have any concerns, you should follow your agency's protocol regarding notifications of the proper authorities.

Examples:

Jane Doe (self)-I've thought about just ending it. I have some pills hidden and once I gather some more pills I figure those with some whiskey. I could put myself to sleep.

Statement clear with a plan

Mary Smith (daughter)- Mom says it's not worth getting up some days but when I push her about whether she would do any harm to herself she says her religion forbids it and she won't make it to heaven to join Dad.

Statement clear but would not

John Doe (spouse) - Jane is always grumping about the pain she's in and wishing it to end...she's been doing that for 20 years! Then she'll ask when we are going out to the senior center.

Vague statements



Sees or has seen MH professionals: Yes ☐ No ☐



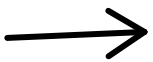
Has the information supplier stated that they or the consumer of concern has ever seen or currently sees a mental health professional?



Expressing issues regarding recent losses: Yes ☐ No ☐



Has the information supplier described a recent (within past year) loss of a spouse, sibling, child, family member, friend, pet or other significant person in their life? If the individual describes a loss, ask when it happened. There is no time limit in asking about this, for some individuals losses that are far away in time may be affecting current functioning. Other examples of loss include spouse/significant other moving to a nursing home, a new medical diagnosis (loss of health, loss of job, change in a relationship)



Statement concerning emotional abuse: Yes ☐ No ☐



Has the information supplier stated that they or the consumer of concern has vaguely mentioned or clearly stated fears of certain people in their life; stressed relationships in which anger is directed at them; been physically hurt; been inappropriately touched? The first step is to find out whether someone is in danger. Be sensitive, but try to ask direct questions.



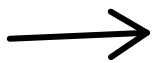
If you have any concerns about the safety of the client or interviewee, you should follow your agency's protocol regarding notification of the proper authorities.

Example questions for exploring physical and emotional abuse:

- What stresses do you experience in your relationships?
- Do you feel safe in your relationships?
- People in relationships sometimes fight. What happens when you and [someone] disagree?
- Have there been situations in your relationships where you have felt afraid?
- Have you been physically hurt or threatened by anyone?
- Has someone forced you to engage in sexual activities that you didn't want?
- Does your spouse, child, or anyone who comes to your home, hurt or hit you?
- Do you feel threatened or encouraged to do something that doesn't seem right?

Finances are another potential area for abuse. To ask about financial exploitation, ask questions such as:

- Are you being pressured to give money or pay bills for others?
- Are you being asked to lend money to someone?
- Is someone asking about inheritance?



Reduced or infrequent social contact: Yes ☐ No ☐



Has the information supplier stated that in the past few months to a year they or the consumer of concern is not going out of their home or people (family, friends) are not coming to visit them as often?



Feelings of hopelessness or helplessness: Yes ☐ No ☐



Has the information supplier stated that they or the consumer of concern expressed feeling worthless or “not good for anything” within the past year month, or recently? If yes, you may wish to revisit the information and questions pertaining suicide.

Comments:



This space may be used for the interviewer's impressions or thoughts, and/or to record additional information provided by the individual.



You may want to add information in the notes regarding mental health issues—e.g., if a mental illness is being experienced and whether issues are treated/untreated at the present time

COGNITIVE

Purpose:

Cognitive status includes long term and short term memory and the ability to use skills and memory in daily life. It may be helpful to acknowledge any concerns that the individual has regarding memory issues.

Cognitive:	
Oriented to time:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oriented to place:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oriented to person:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Becomes lost in familiar places:	Yes <input type="checkbox"/> No <input type="checkbox"/>
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Decision process:</p> <p>reasonable & consistent <input type="checkbox"/></p> <p>at times reasonable & consistent <input type="checkbox"/></p> <p>unable to make decisions <input type="checkbox"/></p> </div> <div style="width: 50%;"></div> </div>	
<p>Comments:</p> <div style="border: 1px solid black; height: 80px; margin-top: 5px;"></div>	



Each information supplier does not need to be asked all the questions within this category. If during the assessment or conversation concerns are expressed in any one of these areas the interview should address this.

Example:

Ask if another family member carries the family memory, e.g., “Does your daughter carry the family memory? I’m wondering if it would be easier if your daughter/family member answered these questions.”

“Sometimes I need to ask routine, direct questions. Can you tell me what your name is,” etc.



Oriented to time: Yes ☐ No ☐

Oriented to place: Yes ☐ No ☐

Oriented to person: Yes ☐ No ☐



These three questions refer to awareness of the individual's environment and the individual's self in terms of person, place, time, and event. Orientation is measuring the parameters of person, place, time, and event. If the person has the functional ability to know and understand who he is, where he is, when it is, and what has happened, they are oriented.

Examples:

- Do they know who they are? Full name.
- Do they know where they are at the present time? Their home, the street, or perhaps the town.
- Do they know what time it is? The exact or approximate time, part of the day, and morning, day, or night.
- In addition, knowledge of the date can be used as an element of orientation.



Becomes lost in familiar places: Yes ☐ No ☐



Has the information supplier stated that they or the consumer of concern related times when they have been unable to find their way home from what would have been a "routine" or local trip or been in a family member's home that they frequented and cannot locate a specific room any longer?



Questions about orientation may be asked directly or information about this may be obtained through observation and discussion. Remember that many have partial or fluctuating capacity. For example older adults who have "sun downing" may still have the ability to make decisions at other times when they are lucid.



Decision process:	
reasonable & consistent	<input type="checkbox"/>
at times reasonable & consistent	<input type="checkbox"/>
unable to make decisions	<input type="checkbox"/>



Decision process is specific to a particular decision or situation at a given moment in time. Even individuals with cognitive impairment may still be capable of making or being involved in rational choices and decisions. Many have partial or fluctuating capacity. For example older adults who have “sun downing” may still have the ability to make decisions at other times when they are lucid.



Information about this may be obtained through observation and discussion.

Examples of some items to consider when looking at decision process:

- Make sure that the individual understands what has been said
- Rule out language barriers, hearing, visual, and/or literacy concerns
- Collect information from supporters regarding their opinion of past or current sensible (or not) choices
- Ask hypothetical questions (e.g., If you smelled smoke in your home what would you do first?) to see if the individual can correctly retell the situation; discuss various choices, describe consequences of choices and why they choose that option in that particular situation

Additional Comments:



This space may be used for the interviewer’s impressions or thoughts, and/or to record additional information about the Cognitive Status portion of the interview.

DAILY LIVING ASSESSMENT

Purpose:

Measuring the functional capacity of someone to perform activities to take care of him or herself can help identify what services may be useful. A scale is used to rank the individual level of independence in performing these tasks. This assessment is based on evaluation questions used for the MED.



Daily Living Assessment:

Code:

- 0 = No Problem
- 1 = Mild (assist needed but not daily)
- 2 = Severe (assist needed almost everyday)

Do you have problems bathing/showering?	0
Can you do your own shopping?	0
Can you dress yourself?	0
Can you do your own laundry?	0
Can you feed yourself?	0
Can you fix meals?	0
Can you groom yourself?	0
Can you take your own medication?	0
Do you have problems getting to the bathroom or toilet?	0
Do you have problems keeping your balance?	0
Can you get in and out of your bed or chair?	0
Can you use a telephone?	0
Are you able to walk without help?	0
Are you able to arrange and/or use transportation on your own?	0
Can you clean your house (sweep, dust, wash dishes, vacuum)?	0
Are you able to manage your finances on your own?	0

Daily Living Assessment Continued...



Each information supplier does not need to be asked all the questions within this category. These questions may be asked directly or information about this may be obtained through observation and discussion. If during the assessment or conversation concerns are expressed in any one of these areas the interviewer should ask further questions. In addition, issues should be noted for possible inclusion in the action plan development and/or referrals that may be needed.



Find the **coding** category that best identifies the consumer's level of ability. If the consumer does not fall neatly into a code category then use the comment section to elaborate further. The ADL assessment can be a helpful tool as a comparison when contacts with the consumer or family occur over time. For example: the individual may need no problem (no assist - 0) in certain categories and over time progress to mild (some assist - 1) or severe (total assist- 2).

Examples of approaches to asking these questions could include:

- Your goal is to ____, what activities are you struggling with?
- Tell me what your day looks like—walk me through your typical day
- Is there anything you'd like to tell me that may be uncomfortable to talk about?

Items for the counselor to consider:

- What are you noticing?
- You can prompt the individual if needed.
- Home visit v. phone or office visit
- Dynamics between consumer and someone who is with them
- If someone says 'yes' to something, ask for more information. Example: how do you....

Comments:



This space may be used for the interviewer's impressions or thoughts, and/or to record additional information about the Daily Living portion of the interview.

ENVIRONMENTAL

Purpose:

Many individuals have adapted their living habits to accommodate health concerns. This could include moving downstairs and turning a dining room into a bedroom or sleeping in lounge chairs for comfort. Difficulty getting into the house or accessing specific rooms in the home can pose obstacles to independence.

Environmental Continued...

Environmental:

Rooms spend most time: _____

Access shower/tub: Yes ☐ No ☐

Access housing: Yes ☐ No ☐

Safety hazards: Yes ☐ No ☐

Access bathroom: Yes ☐ No ☐

Has emergency exit plan: Yes ☐ No ☐

Comments:



Each information supplier does not need to be asked all the questions within this category. If during the assessment or conversation concerns are expressed in any one of these areas the interviewer should ask further questions. In addition, issues should be noted for possible inclusion in the action plan development and/or referrals that may be needed.



Plant seeds regarding ideas/resources for the future.



These questions may be asked directly or information about this may be obtained through observation and discussion. The interviewer may clarify/add information under comments at the end of this section. If interview/meeting is not in the home, ask about specifics that you would observe if you were in the home. Ask family, providers, etc.



Rooms spend most time: _____

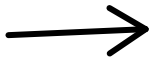


What is the information supplier stating as the rooms or living area most used? Please use the exact phrasing given by the information supplier.



Ask if there are additional/other rooms they'd prefer to be using—if so, what are the barriers to using them?

Environmental Continued...



Access shower/tub: Yes ☐ No ☐



Can the individual safely and with minimal effort get in and out of the shower/tub?

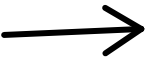
Examples:

Visual cues: grab-bars, commode?

Do you use an adaptive equipment?

Have you ever fallen getting in or out of the shower/tub?

Does someone help you when you bathe?



Access housing: Yes ☐ No ☐



Can the individual safely and with minimal effort get in and out of their home?

Does this vary depending on the time of year?



Safety hazards: Yes ☐ No ☐



Is the information supplier or you as an observer identifying electrical; plumbing; water damage; unsanitary conditions; any clutter/hoarding that could pose a safety hazard?



Access bathroom: Yes ☐ No ☐



Can the individual safely and with minimal effort get to and from their bathroom?

Environmental Continued...



Has emergency exit plan: Yes ☐ No ☐



Can the individual indicate what action they would take to leave their home/apartment in the event of an emergency such as a fire?



If the individual does not have an emergency exit plan, consider assisting them to create one or discuss with your supervisor



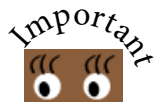
Comments:

Examples:

This space may be used for the interviewer's impressions or thoughts, and/or to record additional information about the Environmental portion of the interview.

Interviewer may wish to note:

- Where the telephone is located for emergency purposes
- Whether carpeting or scatter rugs may affect mobility
- Is the individual using a cane, walker or wheelchair
- Is there potential for fall risk
- Is the lighting sufficient
- Are rooms/doorways free of obstacles?
- Exterior environmental issues, including seasonal concerns



Note safety concerns—bring to team/supervisor

SOCIAL WELL BEING

Purpose:

These questions allow the interviewer to note significant information regarding the consumer of concern that will be useful in discussing the consumer of concern's long term care options. Comments may include: services received, assistance received, support networks, personal relationships, spiritual and religious beliefs, cultural preferences, working history, and socialization patterns.

→

Social Well Being:

Spiritual Supports: _____

Informal Supports: _____

Emotional Supports: _____

Participates in activities: Yes ☐ No ☐

Adult Prot. ☐

Food stamps: ☐

Fuel/Electrical: ☐

LIS: ☐

QMB/SLMB: ☐

Title 20: ☐

Transitions ☐

Services Received:

Adult Day: ☐

Chore: ☐

Homemaker: ☐

MOW: ☐

Personal Care: ☐

Respite: ☐

Emergency Response System ☐

ALF/NF ☐

Transportation Assistance ☐

If you no longer had your current supports, do you have a back-up plan? Yes ☐ No ☐

Do you have special evacuation needs? Yes ☐ No ☐

*If the answer is yes, please indicate needs and plan in the comment box.

Comments:

→

If you no longer had your current supports, do you have a back-up plan? Yes ☐ No ☐

Do you have special evacuation needs? Yes ☐ No ☐

*If the answer is yes, please indicate needs and plan in the comment box.



The back-up plan questions relate to a person-centered plan that addresses unexpected situations that could jeopardize the participant's health or welfare, and which: 1) Identifies alternative staffing resources in the event that normally scheduled care providers are unavailable; and 2) Addresses special evacuation needs that require notification of the local emergency responders.

FINANCIAL

Purpose:

This section is intended to aid the interviewer in considering programs for which the individual may be eligible. Information regarding income and resources may be needed.



Each information supplier does not need to be asked all the questions within this category. If during the assessment or conversation concerns are expressed in any one of these areas the interview should address this.

Financial:

Income:

Resources:

Comments:



Income:



Gross MONTHLY income/salary of any benefits received including Social Security, Supplemental Security (SSI or SSDI), pension, annuity derived incomes.



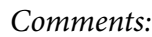
The interviewer may need to calculate this figure based on information supplied by the information supplier.



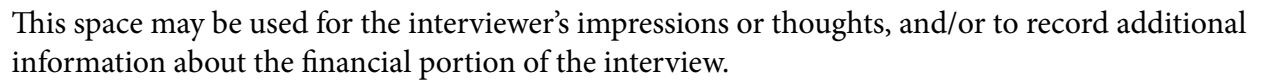
Resources:



This includes items such as banking, checking, stocks, bonds, CD's, IRA's, 401K's, life insurance, and annuities.



--



SOCIAL HISTORY

This question allows the interviewer to note significant information regarding the consumer of concern that will be useful in discussing the consumer of concern's long term care options. Comments may include: Support networks, personal relationships, spiritual and religious beliefs, cultural preferences, working history, and socialization patterns.

Individual Stated Social History

[illegible]

INFORMATION SUPPLIER REFLECTIONS AND GOALS

Purpose:

This section is intended to assist the interviewer in judging the information supplier's understanding of their discussion.



Information Supplier Reflections and Goals:

Please note that the questions in this section are here to guide you. You may write your own questions in the provided spaces or just pull the information based on your interaction with the information supplier.



The questions will address what the consumer wants to have happen; has them verbalize what is needed to move toward their goal; their expectations of the counselor; and confirmation of willingness to take next steps toward their goal.



Information Supplier Reflections and Goals:

1) What do you hope happens? And why?

2) What do you need in order for this change to happen? What should be addressed first?

3) What do you expect from me (options counselor)?

4) Do you know what your next steps are?

5) I respect your right to make your own decisions, could you help me understand how you reached this decision?

*If response to 3&4 indicate no expectations or no wish for next steps then counselor should gently probe to determine consumer understands consequences of decision

Information Supplier Reflections and Goals Continued...



If the consumer cannot clearly outline their goals, needs, or help in prioritizing and developing next steps then the LTSC may need to step back and figure out why (capacity, cultural, literacy). If the consumer is choosing not to take next steps or has no expectations of the LTSC then the LTSC may wish to probe further to determine if the information supplier is able to offer a “reasoned argument” for why he/she has made this choice. It may simply be they wish to put off decision for period of time.

Example probing question:

“How could [the Counselor] assist you in identifying your needs, goals, etc. and then work with you to try to accomplish it?”

Example response may include the following:

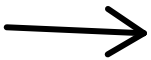
Jane Doe (self)- I want to die in my own home and I’d be willing to accept help if it means I can stay here.

Mary Smith (daughter)- I’d like Mom to stay at home as long as possible but I can’t have her move in with me...it just wouldn’t work with my family and work schedule.



Are there any language barriers, hard of hearing, visual, or literacy concerns? If so is there a different means of relaying information that should be considered?

Comments:



Additional comments may be added here or if the consumer has an actual stated goal, you may record that here as well. Specifically, what has the information supplier stated as their goals for this interview and/or for their life? Goals may differ for the client vs. their family member. Please use the exact phrasing given by the information supplier. If the information supplier is unable to answer the specific questions or provide goals, you can pull from your observations reasons why the client is unable to make a decision at this time.

POST OPTIONS COUNSELING SURVEY

These questions represent the interviewer's opinion about the consumer's understanding of the process and his/her ability to participate in the process of exploring long term support options.

Post Options Counseling Survey:

Can the person make and express their choices?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can the person give reasons for their choices?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the person have factual understanding of the concerns?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the person understand the risks and consequences of the decisions made?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

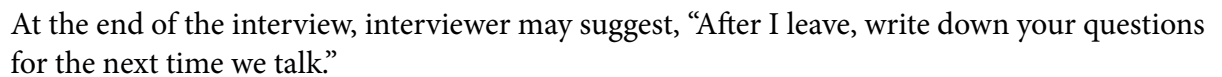
Comments:

Yes ☐ No ☐

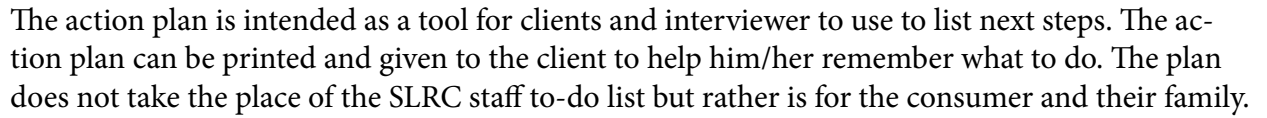
Yes ☐ No ☐

Yes ☐ No ☐

Comments:



ACTION PLAN



Created On: _____ **Action Plan For:** _____

Action Plan Title/Goal: _____

TASK 1:
WHO IS RESPONSIBLE:
WHEN:

TASK 2:
WHO IS RESPONSIBLE:
WHEN:

TASK 3:
WHO IS RESPONSIBLE:
WHEN:

TASK 4:
WHO IS RESPONSIBLE:
WHEN

TASK 5:
WHO IS RESPONSIBLE:
WHEN:

Options Counseling Tool for _____

Date _____

Information Supplier Name: _____

Relationship to Information Supplier: _____

Location of Options Counseling: _____

Directions: *This form is a resource intended to assist staff in noting information for later entry into the Refer database. Because Options Counseling is a relationship-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values, THIS FORM DOES NOT NEED TO BE COMPLETED IN ITS ENTIRETY, nor does it need to be completed in one interview. Some sections of the form may never be addressed with some individuals.*

The Options Counseling Tool:

- Is an aid to record pertinent assessment information in one location
- Allows for comparison of assessment information supplied by different family members or from different periods of time
- Serves to standardize the assessment process

Depending on the circumstances of the contact (call, home visit, office appointment) some of the items in the assessment may not be appropriate to ask or may not have been observed. Likewise, some of the questions may not be appropriate to that particular contact or at all.

Physical:

Consumer stated diagnosis: _____

Understands medical routine: Yes ☐ No ☐

Sees MD regularly: Yes ☐ No ☐

Stated concerns:	eyesight	<input type="checkbox"/>	incontinency	<input type="checkbox"/>
	hearing	<input type="checkbox"/>	physical abuse	<input type="checkbox"/>
	speech	<input type="checkbox"/>	alcohol abuse	<input type="checkbox"/>
	balance	<input type="checkbox"/>	med management	<input type="checkbox"/>

Comments:

Psychological/well being:

Consumer stated diagnosis: _____

Past coping strategies: _____

Expressing suicidal thoughts:

statement clear with plan ☐

statement clear but would not ☐

vague statements ☐

no evidence of suicidal thoughts ☐

Sees or has seen MH professional: Yes ☐ No ☐

Expressing issues regarding recent losses: Yes ☐ No ☐

Statement concerning emotional abuse: Yes ☐ No ☐

Reduced or infrequent social contact: Yes ☐ No ☐

Feelings of hopelessness or helplessness: Yes ☐ No ☐

Comments:

Cognitive:

Oriented to time: Yes ☐ No ☐

Becomes lost in familiar places: Yes ☐ No ☐

Oriented to place: Yes ☐ No ☐

Oriented to person: Yes ☐ No ☐

Decision process:

reasonable & consistent ☐

at times reasonable & consistent ☐

unable to make decisions ☐

Comments:

Daily Living Assessment:

Code:

- 0 = No Problem
- = Mild (assist needed but not daily)
- = Severe (assist needed almost everyday)

Do you have problems bathing/showering?	0
Can you do your own shopping?	0
Can you dress yourself?	0
Can you do your own laundry?	0
Can you feed yourself?	0
Can you fix meals?	0
Can you groom yourself?	0
Can you take your own medication?	0
Do you have problems getting to the bathroom or toilet?	0
Do you have problems keeping your balance?	0
Can you get in and out of your bed or chair?	0
Can you use a telephone?	0
Are you able to walk without help?	0
Are you able to arrange and/or use transportation on your own?	0
Can you clean your house (sweep, dust, wash dishes, vacuum)?	0
Are you able to manage your finances on your own?	0

Comments:

--

Environmental:

Rooms spend most time: _____

Access shower/tub: Yes ☐ No ☐

Access housing: Yes ☐ No ☐

Safety hazards: Yes ☐ No ☐

Access bathroom: Yes ☐ No ☐

Has emergency exit plan: Yes ☐ No ☐

Comments:

Social Well Being:

Spiritual Supports: _____

Informal Supports: _____

Emotional Supports: _____

Participates in activities: Yes ☐ No ☐

Services Received:	Adult Day:	<input type="checkbox"/>
	Chore:	<input type="checkbox"/>
	Homemaker:	<input type="checkbox"/>
	MOW:	<input type="checkbox"/>
	Personal Care:	<input type="checkbox"/>
	Respite:	<input type="checkbox"/>
	Emergency Response System	<input type="checkbox"/>
	ALF/NF	<input type="checkbox"/>
	Transportation Assistance	<input type="checkbox"/>

Assistance:	Adult Prot.	<input type="checkbox"/>
	Food stamps:	<input type="checkbox"/>
	Fuel/Electrical:	<input type="checkbox"/>
	LIS:	<input type="checkbox"/>
	QMB/SLMB:	<input type="checkbox"/>
	Title 20:	<input type="checkbox"/>
	Transitions	<input type="checkbox"/>

If you no longer had your current supports, do you have a back-up plan? Yes ☐ No ☐

Do you have special evacuation needs? Yes ☐ No ☐

*If the answer is yes, please indicate needs and plan in the comment box.

Comments:

Financial:

Income: _____

Resources: _____

Comments:

Social History/Summary:

Individual Stated Social History

Information Supplier Report:

Please note that the questions in this section are here to guide you. You may write your own questions in the provided spaces or just pull the information based on your interaction with the information supplier.

1) What do you hope happens? And why?

2) What do you need in order for this change to happen? What should be addressed first?

3) What do you expect from me (options counselor)?

4) Do you know what your next steps are?

5) I respect your right to make your own decisions, could you help me understand how you reached this decision?

*If response to 3&4 indicate no expectations or no wish for next steps then counselor should gently probe to determine consumer understands consequences of decision

Information Supplier Report:

1) What do you hope happens? And why?

2) What do you need in order for this change to happen? What should be addressed first?

3) What do you expect from me (options counselor)?

4) Do you know what your next steps are?

5) I respect your right to make your own decisions, could you help me understand how you reached this decision?

*If response to 3&4 indicate no expectations or no wish for next steps then counselor should gently probe to determine consumer understands consequences of decision

Comments

Post Options Counseling Survey:

Can the person make and express their choices? Yes ☐ No ☐

Can the person give reasons for their choices? Yes ☐ No ☐

Does the person have factual understanding of the concerns? Yes ☐ No ☐

Does the person understand the risks and consequences of the decisions made? Yes ☐ No ☐

Comments:

ServiceLink ADRC Option Counseling Action Plan

Created On:

Action Plan For:

Action Plan Title/Goal:

TASK LIST

TASK 1:

WHO IS RESPONSIBLE:

WHEN:

TASK 2:

WHO IS RESPONSIBLE:

WHEN:

TASK 3:

WHO IS RESPONSIBLE:

WHEN:

TASK 4:

WHO IS RESPONSIBLE:

WHEN

TASK 5:

WHO IS RESPONSIBLE:

WHEN:

TASK 6:

WHO IS RESPONSIBLE:

WHEN:

Appendix H:
SLRC Options Counseling Brochure

OPTIONS COUNSELING HELPS YOU:

- Explore your future care
- Evaluate your long-term care options, including the pros and cons of specific choices for now and for the future
- Develop an action plan based on what is important to you
- Connect with local resources



NOTES



Call your local ServiceLink
1-866-634-9412 (Toll Free)
or
www.servicelink.org

This information is provided by an Agreement between the NH ServiceLink Aging and Disability Resource Center and the NH Department of Health and Human Services' Bureau of Elderly and Adult Services and partially funded by the Centers for Medicare & Medicaid Services under grant #11-P-20220.

Options Counseling



Counseling that can help
you with choices as
you age



1-866-634-9412
www.servicelink.org

COUNSELING **OPTIONS COUNSELING** COUNSELING



WHO PROVIDES OPTIONS COUNSELING?

Each local ServiceLink Aging and Disability Resource Center has a Long-Term Support Counselor on their team.

A Long-Term Support Counselor is a knowledgeable, caring, and experienced guide to support you while you explore your options and make choices about your long-term needs.

Based on your preference, Options Counseling can be provided through home visits, office visits, community appointments, as well as by phone or email.



SOMETIMES YOU NEED HELP BUT JUST DON'T KNOW WHAT OPTIONS YOU HAVE

CAN OPTIONS COUNSELING HELP YOU WITH YOUR LONG-TERM CARE CONCERNS?

Are you confused by the choices you face as you age?

Are you or is someone you love trying to make difficult care decisions?

Are you trying to stay in your home as you age?

Has it been suggested that you need nursing home care?

Do you need to plan for future care needs such as legal, medical, and financial?

Do you need help understanding how long term care is paid for?

If you answered "yes" to any of these questions, call ServiceLink for assistance

**1-866-634-9412 (Toll Free) or
www.servicelink.org**

WHAT CAN YOU EXPECT?

Our counselors can assist you through the decision process.

They can guide and support you in identifying and reaching your long-term care goals.

Options Counseling is part of ServiceLink's customized team approach, also offering:

- **Information about and connections to local resources**
- **Caregiver and family support**
- **Medicare and Medicaid counseling**