**Course Outline**

**Coordination of Long-term Services and Supports (LTSS)**

**Across Programs and Settings: Part A and B**

***Draft of lesson descriptions, objectives, outline and definitions***

**Course Description:**

This course is intended to acquaint workers with the variety of services available to older adults and people with disabilities through programs funded and supported by federal and state governments and administered by state and local agencies. In order to properly serve the people who seek information about their eligibility for services and their right to obtain these services, workers must be knowledgeable about the long-term services and supports available. Each state has its own eligibility requirements, and depending on its social service mission, philosophy, and budgetary needs provides different services. It is not expected that workers in one state will be familiar with all other state programs, but it is essential for them to know what services are available in their own state for older people and people with disabilities. Throughout the course you will find links to help you locate services in your own state as well as those in other states.

It is also important to understand that programs for different age groups intersect: a younger adult with a disability may be providing care for children, or an older adult may also care for her parent with long-term needs. Many adults over age 65 who meet federal income poverty levels are also eligible for Medicaid. People over 65, people who are visually impaired, or younger people who have a disability that prevents substantial work are also eligible for Supplementary Security Income (SSI). These are just some of the programs available to service the needs of older adults and people with disabilities.

By the conclusion of this course, you should be able to help the people who come to you for information or services to determine what they are eligible for that meets their particular needs, and to navigate the long-term services and support system.

**Lesson List: (Nine 15-minute lessons)**

Lesson #1: An Introduction to Federal LTSS

Lesson #2: LTSS at the State and Organizational Levels

Lesson #3: Making Use of Community and Local Resources

Lesson #4: Partnering with the Person to Successfully Navigate LTSS

Lesson #5: Discussing Personal Finances and Encouraging Financial Literacy

Lesson #6: Person-Centered Planning in Coordinating LTSS

Lesson #7: Participant Direction

Lesson #8: Care Transitions and Health Promotion

Lesson #9: Collaboration in the No Wrong Door System

**Our Target Group of Learners:**

This course is targeted to all workers, regardless of title, who work in the No Wrong Door (NWD) System and who work directly with people who need long-term services and supports (LTSS). There are many titles now (Options Counselors, Independent Living Specialists, Community Living Specialists, etc.), the focus is on the development of person centered thinking/planning/practice (PCC) skills in serving those individuals with LTSS needs in the NWD system who serve all populations. Staff will need competencies to understand who we serve in this system regardless of the complexity of their situation.

The primary audience(s) for this course is:

* Any person who works in the No Wrong Door System
* Any staff member that works with people who are in need of long-term services and supports
* Any person who works with people of all ages with disabilities and/or older adults

The secondary audience(s) for this course is:

* Options counselors
* LTC Assessors
* Peer Support Specialists
* Independent Living Specialists/Coordinators
* Transition planners
* Social workers
* Information and Referral Specialists
* Case Managers/Support Navigators/Care Coordinators
* Advocates
* Support Agency leaders
* Frontline Supervisor
* Direct Support Professional (comprehensive, broad support roles and skill sets)
* Personal Care Assistant or Home Health Aide (limited work roles and skill set)
* Family members of person with support needs
* Persons with support needs
* Medical and service professionals
* Other (please describe):\_\_\_\_\_

**Why is this course important to the learner and audience:**

Long-term services and supports are often complex, fragmented, and difficult to navigate. This can make accessing the right services a daunting task for individuals and their family members. The No Wrong Door (NWD) system supports state efforts to streamline access to long-term services and supports for older adults and individuals of all ages with disabilities. Workers in the NWD system work with older adults and individuals with physical disabilities of all ages. As workers increasingly work with diverse populations of all ages it is critical that they understand the unique quality of life needs of the multitude of populations with whom they work, but also that each person is unique. Workers must also understand how to engage individuals in a manner that is in line with the practice of person-centered counseling; with an empowering and consumer controlled approach; supporting informed choice and tailoring of choices based on an individual’s preference, strengths, and desires.

This course will provide information and resources that apply to people receiving support in the following age groups:

🗷 Birth to early childhood 🗷 School-age 🗷 School to work transition 🗷 Adult (18-60) 🗷 Adult (60+)

This course will provide information and resources that apply to people receiving support in the following settings:

🗷 Vocational/Employment 🗷 School/education 🗷 Home 🗷 Community/recreational

🗷 Medical/Health care homes and/or Behavioral health homes 🗷 Long-term care facilities

This course will provide information, illustration, and resources that apply to providing support to people with the following needs:

*🗷 Mental Illness* *🗷 Intellectual Disabilities & DD 🗷 Physical Disabilities*

*🗷 Significant Physical Disabilities 🗷 Aging Related Disabilities 🗷 Dementia*

*🗷 Attention Deficit Disorder 🗷 Traumatic Brain Injury 🗷 Emotional & Behavioral*

*🗷 Brain and Processing Disorders 🗷 Autism & Spectrum Disorders 🗷 Substance Abuse or addiction 🗷 Visual/Auditory Impairments 🗷 Other (list) \_\_\_\_\_Any person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Describe in what ways the information in this course might be influenced by diversity issues related to the learner and/or consumer of services (reflect on: culture, race, ethnicity, gender, sexual orientation, age, etc.):**

This course is about the multitude of different people who are served by the No Wrong Door (NWD) system, including older adults and people of all ages with disabilities. Awareness of the common quality of life needs and of the cultural and diversity issues of the many populations served by the No Wrong Door (NWD) system is very important for all workers. Learners must also be aware or personal biases, linguistic patterns, and cultural views that may be a barrier to their work. A good understanding of the influences of poverty, race, ethnicity/culture, immigration history, sexual orientation, and concurrent trauma experiences will be helpful. In addition, accessibility efforts, universal design approaches and access to translation services are critical to ensuring access and understanding for all people. Being person-centered and embodying a consumer controlled philosophy in working with all populations will require continual learning in these areas and a willingness to seek specific information and resources as needed to best work with individuals.

The content of the course will use multiple examples that support an understanding of how these situations can influence the learner’s interactions with others. The content will demonstrate best practices and common challenges that support incidental learning of these core diversity and resources issues while engaging the basic principles and learning outcomes of person-centered thinking content. (For example, explicitly varying examples so that people have different needs, background, education, cultures, sexual orientations and gender expression, methods of communication, etc. Use examples of everyday learning skills that highlight “missing” these critical aspects and the learner correcting course when this happens.) Resources that support further learning and action in these areas will be included.

**If a concept is important to your course and is comprehensively covered in another course identify the other course and how you will handle the overlap: (For example, you may state in one of your lessons that a learner should review the course before starting your course.)**

This course is one of the six courses to be developed in the National Training Program, along with a blended learning program that includes a day of classroom/facilitated learning on person-centered plan development and implementation. The learner must complete all six courses: Introduction to Person Centered Thinking and Practice, Person Centered Plan Development & Implementation, Introduction to the No Wrong Door System; Who We Serve: A Look at Disability and Aging Groups; Coordination of LTSS Across Programs and Settings; and Protection and Advocacy.

Effective person-centered support often requires specific knowledge of medical or developmental conditions, system and services, and local community resources. In addition, advance and ongoing learning in cultural competence and diversity issues is fundamental to being able to support people in ways that are meaningful to them. Learners are urged to continue their growth and knowledge in areas of interest and relevance to their specific positions.

**OUTLINE OF LESSONS**

**(brief description of each lesson, learning objective, and draft content based on initial research and planning sessions)**

**Lesson #1: An Introduction to Federal Long-term Services and Supports (LTSS)**

**Lesson #1 Description:**

This lesson describes entitlement programs providing long-term services and supports (LTSS), which are funded and administered at the Federal level. Learners are introduced to the goal of each program, the basic services and supports provided, and the requirements for eligibility. Social security, Medicare, Medicaid, and Veterans Benefits are covered.

**Lesson #1 Learner Objective:**

Identify the primary LTSS available in Social Security, Medicare, Medicaid, and Veterans Benefit programs and state the core eligibility requirements.

**Lesson #1 Content Outline:**

1. Individuals have a right to services; laws and regulations are in place to protect the rights of older adults and those with disabilities to participate in entitlement programs and access public services to live independently and enjoy good quality of life. Reference Olmstead Act, Americans with Disabilities Act, Affordable Care Act etc.; workers have a responsibility to increase an individual's understanding of his/her rights to access programs and services, including interpreters, adaptive devices, etc.; materials should be made available to individuals which explain their legal protections, civil rights, human rights, etc.

Sources:

BU CADER - A Guide to Aging and Disability Networks, sections 4.5 - 4.10.

U.S. Department of Justice. (2009). *A Guide to Disability Rights Laws.* <http://www.ada.gov/cguide.htm>.

1. Overview of Social Security

Intent of social security program - protect American citizens from economic risk of unemployment and old age; general description of benefit categories - retirement, disability and survivors’ benefits as well as Supplementary Security Income; mention family payments to spouses and children of retirees and those with disabilities; compare how old age and survivors benefits (OASI) and Supplementary Security Income (SSI) are funded; Compassionate Allowance (CAL) - benefits provided quickly for serious medical conditions that qualify as disabilities- minimal medical information needed. CAL list of conditions includes early onset Alzheimer's.

Sources:

BU CADER - Guide to Aging and Disability Networks, p.35

Social Security Administration. <http://ssa.gov/>

<http://www.ssa.gov/compassionateallowances/>

1. Eligibility for Social Security Benefits

Provide broad overview of eligibility for Social Security benefits - retirement, disability, survivor; link to SSA website

1. Overview of Medicare

Medicare definition - a medical insurance plan provided by the Federal Government. Description of four Parts - Part A is hospital insurance, Part B is medical insurance (outpatient services, testing), Part C is Medicare Advantage, and Part D offers prescription drug coverage. The intent of Medicare, who's eligible (general terms) and coverage specifics are provided.

1. Eligibility for Medicare - Provide broad overview of eligibility for Medicare and Medicare Advantage Plans; link to Medicare website: <https://www.medicare.gov/>
2. Medicaid - Purpose of Medicaid; joint federal and state health insurance program; administered by states; offers specific services to those who financially qualify; list of the services - inpatient hospital, outpatient hospital, physician services, medical and surgical dental services; nursing facility services for people aged 21 or older; home health care for people eligible for nursing facility services
3. Provide broad overview of eligibility for Medicaid - income, assets, other financial resources; explain state variations in eligibility and provide link to state-by-state guidelines; very broad overview of which family members may be eligible for benefits; quick introduction to estate recovery; provide link to <http://www.medicaid.gov/>
4. Dual eligibility - provide definition and outline what dual eligibles are entitled to; describe impact of the Affordable Care Act; List goals and most important responsibilities of Medicare-Medicaid Coordination Office; provide link to this Coordination Office

Sources & Links:

State Medicaid and CHIP Policies 2014 - <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>

Dual Eligibles - <http://www.medicaid.gov/AffordableCareAct/Provisions/Dual-Eligibles.html>

Medicare-Medicaid Coordination Office -

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>

1. Veterans Benefits - Provided by U.S. Dept. of Veterans Affairs, offers medical, health and financial benefits; general eligibility - veterans, dependents, and survivors can access VA Benefits; Benefits are listed - outpatient & inpatient medical care, financial stipends, disability compensation, etc.; link provided to www.va.gov.

The U.S. Department of Veterans Affairs provides a host of medical and health benefits for eligible veterans, dependents, and survivors. Eligibility is based on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (and with a discharge under other than dishonorable conditions). Those who served in the Merchant Marines in World War II are also eligible to receive Veterans services. Benefits may include:

* Outpatient medical care
* Inpatient medical care
* Financial stipends (for those with low income and assets)
* Physical rehabilitation
* Drug and alcohol treatment
* Nursing home coverage
* Pharmacy services
* Counseling
* Pensions (all veterans who are 65 or older and meet service and income requirements are also eligible to receive a pension, regardless of current physical condition)

Sources: BU CADER - Guide to Aging and Disability Networks p.34

U.S. Department of Veterans Affairs, Veterans Benefits Administration - <http://www.benefits.va.gov/benefits/>

1. Eligibility for Veterans Benefits: Provide broad overview of eligibility for individuals and family members

**Lesson # 1 Suggested Learner Activities and Interactions:**

**1. Read and Reflect**

Scenario about an individual born with a developmental disability who now meets ACA guidelines as dual eligible.

*Questions for learner reflection:*

* How might dual eligibility allow him to reach his life goals?
* Which Medicare benefits are most relevant to him?
* What Medicaid benefits are most relevant to him?
* Will his family benefit and if so, how?

**2. Objective questions**: Questions will assess understanding of the main features and eligibility requirements for federal benefits.

*Possible* *examples:*

* Social Security Disability Benefits are available only to individuals with disabilities and not to their immediate family members T, F
* An individual who qualifies for Veterans Benefits may be eligible for Medicare. T, F
* Individuals under age 65 who have a disability are not subject to income or resource requirements when applying for Supplemental Security Income. T, F
* Coverage for blood tests to check for anemia may be available through:

A. Medicaid B. Medicare Part B C. Veterans Administration D. All

* Payments to a home health aide caring for a patient with dementia are likely to be made by:

A. Medicaid B. Medicare Part B C. Social Security D. All

**Lesson #1 Glossary:**

Affordable Care Act

Americans with Disabilities Act

Dual eligible

Medicare

Parts A, B, C, D

Medicare Advantage Plan

Medicaid

Olmstead Act

Social Security

Old Age & Survivor Benefits

Compassionate Allowance

Supplemental Security Income

Veterans Benefits

**Lesson #2: LTSS at the State and Organizational Levels (Aging and Disability)**

**Lesson #2 Description:**

This lesson provides a general overview of common LTSS available at the state level, and makes the learner aware of the variability of programs, services, and eligibility requirements that exist from state to state. Also covered are the LTSS available through aging and disability organizations in the No Wrong Door system, including AAAs, CILS and ADRCs.

**Lesson #2 Learner Objective:**

Describe the primary services offered through the State Units on Aging and through Area Agencies on Aging, Centers for Independent Living and Aging and Disability Resource Centers.

**Lesson #2 Content Outline**

1. All states have LTSS for older adults and individuals with disabilities. However, programs and services may differ from state to state. Even the same programs and services may have different names. Each state sets its own eligibility standards. Provide links to websites that contain information on individual state programs.

Sources:

State specific websites

Houser, A. et al. (2012). *Across the States 2012: Profiles of Long Term Services and Supports.* Public Policy Institute. <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>

1. Describe the role and purpose of State Agencies for Aging and Disability. List primary services administered through their network. Describe state agencies as system for linkage to community resources & services.

*State Agencies for Aging and Disability*

* Called different things in different states - Bureau on Aging.; Dept. on Aging
* Provide the opportunities and supports for older people to live independent, meaningful, productive, dignified lives and maintain close family and community ties.
* State agencies administers a network of primary services for older adults that includes home-care, congregate and home delivered meals, transportation, information and assistance, and advocacy on behalf of individual older citizens.
* The foundation of each state agency is a centralized information system linking consumers to the resources and services they need in their communities.

Sources: BU CADER Aging and Disability Networks, page 39

National Association of States United for Aging and Disabilities. *About State Agencies.* <http://www.nasuad.org/about-nasuad/about-state-agencies>

1. State Agencies’ Core Services - Description of Adult Protective Service, LTC Ombudsman, Legal Services, and State Health Insurance Assistance Program
2. *Adult Protective Service*

The Adult Protective Service/Elder Abuse Program is designed to help those who are unable to protect their own interests, health, or safety. Each state's Adult Protective Service/Elder Abuse Program is committed to preventing and remedying abuse, neglect, or exploitation of older adults and adults with disabilities (NASUA, 2005)

1. *LTC Ombudsman*

Long-Term Care Ombudsman Programs investigate and resolve complaints concerning the health, safety, welfare, and rights of residents of long-term care facilities, and educate residents and their families about their rights, benefits, and the need for self-advocacy (NASUA, 2005).

#### Legal Services Program

The Legal Services Program offers advice, counsel, and legal intervention to older persons on issues such as public benefits, health care, pensions, financial exploitation, consumer problems, advanced directives, and guardianship (NASUA, 2005).

1. *State Health Insurance Assistance Program*

Specifically, SHIP does the following:

* Educates older adults about their health insurance coverage and benefits
* Provides advice and service to consumers in understanding their health insurance coverage and eligibility for programs
* Protects consumers from fraud
* Secures answers about claims and billing issues
* Resolves disputes between health care providers and insurers
* Serves as an advocate in appeals of coverage denials by Medicare, Medicaid, or private insurers
* Assists beneficiaries in filing grievances and complaints with oversight agencies

1. Area Agencies on Aging (AAAs)

AAA's offer Information and Assistance - provide referrals for wide range of aging and LTC resources - housing, transportation, home health services, elder abuse protection and more. Some provide services directly while others contract with local providers. Provide link to National Association of Area Agencies on Aging: <http://www.n4a.org/>.

Example shows use of an AAA senior hotline for resources involving installation of grab bars in the shower, obtaining a bath chair and receiving home-delivered meals; AAA sponsors a chronic-disease self-management workshop

Sources:

BU CADER

AAA, Region One, Incorporated - <http://www.aaaphx.org/seniorhelp>

<http://www.aaaphx.org/CAREGIVER+RESOURCES>

National Association of Area Agencies on Aging - <http://www.n4a.org/>

1. Centers for Independent Living (CILs)

Centers for Independent Living are community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities. CILs are unique in that they operate according to a strict philosophy of consumer control, wherein people with all types of disabilities directly govern and staff the organization. Centers for Independent Living provide: Peer Support; Information and Referral; Individual and Systems Advocacy; and Independent Living Skills Training. Provide link to National Council on Independent Living (NCIL): <http://www.ncil.org/>

Example shows a CIL assisting with a resume update and a review of potential jobs; providing transportation to and from medical and other appointments; and sponsoring cooking classes.

Sources:

National Council on Independent Living (NCIL) - <http://www.ncil.org/about/aboutil/>

Association of Oregon Centers of Independent Living -

<http://aocil.org/index.php?option=com_content&view=article&id=27&Itemid=89>

<http://aocil.org/index.php?option=com_content&view=article&id=24&Itemid=84>

1. Aging and Disability Resource Centers (ADRCs)

A collaborative effort by 3 federal agencies/departments to streamline access to LTSS options for older adults and people over 18 with disabilities; predominant resource for people seeking information onaccess to publicly funded and private LTSS; provide information about services and supports at federal, state and community; help people access their level of need for services and determine their eligibility. LTC Services include health and medical services, homemaker services, adult day programs, supports for informal caregivers, and more. Provide link to ADRC Technical Assistance Exchange: <http://www.adrc-tae.acl.gov/tiki-index.php?page=ADRCHomeTest>

Example shows an ADRC helping with sources of in-home care and light housekeeping;

Sources:

ADRC Technical Assistance Exchange - <http://www.adrc-tae.acl.gov/tiki-index.php?page=ADRCHomeTest>

BU CADER - Aging and Disability Networks

Wisconsin Dept. of Health Services - ADRC Customer Page

<http://www.dhs.wisconsin.gov/publications/P0/p00122.pdf>

<http://www.dhs.wisconsin.gov/aging/EBS/index.htm>

Acollaborative effort by the Administration for Community Living (ACL) (formerly the Administration on Aging), the Centers on Medicare and Medicaid Services (CMS), and the Veterans Health Administration (VHA) to support state efforts to streamline access to long-term services and support (LTSS) options for older adults and people over 18 with disabilities. ADRCs are meant to augment the services of local area agencies on aging, which have long been a focus for older people who need information about available services. Many of the services for older adults overlap with those for people with disabilities, making it more efficient to have one point of entry for information on how and where to obtain services.

Sources:

BU CADER - Aging and Disability Networks

U.S. Department of Health and Human Services, Administration for Community

Living - <http://www.acl.gov/Programs/CDAP/OIP/ADRC/index.aspx>

Reinforce intent of No Wrong Door System - streamlined access so all populations in need of LTSS can easily learn about and access services and supports. What does NWD mean for you as a worker? If you can't give them information or assistance, you will find another organization who can. Individuals will not have to repeat the reason for their call - you will make the introduction and pave the way for them to get what they need. Use NWD schematic to show the network and all the other organizations on which a worker can depend. Provide link for more information: <http://acl.gov/Programs/CDAP/OIP/ADRC/Index.aspx>

**Lesson # 2 Suggested Learner Activities and Interactions:**

1. Interactive chart showing which public programs and organizations (Federal, State Agencies, ADRC, CIL, AAA) provide information, assistance and referrals for the following important, frequently used services & supports. Click and mouse - over to expand and reveal details. Brief description of each service/support is included.

* Adult day services
* Care management
* Employment opportunities
* Financial information, literacy and services
* Housing options for aging adults and people with disability
* In-home services
* Legal assistance
* Training and education
* Transportation

**1. Scenario/case study - read and reflect**

#### Ms. Helwig

Ms. Helwig was referred to Bob, an Options Counselor, for a consultation. Ms. Helwig is a 55-year old lab-technician who, at the time of the meeting, was living in a small one-bedroom cabin, which she owned. Ms. Helwig had lived in her home for over twenty years. Ms. Helwig never married and had no children. She was brought to the attention of the worker after her niece, who lives over 2000 miles away, paid her a visit. Bob found Ms. Helwig in deteriorating health and the home in a severe state of ruin. The Options Counselor also learned that Ms. Helwig, a diabetic, was not eating properly, had blood sugar levels registering at unsafe levels, and had had several recent falls in the house. In addition, Ms. Helwig complained of poor memory, noting that she was consistently forgetting appointments and other details. Moreover, the home was severely cluttered and reeked of urine; nearly all of the carpet in the small home was soiled. Ms. Helwig had available funds and the niece was willing to do whatever necessary to help Ms. Helwig live in a safer, healthier environment.

*Questions for the learner:*

* Based on Ms. Helwig's reported physical, cognitive, and behavioral profile, what are the next steps, including legal/advocacy referrals that a worker might advise the niece to consider on behalf of Ms. Helwig?
* Is it realistic to try to keep Ms. Helwig in her own home?

**3. Objective questions:**

*Possible questions*

* *Under the No Wrong Door System, individuals with disabilities can find information and assistance by contacting Area Agencies on Agency. T, F*
* *A State Long Term Care Ombudsman investigates issues related to the health and safety of all individuals receiving long term care services, whether in an institution or at home. T, F*

**Lesson #2 Glossary Terms**

Adult Protective Services

Aging and Disability Resource Centers (ADRCs)

Area Agencies on Aging (AAAs)

Center for Independent Living (CILs)

Long-term Care Ombudsman

State Health Insurance Assistance Program

State Units on Aging

No Wrong Door System (NWD)

**Lesson #3: Making Use of Community and Local Resources**

**Lesson #3 Description:**

This lesson stresses the wide variety of resources that are available at the local level to meet basic needs such as food, clothing and shelter and more. Learners are introduced to a long list of needs that may be addressed locally and in the community by agencies, groups and individuals/professionals/practitioners.

**Lesson #3 Learner Objective:**

Identify LTSS needs that may be addressed by community and local resources.

**Lesson #3 Content Outline**

1. Many community and local resources exist that can provide services and supports that address a wide variety of needs. Learn about them and build personal relationships with people who work and/or volunteer there to make the most appropriate referrals and facilitate approval for services and/or admission to programs.
2. Organizations and groups at the local or community level may be a particularly good fit for basic needs, such as food, clothing and shelter - examples: food pantries or banks; clothing banks; housing authority and crisis housing or shelters.
3. Seek local and community resources pertinent to adult education including GED prep; financial or credit counseling; health insurance; immigrant resources, including English Language instruction; domestic violence shelter and support; legal services; medical education; mental health and substance abuse services; transportation; utility assistance; and more.

More in-depth explanation: legal services may include custody issues, disability resources, divorce, estate planning, housing issues (evictions or foreclosure) and the guardianship process; substance abuse services may include providers of treatment and counseling as well as local chapters of Alcoholics Anonymous, Alanon and Alateen; financial counseling to repair poor credit or educate first-time home buyers; public or private programs for assistance with energy expenses such as electricity and fuel oil; child care services so an individual can be trained to enter or re-enter the workforce; senior centers where individuals can be safe, engaged in enjoyable activities and benefit from congregate meals.

Sources:

Boston Medical Center. *Social Work Resources. -*

<http://www.bmc.org/socialwork/resources.htm>

BU CADER course, Mental Resilience and Wellness Among Immigrants and Refugees

1. With growing numbers of immigrants, it is important to reach out into the ethnic community to find community supports - religious organizations, ethnic social clubs, coffee shops, anywhere that people of the same ethnicity tend to gather and socialize. For example in a Turkish neighborhood in a large city, there may be a park where older men gather to play chess and talk; and playgrounds where mothers, grandmothers, and children come to play and talk. Outreach workers or volunteers who are from the same ethnicity or speak the language can pave the way for both formal and informal activities.
2. Consider finding culturally specific leisure activities for immigrants at the local level. Helps them maintain cultural connections to ease transition. Show photos with captions for Tai Chi classes, Club Bamboo food and fitness for Asian-American seniors, Dominican Republic social club, and Italian social club.

Source:

BU CADER course, Mental Resilience and Wellness Among Immigrants and Refugees

**Lesson #3 Suggested Learner Activities and Interactions:**

1. Read and reflect - scenario regards identifying community resources for a family with multiple LTSS needs. Federal benefits and state benefits have been addressed and now there's a need for food, clothing, housing, treatment for alcoholism, etc. The learner is asked whether they agree with the worker's approach to finding resources. Has she identified everything? Has she been creative in her thinking and her research? How do her existing relationships with community organizations help or hinder the service she's providing?

2. Objective questions - focus on types and sources of community and local LTSS.

**Lesson #3 Glossary Terms**

Alcoholics Anonymous

Al-Anon

Alateen

Clothing bank

Crisis housing

Credit counseling

Food bank

GED

Social Club

Utility Assistance

**Lesson #4: Partnering with the Person to Successfully Navigate LTSS**

**Lesson #4: Description:**

Here, learners build on the knowledge of LTSS they gained in the previous lessons. The focus is on practical tools and sources of information workers and individuals can use together to select the most appropriate services.

**Lesson #4: Learner Objective:**

Describe the benefits of using web-based tools to select appropriate services and supports.

**Lesson #4: Content Outline:**

1. There are tools you can use in partnership with the individual that help to determine what programs provide appropriate services and outline eligibility; these tools make your job a little easier and are very empowering for individuals who are willing and able to learn to use them with you and independently.

1. SSA - Benefit Eligibility Screening Tool - <http://www.benefits.gov/ssa> - answer questions and tool helps determine eligibility for SSA benefits and provide information about how to quality and apply. It's not an application for benefits - it doesn't ask for an individual's name, SS# and doesn't estimate benefits amounts.
2. NCOA Benefits Check-up Tool - a questionnaire lets you determine eligibility and apply for many state and federal public benefits for older Americans, including Medicare Savings Programs, Medicaid for Aged, Blind, and Disabled, Supplemental Security Income (SSI), Employment Programs, Veterans Assistance and more. Access with this link: <https://www.benefitscheckup.org/cf/frmwelcome2.cfm?partner_id=22&subset_id=49&CFID=3636733&CFTOKEN=78345944>

Include example of how using tool was able to help pinpoint eligibility for many benefits the worker and individual, an aging veteran with sensory impairments, might not have discovered or considered otherwise.

1. Good state-specific tools also exist. Here are a few examples.

MA Council on Aging (COA) Benefits Check-up - screens for eligibility for over 200 programs to help seniors pay for food, medicine, heat, and more: <http://www.mcoaonline.com/content/benefitscheckup/faqs.php>

Tools from Wisconsin, Utah and other states will be researched and added.

1. ADRC Technical Assistance Exchange (TAE) - provides information and resources by state and by organization - monthly newsletter that provides the latest resources and materials. Provide examples. Mention organizations represented. Link: <http://www.adrc-tae.acl.gov/tiki-index.php?page=AboutTAE>
2. Examples of other types of tools. On Medicare.gov, there's a fast, easy to use interactive tool that helps determine if a medical test, item, or service is covered by Medicare.

The site also provides an in-state search function to find individuals who are knowledgeable about Medicare-related subjects. For example, you can access accredited providers of durable medical equipment and find health support groups.

<https://www.medicare.gov/coverage/your-medicare-coverage.html>

**Lesson # 4 Suggested Learner Activities and Interactions:**

**1. Objective questions**

* *Two of the many benefits of using online tools in LTSS searches include comprehensiveness and speed. T, F*

* *The SSA Benefit Eligibility Tool is designed for use by workers and cannot be accessed by individuals at home. T, F*
* *Certain tools allow individuals to determine their eligibility for benefits and apply online. T, F*

**Lesson #4 Glossary Terms**

Council on Aging

National Council on Aging

**Lesson #5: Discussing Personal Finances and Encouraging Financial Literacy**

**Lesson #5 Description:**

This lesson describes best practices in eliciting important financial information from an individual with respect to program eligibility and private LTSS. Financial literacy is presented as an important objective, and ADRCs are cited as sources for classes and services related to personal finance. Long-term care insurance and reverse mortgages are discussed as financial strategies for meeting anticipated future long term care expenses that will be paid out of pocket.

**Lesson #5 Learner Objective:**

Describe ways of tactfully eliciting accurate personal financial information in connection with LTSS choices and eligibility.

**Lesson #5 Content Outline:**

1. Partnership with an individual to find the right mix of services and supports typically requires understanding their personal financial situation. Financial subjects can be hard to discuss with someone you just met or don't know well. Even before attempting to determine eligibility, try to determine if money is a concern. As you uncover their needs and explore their options, ask them if money has been or will be an issue in having their needs met.
2. When you get into eligibility for specific services, you will need to get a sense of the person's financial situation. For example, you'll want to know specifics about the individual's income, assets and other financial resources to determine Medicaid eligibility. Rather than asking them about their income, assets, etc. outright, you might communicate your state's eligibility guidelines and then ask if s/he thinks s/he will meet them.
3. If an individual doesn't qualify for benefits for financial resources, you'll want him/her to begin to think about how much of their income and assets they can spend on services. If they don't qualify for a public program that pays for a home health aide and they have to hire one privately at $35/hour, how many hours per day or week can they afford? If their initial wish was for 14 hours per week, is that possible if the worker must be paid out of personal funds? If not, might 8 hours suffice and fit the budget?
4. Most ADRCs offer classes or counseling on financial literacy or training on the basics of personal finance. Individuals can get experience with setting up a budget and developing a disciplined approach to money management. For those who choose not to pay their own bills or have difficulty doing so, bill paying services - both formal and informal - are commonly available.
5. Individuals whose assets and incomes may be too high for entitlement programs, but too low to cover the high cost of long term care services out-of-pocket, may want to consider planning for future expenses by purchasing long term care insurance (LTCI). Today's policies typically cover care in nursing homes, assisted living centers or at home when the insured can no longer perform at least two activities of daily living (walking, eating, toileting, getting in and out of a car are examples), due to a physical or cognitive impairment. Coverage can be expensive at older ages, so it is best purchased in mid-life or earlier. It is underwritten, like life insurance, so applicants can be denied coverage due to poor health. This is another reason to purchase coverage in middle age or earlier. ADRCs can direct individuals to a knowledgeable financial advisor for detailed coverage information, pricing and purchase.
6. Individuals, particularly older adults, who wish to free up money to pay for services may want to consider a reverse mortgage if they own their own home. A reverse mortgage allows them to tap the equity in their home in the form of monthly income or a line of credit. Interest charges are assessed, but no mortgage payments are due until the individual dies or the home is sold. At that time, re-payment is required. ADRCs can assist individuals in determining whether a reverse mortgage is suitable or provide the appropriate referrals. Support is available for completing the applications and follow-up paperwork, either on-site or by way of a referral.

**Lesson # 5 Suggested Learner Activities and Interactions:**

**Read and reflect**:

*Scenario involves determining the financial situation of an individual who qualifies for Medicaid benefits, but feels in need of more hours of in-home care. A little investigating shows that the individual has sufficient equity in her home to consider a reverse mortgage. Withdrawals from the mortgage assets could cover the additional care. The individual has heard negative things about reverse mortgages and isn't interested. Besides, she doesn't think she's up to the job of filling out all the paperwork to apply.*

*Questions that guide reflection :*

* *Did the worker handle the financial discussion well? Why or why not?*
* *If the worker strongly believes the reverse mortgage may be her best option, what should the worker say when the individual is critical of the suggestion?*

**Lesson #5 Glossary Terms:**

Financial literacy

Long term care insurance

Reverse mortgage

**Lesson #6: Person-Centered Planning in Coordinating LTSS**

**Lesson #6 Description:**

This lesson presents person-centered planning as a guiding philosophy in identifying and selecting LTSS. A description of recommended communication techniques - active listening and shared decision-making - is included. The individual's right to fail is emphasized, and the concept of the "dignity of risk" is emphasized. Learners are taught that person-centered planning and consumer control must guide decision-making when others express conflicting opinions. The worker's role in conflict mediation is covered and the need for cultural humility is stressed.

**Lesson #6 Learner Objective:**

Describe ways person-centered planning is demonstrated in communicating with individuals about quality of life needs, helping them identify and select LTSS, and in mediating conflicts with informal supports and others that may express disagreement or objections.

**Lesson #6 Content Outline:**

1. Determination of available benefits and determining eligibility begins with an understanding of what the individual wants and needs are. Some individuals won't find it easy to express what they want; others might not be able to conceptualize their needs. Use active listening skills to help them explore their needs and preferences: ask open-ended questions, be patient and give them whatever time is necessary to express themselves; reflect on what they've said; summarize; and affirm their feelings and wishes.
2. Use techniques of shared decision-making to help them determine what their needs are and choose the mix of supports and services they feel is best. Shared Decision Making has three phases: Team Talk - considering options together; Option Talk - discussing pros and cons; and Decision Talk where preferences are formed. You are building a relationship that respects their autonomy.

Sources:

Barry, M.J. & Edgman-Levitan, S. (2012) Shared decision making – the pinnacle of patient-centered care. *New England Journal of Medicine*, 366, 780-781.Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMp1109283>.

Dartmouth-Hitchcock. *About Shared Decision Making.* <http://patients.dartmouth-hitchcock.org/shared_decision_making/about_shared_decision_making.html>

Mayo Clinic, Shared Decision Making National Resource Center - <http://shareddecisions.mayoclinic.org/>

1. Respect the person-centered nature of the plan regardless of your personal opinions. The individual must always remain in control of the decision-making process and take ownership of the choices made. Regardless of your job, you are there to help and facilitate. Do not impose your views or filter information, even if you are doing so out of fear for the individual's safety and the desire to protect. Remember: everyone must be given the right to fail. Their right to risk or the dignity of risk must be protected. Taking away that right - no matter how well meaning - is a violation of that individual's basic human rights.

Sources:

BU CADER course, Mental Health Options Counseling, section 7.3

Disability Practice Institute. *Dignity of Risk.* <http://www.disabilitypracticeinstitute.com/services/%E2%80%9Cdignity-of-risk%E2%80%9D/>

Opportunity for Independence. *Dignity of Risk.* <http://ofiinc.org/dignity-risk-0>

1. Sometimes friends and family members will openly disagree with the choices made by the individual and attempt to intervene, showing little understanding for the philosophy of consumer control. One way to mediate the conflict is to redirect the conversation to focus on a description of your own role in the process. If you are clear about addressing the consumer and restating the individual's and the consumer's roles, the process will most likely move forward rather than getting mired in family conflict.

Source:

BU CADER course - Consumer Choice, Control and Direction in Options Counseling

1. Individuals are shaped, in part, by their culture and socio-economic backgrounds. Be sensitive to cultural differences. Assess your biases and set them aside to foster good relationships and positive outcomes.

**Lesson # 6 Suggested Learner Activities and Interactions:**

1. Read, analyze and reflect:

*Mr. Turner has had a history of abusing alcohol, major depression, and he has also had a number of falls recently. You are meeting with him before he moves back to the community after rehabilitation from his most recent fall down two flights of stairs. He needs information on transportation services on the north side of town. He's excited to talk about the living situation he has set up. He will be moving in with a best friend to a second floor apartment on Main and South. His best friend owns the apartment and the bar directly below on the street level. You know of two liquor stores on this block and also know the train runs behind that building most of the day causing significant noise. He has told you it makes sense because his buddy is always working downstairs if he gets down or feels upset, he can just go down and talk to his friend at the bar. Plus, he knows the area and he doesn't have to pay much rent.*

*Source: BU CADER course, Mental Health Training in Options Counseling*

*Questions to guide learner analysis and reflection*:

* *Should the worker be concerned about Mr. Turner's safety?*
* *If so, what should she say or do?*
* *How should she handle his request for information about transportation services?*

2. Objective questions

* *These will focus on demonstration of person-centered planning in shared decision making, risk-taking and conflict mediation.*

**Lesson # 6 Glossary Terms**

Active listening

Biases

Conflict mediation

Cultural humility

Dignity of risk

Open-ended questions

Right to fail

Shared decision making

**Lesson # 7: Participant Direction**

**Lesson #7 Description:**

This lesson introduces participant direction as an option for individuals who wish to direct their own services and supports. The basic features of the participant-directed plans are described and the role of a financial management service and a support broker are outlined. Participant direction is presented as being appropriate for anyone wishing to use it, which in some cases may involve the election of a personal representative. Learners discover that this social model has a history of positive outcomes with respect to physical and mental health, physical and financial safety, and quality of life. The lesson concludes with a description of participant direction's benefit in pairing individuals with workers who share the same culture and language.

**Lesson #7 Learner Objective:**

Describe the basic features and benefits of participant-directed plans.

**Lesson #7 Content Outline:**

1. Provide definition of consumer control, person-centeredness and participant direction. Explain how participant direction is related to the philosophies of consumer control and person-centeredness.

Person-centeredness involves discovering and acting on what is important to the person. Examples include: what the person values, what they want from life, and how they want to live. Underlying this are important values: respect for the individual, a belief in the right to self-determination, and mutual respect and understanding.

Source: BU CADER course, Managed Long-Term Services and Supports

In the Independent Living Movement, consumer control over services means that it is the consumer who has the primary responsibility for identifying needs, setting goals, developing plans and strategies, and achieving independent living objectives. They decide for themselves what services they want, how they want them delivered, by whom and in what context. Consumers in this model are active participants in the service process rather than passive recipients, as in the traditional medical or rehabilitation model of service delivery.

Source: <http://www.mwcil.org/home/files/discconsumer_control_in_independent_living_manualedited.pdf>

Participant direction programs allow people of all ages, across all types of disabilities, maintain their independence at home by choosing the mix of services and supports that work best for them. They are built on the belief that the participant is in the best position to identify his/her own needs and goals and direct and manage his/her own services and supports. Participants play an active role in the development, implementation and evaluation of the services and supports they receive in their homes.

Sources:

BU CADER course, Managed Long-Term Services and Supports

U.S. Department of Health and Human Services, Administration for Community Living. *Participant Direction Program.* <http://www.acl.gov/Programs/CDAP/OIP/ParticipantDirection/index.aspx>.

1. Some individuals may see participant-direction, which is directing their own services and supports, as the best way to realize their quality of life goals. Explain the basic features of participant-directed plans.

* Employer authority - can select, hire, fire workers - set hours and wages, etc. The worker may be a relative or friend the person already has a trusted relationship with.
* Budget authority - Some programs offer budget authority, which allows the participant to manage an approved individual budget that can be used to pay for goods and services that enhance the ability to live independently. Examples: wheelchair ramp, grab bars in bath, and microwave to aid in meal preparation.
* Typically, the individual is aided by a support broker who provides guidance and assistance.

1. Financial Management Service - provides accounting services for participants. Can take care of difficult tasks of making payments to workers and deducting the necessary taxes from paychecks. Guards against fraud. Also responsible for financial reporting to administrators to sponsoring agencies, etc.
2. Anyone can self-direct. Even those who are cognitively impaired can choose to do so, if they elect a personal representative. Responsibility of personal representative.
3. Past experience has shown good outcomes - reduced unmet needs of Medicaid participants who require personal assistance services; positive health outcomes, fraud and abuse comparable to traditional care models; improved quality of life for participant and caregiver.

Source: National Resource Center for Participant-Directed Services. *Cash & Counseling.* <http://www.bc.edu/schools/gssw/nrcpds/cash_and_counseling.html>

1. Particularly useful in cultural situations where individual wants a worker who understands his or her customs, language and cultural. Participant direction makes it possible to hire a family member, friend, or other person from the community who fits this description.
2. It's important to explain all aspects of participant direction so individual understands just how much is expected of him or her. Some individuals will enjoy the freedom and sense of control it offers. Others may not feel confident that they can handle the responsibility or they may feel it is too much work. People who are transitioning from an institutional setting often lack the confidence to direct their own services. However the decision about whether or not to self-direct is not final. They can change their minds.
3. Often pays for supports and services that traditional programs won't. Examples of some of these types of services in a short scenario. Can involve art therapy, music therapy, etc. Can involve a backyard fence or monitoring system for an individual with Alzheimer's.

**Lesson # 7 Suggested Learner Activities and Interactions:**

1. Video - Watch and reflect

*Existing video - Boston College (NRCPDS)*

*Donna Nelson is using a participant direction program to care for her elderly father. He loves being at home. He has a pianist come in to play for him weekly. She describes how both he and she have benefitted. Interviews with support broker and care manager.*

*Questions to guide learner reflections*

* *Why are the Nelson's good candidates for participant direction?*
* *How is it benefiting them?*
* *What do you see as the drawbacks?*

2. Objective questions - focus on the features and benefits of Participant Direction

*Examples:*

* *Given employer authority, a participant can do which of the following:*

*A) Set worker wages B) Set worker hours C) Fire a worker D.) All 3*

* *An individual who is cognitively impaired cannot direct his own services. T, F*

**Lesson #6 Glossary Terms:**

Budget authority

Employer authority

Consumer control

Financial Management Service (FMS)

Participant direction

Person-centered plan

Support broker

**Lesson #8: Care Transitions and Health Promotion**

**Lesson #8 Description:**

This lesson describes some of the reasons why care transitions can be problematic and how these issues can be addressed by care transition models. The objectives and features of models relating to long-term care and hospital transitions (Coleman, TCM and RED) are presented as are models used in transitions originating in primary care settings. The objectives of health promotion programs are covered, as are the features of the AoA's Evidence-Based Disease and Self-Management Programs and the Stanford Chronic Disease Self-Management Program

**Lesson #8 Learner Objective:**

Explain objectives and core features of care transition and health promotion programs.

**Lesson #8 Content Outline:**

1. Many possible care transitions experienced by individuals with one or more chronic conditions or disabilities. Lack of successful care coordination due to the fragmentation of health care system; professionals' lack of time for and training in complexities of discharge planning; patients' lack of engagement in decision-making and reliance on authority figures/medical professionals. Increasing cultural and socio-economic diversity, marked by lack of language proficiency and illiteracy, contribute to poor outcomes.

Source: BU CADER course, Care Transitions

1. Many possible care transitions that older adults and individuals with disabilities must navigate:

* Hospital to home
* Hospital to skilled nursing facility
* Hospital to nursing home
* Hospital to palliative care or hospice
* Skilled nursing facility to nursing home or patient's home
* Home to nursing home
* Home to specialty care providers
* Transition within hospital or nursing home (from one care unit, room, or floor to another)
* Transitions driven by the Medicare insurance system (e.g., at the end of a  Medicare service period or from Medicare to Medicaid because of financial need)
* Transitions because of caregiver loss or change

Source: BU CADER course, Care Transitions

1. Describe care transition models in a hospital setting. All models provide planned interventions related to care coordination and patient education. All promote self-management to a greater or lesser degree. All designed to reduce hospital re-admission. Duration varies, but in all cases it is limited to the post-discharge period.

All are examples of evidence-based practices - been tested and used successfully. Have shown positive results in reducing post-discharge emergency room visits and re-admissions.

1. Coleman Model

Goal is to help (older) individuals and caregivers assume a more active role in care transitions to reduce re-hospitalization.

Coleman's care transition intervention plan (CTI) made the assumption that patients and their families or caregivers were consumers of health care and have the right and responsibility to participate in their own health care planning. However, in order to participate fully, patients need to be provided with information about their medications and health conditions, and to be coached during the month following hospital discharge by a specially trained care-transition coach. According to Coleman, this approach to care transitioning is a "self-care" model, rather than an addition of yet another care professional, in that the role of the coach is time-limited and focused (Coleman, CMS National Conference, 2010).

Individuals were visited by a CTI health coach once in the hospital and once at home, and were phoned three times; the length of the intervention was 24 days. The results showed that patients instructed in self-management techniques were less likely to need to be readmitted to the hospital for up to 180 days post-discharge.

Sources: BU CADER course, Care Transitions

Care Transitions Program - <http://www.caretransitions.org/>

1. Transitional Care Model (TCM)

An advanced practice nurse (APN) who followed the patient for one month was responsible for the discharge planning. Tailors 8-week intervention plan "focused on medications, symptom management, diet, activity, sleep, medical follow up, and the emotional status of patient and caregiver" (Naylor et al., 1999, p. 615) In this model, the APN directs care after discharge and also instructs the person in self-care management. For example, the APN will, if needed, call the physician for a change in medications if she feels it is warranted by the person's symptoms. (I'm going to call your doctor about your medications because I notice that you seem more short of breath.) S/he might also accompany the person to the doctor's office on the first post-discharge visit. However, the APN also helps the person understand his conditions and their warning signs, and coaches him on how to communicate with his physician on his own. (I would like you to explain to Dr. Hall what causes you to be short of breath. Perhaps if you explain it to me first, it will be easier to remember when you see Dr. Hall.) Patient education and self-management are important parts of the Transitional Care Model program; however, the APN has greater latitude to take direct action when warranted by the person's condition than the coach does in Coleman's CTI model.

Sources: BU CADER course, Care Transitions

Transitional Care Model - <http://www.transitionalcare.info/home>

1. Re-Engineered Discharge Model (RED)

The Nurse Discharge Advocates (DAs) carries out all aspects of the transition intervention and is responsible for patient education. The DA gathers all the information about the patient from admission to discharge from medical records and the hospital medical team and devises an after-hospital care plan (AHCP) with the patient's input. For example, the DA might say: I have made an appointment with Dr. Perez for Monday October 10th at 2:00 PM. Is this a good time for you? Dr. Perez is going to make sure that you're doing well on your meds, check your heart and lungs, and probably test your urine and blood. Do you have transportation? If not, let's plan how you'll get there. Now, let's go over your list of medications. I want to be sure you understand about each medicine you're taking. I also want to make sure that you have all the phone numbers you'll need, such as the drugstore, your doctors, and who to contact in an emergency. Now let's go over everything again. This time I'd like you to explain to me how you're going to take care of your health needs when you get home.

The AHCP is entered into the computer, and the person is given a personalized packet to take home with her. This includes a color-coded calendar containing her medication schedule, a list of tests with pending results at discharge, and what to do if problems arise. A discharge summary is sent to the person's physician and whoever else might be responsible for her after-discharge care. In the RED model a pharmacist telephones the person two to four days after discharge to reinforce the discharge plan. For example, the pharmacist might say: Mrs. Jefferson, would you please get your medicine bottles, and let's go over what they are and what the directions are.

Unlike Coleman and TCM, DAs do not see patients in person after discharge.

Sources: BU CADER course, Care Transitions

U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. <http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>

1. Somecare transition models are directed to care that originates in a primary care setting. These are oriented to helping individuals’ self-manage chronic diseases to limit the advancement of disease and minimize need for emergency treatment or hospital admission.
2. Geriatric Resources for Assessment and Care of Elders Model (GRACE)

The intervention was designed for high-risk, low-income older adults who needed help with "chronic disease management to avoid a decline in physical and functional status" that would require hospitalization or long-term care (Agency for Healthcare Research and Quality [AHRQ], 2011, p. 2).

An interdisciplinary team consisting of a nurse practitioner and licensed social work practitioner with geriatric clinical experience led the interventions. Care was delivered in a primary care office and the person's home.

The first step in the GRACE program is a meeting with the person (and family, if available) in his or her home with the nurse practitioner and social worker (the support team). This first session includes a geriatric assessment, review of medical history and medications, and discussion of advance care plans. The support team also performs a home safety check and pays special attention to the person's functional status and social support system. The next step is a meeting with the entire interdisciplinary care team to decide on an evidence-based care plan. The initial assessments and recommendations for treatment are summarized in writing. The support team then meets with the person's primary care physician (PCP) to go over the plan and make any necessary adjustments. Implementation of the plan includes home visits, ongoing care management and maintenance, communication with the PCP and other providers, and an annual reassessment and follow-up visit. All information is documented by using electronic medical records. Information is tracked by a Web-based care management tool.

Sources:

BU CADER course, Care Transitions

Counsel, S.A. & Mitchell, M.E. (2011). The GRACE Model: Geriatric Resources for Assessment and Care of Elders. <http://www.adrc-tae.acl.gov/tiki-download_file.php?fileId=30186>

1. Guided Care Model

Patients eligible for Guided Care are at high risk from more than one chronic condition and have complex care needs that are addressed in a primary care setting. Guided Care interventions are led by a specially trained guided care nurse. Intervention begins with a two-hour assessment that includes information about physical and medical status, exercise, nutrition, caregiver support, home safety, other providers seen, and insurance status. This information is entered into an electronic health record (EHR), which then generates an analysis of the person's conditions matched with the evidence-based best medical practice for treatment of each one. The guided care nurse devises a personalized care plan that includes medications, medical and other appointments, targets for diet and exercise, and follow-up care. A final two-page summary in a plastic jacket is prepared for the person. This can be placed on the refrigerator as a ready reminder of when to take medicines or go for appointments.

The guided care nurse follows up by telephone to ensure that the person understands her care plan, and during these contacts uses techniques such as motivational interviewing to help the person develop skills in managing her own care

Guided Care also has a health education program for older adults that helps them understand their health problems and the need for a balanced diet and exercise. In addition, the guided care nurse also works with the caregiver in six-week sessions to provide general information about the issues of caring for older people who have chronic health problems. The guided care nurse also prepares a complete summary of the care plan for other providers, including home health agencies, and facilitates access to community services such as Meals on Wheels, transportation, senior centers, and the Alzheimer's Association (Boult, Karm, & Groves, 2008).

Sources:

BU CADER course, Care Transitions

Johns Hopkins Bloomberg School of Public Health. Guided Care: Comprehensive Primary Care for Complex Patients. <http://www.guidedcare.org/>

1. AoA Supported Programs for Healthy Lifestyles and Disease Self-Management

AoA has provided funding to states for programs that enhance self-efficacy and self-management; programs are designed to teach and empower adults to take control of their health through classes in non-clinical settings and the formation of peer learning groups. Programs focus on: physical activity and exercise, with an emphasis on low-impact aerobic exercise, strength training and stretching; decreasing the fear of falling and improving balance; improving nutrition through better food choices and dietary habits; and the management of mild depression. AoA supports use of the Stanford University Chronic Disease Self-Management Program which teaches people with chronic diseases how to change their behavior, improve their health status, and reduce their use of hospital services. All have been proven effective evidence-based practice. Provide link to specific programs by type or by state: <http://www.aoa.gov/AoA_programs/HPW/Evidence_Based/index.aspx>

Source:

Department of Health & Human Services, Administration on Aging. Evidence-based Disease and Disability Prevention Program (EBDDP). Retrieved from: <http://www.aoa.gov/AoA_programs/HPW/Evidence_Based/index.aspx>

**Lesson # 8 Suggested Learner Activities and Interactions:**

1. Read and reflect - Scenarios regarding 1) health promotion needs for chronic care management in a primary care setting and 2) care transition needs related to discharge from a rehab setting to home. Learners are asked to identify some of the current or anticipated issues involved and explain how they may be addressed by the features of a given care transitions or disability prevention/disease management model.

2. Objective questions - related to the objectives and benefits of the models and programs described in the lesson as well as the complexities of transitioning between settings.

**Lesson # 8 Glossary Terms**

Care Transitions

Care Transitions Models

Coleman Model

Disease Self-Management

Geriatric Resources for Assessment and Care of Elders Model/Program

Guided Care Model/Program

Re-engineered Discharge Model (RED)

Transitional Care Model

Stanford University Chronic Disease Self-Management Program

**Lesson #9: Collaboration in the No Wrong Door System**

**Lesson #9 Description:**

This lesson addresses creative problem solving through collaboration in the No Wrong Door system. Learners discover ways to reach out to others within their organization and throughout the system to identify appropriate LTSS. The necessity of building personal relationships with individuals in local and community service organizations is stressed. Workers are encouraged to be patient and flexible, to view problems as creative challenges not dead-ends, and to accept frustration as normal.

**Lesson #9 Learner Objective:**

Describe collaborative approaches that can be effective in finding solutions to gaps in LTSS.

**Lesson #9 Content Outline**

1. If there aren't programs you can find - make sure you ask your colleagues. People in your organization who have years of experience may know the answer. Don't be afraid to reach out for support. You should not have to work in isolation.
2. Supports don't have to be formal to be appropriate. Often informal supports are a better answer. If transportation presents a problem, maybe the individual has a relative who can drive him to a MD appointment once a month. Or maybe there's a member of his or her church that volunteers to drive seniors to the supermarket one day a week. Use example to illustrate.
3. Make opportunities to build relationships with people and organizations in your communities. When you need resources - especially at a moment's notice - it's nice to be able to dial the phone and speak to someone you already know. You're more apt to get the answers you need faster and more efficiently. Use an example to illustrate.
4. Reach across the No Wrong Door System. You may not have the answer, but others will. If your ADRC can't identify a resource, ask another. Or contact other organizations.

Use an example to illustrate this.

1. Sometimes a team approach is required to meeting the individual's needs. You may be a member of the team or the initiator/ leader - the one who brings the others in to serve the individual. You should advocate with the person based on what you know s/he wants. Share your understanding of the person with others. Brief others about the individual's needs, communication style, etc. If team members are more accustomed to the medical model, represent the social model and the "whole person".
2. Be flexible about outcomes. If you can't find exactly what you want, you may have to settle for something a little different. Think creatively about other options that will work. There's often more than one solution to a problem.
3. Expect a range of emotions - from yourself, others and the individual you are serving. You may hit delays and roadblocks that will be frustrating. Lack of services or ineligibility may spark angry feelings. Be prepared for and acknowledge these feelings as normal.

**Lesson # 9 Suggested Learner Activities and Interactions:**

One or two "read-analyze-reflect" scenarios about creative approaches to problem solving and filling gaps will be included.

**Lesson #9 Glossary Terms**

Informal supports