## Service Delivery

## A. Confidentiality

Each Aging & Disability Resource Center must have a written confidentiality policy that conforms to laws and regulations to protect and safeguard client information contained in paper and electronic files. Programs will ensure that client information remains confidential in accordance with state and federal law, the AAA Policies and Procedures Manual, contractual requirements, and program standards.

The client must give the ADRC Specialist explicit written or verbal consent for information to be disclosed to another agency or person. Verbal consent will be documented in the client record. Use of the Washington State Health Care Authority Authorization for Release of Information consent form [HCA 80-020](http://www.hca.wa.gov/documents/80-020.doc) is recommended when obtaining written consent to contact DSHS, or other entities. Release of information without consent is permissible only when ADRC personnel report suspected abuse, neglect, abandonment and/or exploitation or when the client is in imminent danger to self or others. ADRC personnel are mandatory reporters to Adult Protective Services (APS) and Child Protective Services (CPS). See Section J.Mandatory Reporting.

## B. Awareness

## The purpose of the *Awareness* function is two-fold:

* 1. Build community awareness of the ADRC so it becomes known as a highly visible and trusted place where people of all ages, disabilities and income levels know they can come for objective and unbiased information on the full range of home, community-based and long term services and supports (LTSS) as well as other services/supports that can enhance an individual’s ability to engage with their community; and
	2. Promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach, and private paying populations, as well as options individuals can used to plan ahead for their long-term needs.
1. The ADRC has an effective outreach and marketing plan locally tailored and focused on establishing operating organizations as highly visible and trusted places where people can turn for the full range of home, community and other long-term support options as well as raising awareness in the community about LTSS options. At a minimum, the outreach and marketing plan includes:
2. Consideration of all populations served including different age groups, people with different income levels, different types of disabilities, culturally diverse groups, underserved populations, individuals at risk of nursing home placement, family caregivers and professionals;
3. A strategy to document and assess the effectiveness of the outreach and marketing activities; and
4. A feedback loop to modify activities as needed.
5. ADRC actively markets to and serves private pay individuals in addition to those that require public assistance. Would be good to have a model – add in an appendix?

## C. Case Finding

Case Finding is a combination of methods used to identify and connect with individuals who are interested in and/or could benefit from ADRC services. An ADRC will develop case finding strategies that prioritize individuals at risk of entering institutional care; minorities, especially those who are low-income; individuals with limited English proficiency; individuals with dementia, and individuals who are socially or geographically isolated.

1. Referrals for ADRC services will be accepted from any source and may include persons seeking or already receiving another service through Department of Social & Health Services, the Aging Network or a community agency.
2. The person making the referral can request to remain anonymous.
3. Once a referral is received, it is the responsibility of the ADRC to contact the individual referred within one working day. All attempts at contact should be documented.
4. If requested, the ADRC Specialist may provide contact confirmation with referral source while retaining confidentiality about specific circumstances, unless permission to share information has been given.
5. In addition to traditional referral sources, each ADRC will identify and maintain contact with non-traditional referral sources (often called *Gatekeepers*) in the community who are likely to come into contact with vulnerable persons in its service area, especially those who may be socially isolated, unable to self-refer, or are at risk of institutionalization . The goal is to educate and/or train them on identifying when someone may be at-risk of losing their ability to remain independent, the goals of the ADRC, the services it provides, and its relationship to other programs within the area. *Gatekeepers* can be instructed to play a vital role in the service delivery system by referring the names of vulnerable at-risk persons to the ADRC and/or its partners and helping build community knowledge about those services. Examples of those Gatekeeper-type contacts might include, but are not limited to:
	1. apartment, hotel, and mobile home park managers;
	2. postal carriers;
	3. gas, electric, and water meter readers;
	4. fuel oil dealers;
	5. clergy;
	6. appraisers;
	7. police and firemen;
	8. grocery store clerks (especially those who deliver groceries);
	9. pharmacists;
	10. bartenders;
	11. hospital emergency room staff;
	12. bi-lingual and/or bi-cultural community leaders

##

## D. Information Giving

1. The purpose of information giving is to provide a person and/or their representative with enough information to enable them to locate and obtain needed services without additional assistance from the ADRC. This component is utilized when the caller can identify the person’s need and make a direct request for resource information to meet that need. Alternatively, if a person is unable to self-refer and has a willing informal support system, information and support is provided to the person’s informal support system to enable them to make the appropriate referrals.
2. Information-giving can be provided in-person in an office, community, or in-home setting; by telephone; and/or through electronic communications.
3. Information-giving can also be provided in group settings.
4. When available, objective information on multiple referral options, both public and private-pay, will be described and access information provided.
5. Inquirers will be encouraged to call back if the information proves to be incorrect, inappropriate or insufficient to meet their needs.
6. Individuals whose interests and need are outside the purview of the ADRC shall be given contact information to access appropriate information and services.
7. If the simple provision of information is not enough to enable the person or their representative to access needed services, the ADRC Specialist shall conduct a person-centered interview to determine the need for options counseling, access assistance and/or referral to additional services and supports.
8. All contacts, including follow-up results, will be documented in the client record. Include a summary of the discussion.

# **E. Resource Directory**

1. In coordination with Aging & Disabilities Services Administration (ADSA), develop and maintain the PSA portion of the statewide web-based ADRC resource database and ensure that it is accessible to ADRC staff, community partners, ADRC target populations, and the public at large.
2. Coordinate the updating of Information and Assistance resource files in accordance with statewide policies and procedures:
3. Research and assist with the development and maintenance of a website.
4. Maintain, troubleshoot and repair databases. Assist with the production and management of Agency databases.
5. Coordinate software product updates to ensure seamless transitions of data and user access.
6. Assign and coordinate writing tasks for consumer directories, as requested.
7. Maintain and develop database forms and reports.
8. Coordinate, or work with others for, the distribution of updated material to designated staff and community partners.
9. Communicate with ASIS Policy Committee and State Resource Directory Administrator:
	1. Resources that should be changed/added on statewide or regional levels
	2. Taxonomy term application challenges/strategies
	3. Lessons Learned and Effective Practices
	4. Change Requests
10. Participate in the statewide ADRC Resource Directory Advisory Subcommittee and may be selected to represent the subcommittee on the statewide ADRC Information System Policy Committee.

# **F. Crisis Intervention**

Crisis Intervention means to respond to situations of immediate jeopardy to the health or welfare of an individual, by means of remedy, removal from danger, protective services, or other timely safety measures. Frequently persons will call and appear to be in crisis; however, after being given an opportunity to de-escalate they are often able to self-identify needs and solutions. The ADRC is not a formal crisis intervention center and must therefore equip its staff to handle people in crisis appropriately with protocols in place to address situations that are beyond an ADRC Specialists responsibilities ~~Look at training topic list to ensure ability to ID and assist individuals with Behavioral health issues is addressed. Suggestion: lethality assessment form at each desk. Someone with PD might want to just talk – also need to know how to bring a call to an end successfully (part of 101 training)~~ - *DONE*

1. The ADRC Specialist shall have the intervention skills to:
2. De-escalate and stabilize the individual and help him/her remain calm;
3. Help the inquirer talk about and work through his/her feelings as part of the assessment and problem solving stages of the interview;
4. Understand and follow agency protocols for when to access 911 or other emergency personnel
5. The ADRC Specialist shall be familiar with his/her responsibilities under the prevailing legislation of the jurisdiction regarding mandatory reporting and shall file a report when indicated.
6. When feasible, ADRC Specialists shall connect inquirers in crisis situations to a formal crisis intervention service in their community for longer term assistance and support once the inquirer’s immediate, short-term needs have been met. The connection shall be made by direct transfer, when possible, and the specialist shall follow the protocol established by agreement with the crisis center.
7. In cases where the inquirer has been referred to a formal crisis intervention service rather than transferred directly, the ADRC Specialist shall follow up to ensure that the individual has the ongoing support s/he needs.

**G. Options Counseling and Access Assistance**

Options Counseling is a person-centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. The process may include developing action steps toward a goal or a LTSS plan, and, when requested, assistance in accessing support options. It also includes following-up with the individual. Options Counseling is available to all persons regardless of their income or financial assets.

Note: Statewide tools and training will be developed in concert with ADRCs to build professional expertise and statewide consistency.

1. Essential Components of Options Counseling include:
2. Person-centered interview,
3. Identification of desired and available options (including personal, public, and private resources),
4. A facilitated decision-support process (weighing pros/cons of various options),
5. Assistance, as requested, to develop an action steps plan or LTSS plan that is directed by the individual,
6. Connections to services and supports when requested, and
7. Follow-up.
8. Service Prioritization:

Options Counseling is ideally available to persons 18 and over with a disability, older adults or caregivers who request or require long term support services for a current need and/or persons of all incomes and assets who are planning for their future long term support service needs.

However, if funding is limited, it may be prioritized to persons in the following categories:

* 1. Individuals transitioning from hospitals;
	2. Individuals transitioning from skilled nursing facilities or extended care facilities;
	3. Individuals at high risk for institutionalization; and/or
	4. Other individuals that through research, the ADRC has determined could benefit most from Options Counseling.
1. Informal caregivers seeking assistance with decision-making will be offered a referral to the local Family Caregiver Support Program for TCare Screening®, Assessment, and Consultation services.
2. Initiation/Referral Protocols for Options Counseling:
3. In collaboration with ADSA, each ADRC will have in place a mechanism for receiving initial inquiries/referrals regarding, or contacts that may lead to, the initiation of the Options Counseling process. Each ADRC will have in place a uniform process regarding the initial contact and determination of need or trigger for options counseling that is utilized at all locations and with all partners.
4. The following situations and/or triggers may indicate the individual could benefit from Options Counseling:
5. Requests or indicates an interest in receiving information or advice concerning long-term support options;
6. Is referred to the ADRC by a hospital, nursing home, assisted living home (or other long-term residential setting), home and community based waiver services provider, or other agency (including MDS 3.0 Section Q referrals);
7. Has had recent change in life situation and desires deeper discussion about their options;
8. Has LTSS needs and is unsure about the process of accessing services or what services will best meet their preferences and needs;
9. Is requesting assistance in transitioning from one living situation to another;
10. Might be eligible for new benefits and supports and is unsure of what is best for them or what they might be eligible for;
11. Is interested in a participant-directed program;
12. Is admitted to the hospital and needs to know what they should be planning for once discharged;
13. Lacks awareness of existing community resources and suports and could benefit from decision support and education around their options;
14. Has behavioral health needs and would like support on options related to their specific needs or situation;
15. Has multiple needs or a chronic illness and has a need or desire for support on a broad array of options to meet their needs across many services and systems; and/or
16. Was denied LTC Medicaid and needs decision support about other non-Medicaid options.
17. Service Delivery Setting:

Every attempt should be made to deliver Options Counseling in the setting and the method desired by the individual. Settings may include the individual’s place of residence, an agency, a nursing home, hospital, rehabilitation center, medical practice, or even non-traditional settings of the individual’s choosing. Modes of service delivery may include in person, by phone, by e-mail, by video conferencing technology, or other electronic method. Whenever possible an in-person meeting with the individual is preferred. In-home visits are a particularly useful method to help identify the values and preferences of the individual as well as actions needed to maintain independence. The ADRC may wish to establish guidance for staff on when to offer an in-person meeting or home visit.

1. Options Counseling Service Components:
2. Person-Centered Interview:

A key component of effective options counseling is a person-centered dialogue to learn about the person’s values, strengths, preferences, and concerns. This discussion is a process of discovering factors important to the individual to assist the person in exploring options and developing an action steps plan or long term services and support plan. Sometimes this process is called screening.

This conversation may occur once or over a series of interactions. The conversation should touch on key areas that would influence available options relevant to the individual’s situation including strengths, physical, emotional, social, financial, and functional aspects. The Options Counselor may need to obtain specific, pertinent information to assist the individual with any applications for publically funded services and supports.

The conversation should occur in a timely manner and meet the schedule and needs of the individual. A tailored list of needs and resources that the individual identifies as helpful for him or her to live independently in their community should be made available to them in a timeframe that gets the information to them when they need it to make decisions.

The person-centered interview will help determine:

* 1. An individual’s strengths and abilities;
	2. An individual’s concerns, goals and preferences:
	3. An Individual’s current formal and informal supports, including their ability and desire to continue;
	4. An individual’s circumstances, including financial;
	5. An inventory of an individual’s functional and behavioral support needs. This includes exploring vulnerability status, risk for institutional placement, and special needs such as Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLS), disability access, transportation etc.;
	6. Other service or support options the individual has contacted;
	7. An individual’s ability to take action, self-advocate and follow-up;
	8. An individual’s need/desire for information, assistance, options counseling, advocacy, care coordination; and/or other ADRC services.
	9. Whether the primary needs expressed are related to caregiving and if the individual could benefit from a referral to the Family Caregiver Support Program, or Kinship services and supports.
	10. Whether an older individual meets vulnerability criteria as defined in Attachment \_\_ for older adults seeking care coordination and would could benefit from a referral to care coordination for a comprehensive assessment, service plan development, and service coordination;
	11. Whether an individual or family meets risk criteria for referral to Children’s Administration, Child Protective Services (CPS) or Aging & Disability Services Administration (ADSA), Adult Protective Services (APS);
	12. Whether an individual appears eligible for other specialized community services and supports, ,; and/or
	13. Whether an individual appears functionally and financially eligible public long-term services and support (LTSS) LTSS and should be referred to HCS for intake and response; or appears eligible for other state managed public programs and should be referred to appropriate entities to determine eligibility. These entities may include but are not limited to Division of Developmental Disabiliites (DDD), Department of Veterans Affairs (DVA), Department of Vocational Rehabilitation (DVR), Children’s Administration (CA), Behavioral Health and Recovery (DBHR), etc.
	14. Completion of a comprehensive Benefits*CheckUp* screening can be helpful with assisting people to learn about public benefit programs for which they may be eligible, including but not limited to, SSI, Medicaid, Basic Food, Medicare Savings Programs, Low-Income Subsidy, energy assistance, subsidized housing, and veteran’s benefits;
	15. A tailored list of relevant service and support options resulting from the expressed needs and preferences.
1. Exploring Options and Planning:

Options Counseling (OC) includes the exploration of resources so they can choose what is right for them to assist with current or future long term services and supports. Resources may include informal support, privately funded services, publically funded services and benefits, among others.

1. OC should include discussion of available options without the personal bias of the Options Counselor.
2. Organizations providing OC should not have a vested interest in decisions made by individuals.
3. As part of the OC process, the options counselor will encourage the individual to explore informal supports that might be available such as support from community groups, faith communities, neighbors, and friends.
4. The OC process will include discussion of publically funded LTSS as well as private LTSS including the approximate cost of services.
5. Options Counselors also should facilitate future(?) planning by talking with individuals about options for services and supports should they be needed in the future.
6. To assist in the exploration of available options, it is recommended that Options Counselors assist individuals, when necessary, in making appropriate connections to persons that have specific training in available benefits and expertise related to the persons options (such as SHIBA counselors, financial, employment, legal services, independent living, mobility assistance, etc.)
7. The ADRC will ensure a mechanism is in place to ensure the individual is connected to ADRC staff or other referral options that can assist with the following additional Options Counseling components:
	1. Employment assistance,
	2. Benefits counseling,
	3. Futures planning, and
	4. Mobility assistance
8. Decision Support:

In addition to discussing and sharing information about available resources, Options Counseling assists the person in evaluating various pathways, including the pros/cons or costs/benefits of specific options. This is one of the key elements that distinguishes options counseling from Information and Assistance (I & A).

1. Decision support is best performed by utilizing specific decision support tools, decision support processes, and decision support techniques, such as motivational interviewing and person centered planning; and person-centered tools such as preferences maps, places maps, mind maps, evaluating options tools, and shaping outcomes tools.
2. *Note: Washington State ADRC Decision Support tools will be chosen and/or developed through a collaborative review process, followed by statewide deployment, training, and implementation.*
3. Collaboration with the Individual to Develop Action Steps: (guardians)

The Options Counselor will offer to assist the individual in developing his or her own personal written plan of action. The written plan serves as a guide for the individual for future work and/or steps necessary to achieve goals or obtain home and community based or other long term services and supports that are important to helping the individual maintain independence.

1. The ultimate pace of the process is normally determined by the individual; however an ADRC may obtain specialized funding requiring different timeframes. It is recommended that ADRCs position Options Counseling within a framework that will flexibly meet the needs of the individual while taking advantage of possible funding sources.
2. The Options Counselor will encourage and facilitate written plans that are developed to the greatest extent possible by the individual, but provide assistance if/when necessary.
3. The plan may be shared by the individual with others as desired, as well as retained in a file or electronically by the Options Counselor for use during follow-up activities.
4. Assistance to Access Services and Supports
5. In addition to decision support, Options Counselors also provide assistance as requested by the individual to access or coordinate chosen services and supports. This support could be short or long process depending on the direction from the individual, degree of urgency expressed by the individual in meeting his or her goals, or availability of funding to provide such support. If this function is not performed directly by the Options Counselor, the ADRC should have appropriate referral protocols in place to support individuals in accessing this support from other sources. Whenever confidential information is to be shared with another entity, the consumer’s permission and a signed release of information shall be obtained. At all times, self-efficacy, self-determination, and independent follow through shall be respected and encouraged.
6. Connection to community supports may include the following components, per the individual’s request and consent:
* Assisting with applications for benefits or services and tracking eligibility determinations;
* Assisting with arranging or scheduling services and supports (e.g. serving as a support broker in a participant directed program, care coordination);
* Accessing resources in order that the individual return to the community from an institution or hospital (e.g. care transition coaching);
* Advocating on behalf of an individual who is unable to self-advocate and who is lacking an informal support system; and when the individual appears eligible for services but is unable to successfully connect to those services.
1. Assistance may be provided over the telephone, in the field, or in the ADRC, as appropriate, according to accessibility needs; and in consideration of the individual’s circumstances and preferences.
2. Within one working day after contact by the person and/or their representative, adults who request and appear to meet eligibility criteria for ADSA-funded long term supports and services shall be referred to HCS intake for ADSA services eligibility screening. If necessary, document reasons why the referral is not completed within this time frame, for example the need to assist with related applications, acquiring documents, or client advocacy.
3. Staff will follow referral protocols to other community services and supports as they exist in Memoranda of Understanding (MOUs), contractual agreements, and/or state or federal regulations.
4. The ADRC network’s capacity to provide on-going support to individuals may vary depending on availability of funding to support OC. ADRCs may want to develop this capacity in order to take advantage of a broad range of funding sources that support independent living in the community.

## Follow-Up

Follow-up is an essential component of Options Counseling and Assistance to be offered to each individual. At this point the Options Counselor learns from the individual what progress towards goals and steps in the action plan has occurred. Any barriers to implementing the action plan can be discussed and the Options Counselor and individual can strategize about alternatives. Data captured from follow up is important for determining the client satisfaction in the program, identifying service gaps or systemic issues, client outcomes, and additional needs a consumer may have.

1. Follow-up may be conducted in person, by phone, or electronically as resources allow and the individual prefers;
2. The ADRC must offer follow-up with all inquirers/representatives who are provided options counseling and assistance;
3. The individual’s action steps plan should guide the time-frame for follow-up; however an initial follow-up will occur within ten business days for those who need assistance accessing services due to capacity or disability issues, or have endangerment issues;
4. Follow-up allows:
* The individual to clarify questions concerning his or her plan
* The individual to receive assistance from the Options Counselor regarding the application and eligibility processes, if requested;
* The individual the opportunity to request assistance regarding the implementation of LTSS; and
* The individual and the ADRC to evaluate the usefulness of the services, such as barriers encountered in achieving his or her goal, whether the goals were realistic, or whether the goals were met.
1. The ADRC must also follow up with a random 5 percent sample of all ADRC contacts to determine if information given by the ADRC was successfully utilized and services provided produced positive results.
2. During the initial contact(s), the specialist should obtain permission to contact the inquirer/representative for follow-up. If permission is denied, it should be duly noted in the individual’s record.
3. On follow-up, should the original referrals prove unsuccessful, ADRC staff will identify substitute resources and referrals if they are available and make another follow-up contact within ten working days.
4. All contacts, including follow-up results, will be documented in the client record. Include a brief description of the reason referrals were unsuccessful and alternate plans to meet client needs.
5. **Care Transitions**

The *Person-Centered Transitions Support* function is defined by an ADRC’s ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home.

The ADRC can play a pivotal role in these transitions to ensure that people understand their options and receive LTSS in the setting that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at some of these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them quickly arrange for the supports and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home or other institution. They can also break the cycle of readmission to the hospital that often occurs when an individual with chronic illness is discharged to the community without the social services and supports they need.

ADRC Care Transitions Support includes the following components:

1. Each ADRC has formal agreements with local critical pathway providers, such as hospitals, physician’s offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include:
2. An established process for identifying individuals and their caregivers who may need transition support services;
3. Protocols for referring individuals to the ADRC for transition support and other services; and
4. Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations.
5. The ADRC will establish an evidence-based care transitions program, within which, at minimum, includes hospital-to-home transitions.
	1. Evidence-based hospital-to-home transition model options include the following:
6. [*Care Transitions Program®*](http://www.caretransitions.org/) - please also refer to Washington State’s[*ADRC Care Transitions Intervention Toolkit*](http://www.adsa.dshs.wa.gov/professional/adrc/), which has been reviewed and approved by the *Care Transitions Program®* team.
7. [*Transitional Care Model (TCM, a.k.a. Naylor Model)*](http://www.transitionalcare.info/);
8. [*Better Outcomes for Older Adults through Safe Transitions (BOOST)*](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/03BestPrac/03_Literature.cfm);
9. [*The Bridge Program*](http://www.transitionalcare.org/);
10. [*Guided Care*](http://www.guidedcare.org/); and
11. [*Geriatric Resources for Assessment and Care of Elders (GRACE)*](http://medicine.iupui.edu/IUCAR/research/grace.asp).

See Appendix \_\_\_, for an overview of different evidence-based models.

* 1. Nursing home diversion activities are considered part of care transitions; however are often provided in the normal course of case finding followed by options counseling and assistance.
	2. Other kinds of transition activities the ADRC may elect to perform include transitions from emergency rooms, institutional settings, and rehabilitation centers, etc. In all cases the ADRC will coordinate with other entities involved in similar transitions to define roles, target populations, and protocols.
1. Each ADRC will work with the local Home & Community Services Roads to Community Living and Washington Roads programs to serve as Local Contact Agencies (LCAs) to provide transition services for non-Medicaid/private-pay institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment. *Note: this is planned for the future: protocols and potential funding streams to be developed.*
2. The ADRC is encouraged to seek additional funding sources to perform these functions, including contractual relationships with healthcare providers and managed care organizations. It is encouraged that ADRCs consider other ADRC services as part of a package that can result in more successful transitions over time.

*Duties, performed regardless of care transitions model, are:*

1. Communicate and collaborate, between and among healthcare and home/community-based service and support providers;
2. Facilitate patient/participant activation;
3. Provide enhanced follow-up with the transition;
4. Track coach-related metrics and report on intervention progress.
5. Direct all urgent /extraordinary requests or incidents to appropriate staff.
6. As requested, connect the individual and/or family members to additional ADRC and other community services and supports, including Options Counseling and Assistance, for longer term successful transition outcomes.

Duties performed using evidence-based Care Transitions models that are different from the Care Transitions Intervention®, will be approved by the ADSA ADRC Program Manager.

1. **Care Coordination**

An individual that is not eligible for ADSA-funded Core LTSS, may be eligible for ADRC Care Coordination.

*Care Coordination Eligibility:*

Based on staff resources, adults age 60+ who reside in the community, are not receiving ADSA-funded LTC Core Services, are able to remain in a non-residential setting, and:

1. Require multiple services and/or related activities performed on their behalf;
2. Are unable to obtain the required services and/or perform the required activities for themselves;
3. Do not have family or friends who are able and willing to provide adequate assistance;
4. Meet a-c above and require ongoing care coordination after an Adult Protective Services (APS) investigation has been completed.

***Goals of Care Coordination***

The primary goals of care coordination are to assist an individual to develop a person-centered plan of care that enables them to reside in the setting of their choice in order to retain or achieve the highest level of independence possible, help facilitate implementation of the plan and to monitor that plan as requested and needed. Care Coordinators support an individual’s independence by coordinating and offering assistance to access needed services.

**Duties include:**

1. Conduct person-centered interview and completion of a comprehensive assessment and/or screening (i.e. CARE). Note: if the individual has an unpaid caregiver who needs information, assistance and support; a TCARE® screeningand/or assessment may also be completed in conjunction with a referral to the Family Caregiver Support Program (FCSP).
2. Facilitate development of a person-centered and person-directed service plan.
3. Assist in the service plan implementation while encouraging the individual and/or caregiver to do as much as possible independently.
4. Provide as requested and needed care coordination supportive functions which may include, but are not limited to: the full array of ADRC functions as well as networking, consultation with healthcare and social service professionals, family support, and crisis intervention.
5. Care coordination termination planning.
6. Follow-up after termination from care coordination.
7. Record maintenance.
8. **Mandatory Reporting:**

All ADRC staff are Mandatory Reporters.

* + - 1. Refer adults in need of Adult Protective Services (APS) directly to the APS program for APS investigation, following instructions in the ADSA Long Term Care Manual, Chapter 6. See also ***Partners in Protection: A Guide for Reporting Vulnerable Adult Abuse*** DSHS 22-810(x)(REV. 12/10). The brochure is available on-line on the ADSA internet at <http://www.aasa.dshs.wa.gov/Library/publications/brochurestext.htm#abuse_mandatory>
			2. Refer Children in need of protection directly to the local office of the Washington State Department of Social and Health Services, Division of Children and Family Services (DCFS), Child Protective Services and/or to the local law enforcement agency where the child resides. See also Children’s Administration’s webpage on mandatory reporting at <http://www.dshs.wa.gov/ca/safety/abuseReq.asp?2>, which includes a multi-media Mandated Reporter Toolkit.

## K. System Advocacy

1. System Advocacy may be undertaken to effect changes in public policy relating to the needs of the ADRC target population. Actions may be taken by the ADRC to seek changes in state and/or community conditions, structures or institutions when modifications in the service delivery system are required to ensure the adequate availability of essential community services. Such advocacy may include the collection, analysis, and dissemination of data on human service needs.
2. The ADRC should maintain a visible presence at community events and develop strong cooperative relations with social service organizations to remain informed of community needs and accessibility barriers. The ADRC should also actively participate in local Disaster Preparedness activities.
3. For the purposes of these standards, system advocacy does not include legislative advocacy (lobbying). All advocacy efforts shall be consistent with written policies established by the governing body of the ADRC.

## L. Staff Supervision

##

An ADRC supervisor shall be knowledgeable about the ADRC fully functional criteria, the state program standards, community resources, the statewide ADRC information system functionalities and processes, ADRC assessment tools and processes, partners, stakeholders, the outreach and marketing plan, reporting requirements, quality assurance and continuous quality improvement procedures, and physical and behavioral health issues experienced within the target population.

## Duties include, but are not limited to:

1. Maintain regular contact with staff.
2. Conduct periodic case record reviews with staff (both electronic and hardcopy; to include information and referral, options counseling/access assistance, care transitions, and case management cases) to monitor for the following:
	1. Actions taken are effective and appropriate
	2. Required forms are accurately completed, including documentation of follow-ups and outcomes.
	3. Review a sample of two options counseling, access assistance, care transitions, and/or care coordination records for accuracy and completeness at least once every 90 days for each ADRC staffer.
3. Provide and arrange for formal staff training.
4. Provide consultation to staff as needed.
5. Arrange for appropriate case consultation by other professionals, as needed.
6. Arrange for shadowing by and for staff, as needed.
7. Conduct a formal evaluation of each staff person at least once a year.
8. Monitor and report both individual and system follow-up activities.
9. Coordinate with QA/CQI staff to analyze case record review outcomes and develop recommendations for remediation and quality improvement.
10. Coordinate with QA/CQI staff to develop and implement CQI procedures and processes.
11. Report identified gaps in target population services to Program Director
12. Assist in development of reports and measures, including for the local information contained in the statewide resource directory.

## ADRC Program Management/Directorship

The ADRC Program Manager or Director oversees all aspects of the ADRC Program. Including, but not limited to, ensuring the following duties are met:

1. Develop and implement program policies, goals and objectives utilizing follow-up information to identify possible gaps in the service delivery system. Advocate and plan for system improvement.
2. Cooperate and advocate with AAA planning unit to determine where gaps in services exist for the target population
3. Hire and supervise appropriate staff.
4. Arrange for volunteer and/or student assistance and supervision as appropriate.
5. Manage or delegate day-to-day program operation.
6. Develop program operating procedures, personnel policies, job descriptions and record maintenance system.
7. Submit required state, federal, and AAA reports in a timely fashion.
8. Develop and maintain linkages with community agencies and organizations that could give support to the program or individual consumers.
9. Effectively identify and take steps to resolve barriers to streamlined access to public and private pay long-term care services.
10. Ensure that a case finding system is developed and maintained by the ADRC.
11. Educate community agencies and groups and the general public on the goals of the ADRC program, the target population and services provided.
12. Develop and oversee the implementation and ongoing deployment of the ADRC outreach and marketing plan,
13. Establish systems for assuring quality, evaluating program effectiveness, and ensuring continuous quality improvement