ADRC Dementia Care Training

Aging Services and Supports for People Living with Dementia: Tier 2

Module 6: Decision Support through Person-Centered Planning
Aging Services and Support for People Living with Dementia

Tier 1:
- Understanding Person-Centered Care
- Communication and Behavioral Expressions
- Medical and Clinical Aspects of Dementia
- Complex Information and Referral Issues

Tier 2:
- Honoring Personhood through Person-Centered Decision Support
- **Decision Support through Person-Centered Planning**
- Decision Support in Care Transitions
- Decision Support for Advanced Care and End-of-Life Planning
Options Counseling Competency Areas

- Understand needs, values and preferences from the point of view of the person (Module 5)
- Support self-determination (Modules 5, 6)
- Encourage a future orientation (Module 8)
- Develop knowledge of private and public resources (Modules 6, 7, 8)
- Provide Follow-up (Modules 7, 8)
Module 6 Objectives

Participants will learn how to:

1. Facilitate person-centered planning

2. Collaborate with people with dementia and their families to locate and access public and private resources

3. Assist families in implementing and evaluating their person-centered plans
Module 5 Review

- Team Performance Model
  - Orientation
  - Build trust
  - Identify goals and roles
  - Commitment
  - Implementation
  - Performance
  - Renewal
Review: Tools & Approaches Used

Daily Routines - Dennis

Timeline - Margaret
Visual Tools

- **Tools of Inquiry (Orientation & Building Trust)**
  - Routines Map (Dennis)
  - Timeline (Martha)
  - Preferences Map (What’s Working/Not Working) (Sarah)

- **Decision Making Tools (Goal Setting, Commitment)**
  - Shape Outcomes (Dennis)

- **Strategic Tools (Implementation)**
  - Action Planning (Dennis)
  - Charting Roles and Responsibilities (Sarah)
Michael Smull on Tools

What's Working and Not Working
What’s Working/Not Working: Principles of Negotiation

- People feel listened to
- Start from common ground –
  - Honestly capture each person’s perspective
  - where there is agreement about what is working and not working
- Be unconditionally constructive
  - Don’t take sides
  - Don’t criticize perspectives
  - Break down issues of safety to understand the central concerns
Introducing Bill & Sarah
What’s important to Sarah?
Sarah’s Preferences (What’s Working/Not Working)
Module 6

Team Performance Model

- Orientation
- Build trust
- Identify goals and roles
- Commitment
- Implementation
- Performance
- Renewal
Goal Clarification

Decision Making Tools

- Envision Success (Outcomes)
- Explore Possibilities (Opportunities)
- Understand Choices
Goal Clarification

Decision Making Tools

- Envision Success (Outcomes)
- Explore Possibilities (Opportunities)
- Understand Choices
Supporting Sarah
Implementing Sarah’s Plan

Changing Roles & Responsibilities Tool

- Maintaining Sarah’s volunteer, other community roles

<table>
<thead>
<tr>
<th>Sarah</th>
<th>Bill</th>
<th>Joyce (daughter)</th>
<th>Jon (son)</th>
<th>OC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate desired volunteer/ community</td>
<td>Talk to hospital coordinator</td>
<td>Talk to friends about taking Sarah to activities</td>
<td>Volunteer with Sarah for meals on wheels</td>
<td>Provide resources to promote involvement</td>
</tr>
<tr>
<td>Participate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Implementing Sarah’s Plan

ADRC of Oregon

- https://www.HelpforAlz.org

Alzheimer’s Association

- http://www.alz.org/i-have-alz/i-have-alzheimers-dementia.asp
And the planning continues . . .
Dennis’ Routines

Dennis and Sofia (options Counselor) at the family meeting with
1) his daughters, Sally & Lola
2) His friend, Fred
3) His granddaughter, Keisha
Planning with Dennis
**Desired Outcomes:**
- Dennis maintains important routines at home
- Sally feels a balance between supporting her father, herself, and her other responsibilities

<table>
<thead>
<tr>
<th>Support Roles</th>
<th>Descriptors</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Morning routine** | • Reading the paper  
• Taking a daily walk  
• Meeting friends for breakfast on Saturday mornings | • Dennis needs a daily paper to have a good start to the day  
• Walking in the neighborhood helps keep Dennis healthy and involved with people, but it puts him at risk as dementia progresses  
• Eating lunch with golfing friends is a long-standing routine enabling him to reminisce and joke with old friends |
| **Daytime supports** | • Eating a hot lunch  
• Going to the community center  
• Spending quality time with Sally | • Inability to work the microwave leads to anxiety and frustration  
• Sally and Dennis have their best times over lunch  
• Sally values time with Dennis, but can’t be there every day. Completing tasks for Dennis takes away from quality time with Dennis  
• Playing cards lifts Dennis’ spirits – he seems to be happier and less confused afterward |
| **Evening routines**  | • Talking with Lola  
• Watching news | • Dennis and Lola enjoy shared time, especially talk of sports |
| **Errands & chores** | • Assistance with housekeeping, Laundry, grocery shopping, meal preparation | • Household chores are taking time away from Sally’s personal time with Dennis  
• Meal preparation for Dennis is part of Sally’s own family routine  
• Grocery shopping with Dennis is increasingly challenging for Sally but enjoyable for Dennis |
Dennis’ daughters

Sally

Dennis

Lola
Commitment & Implementation

- Pursue resources needed to implement plan
  - Informal networks
  - Formal services
  - Financial supports
- Clarify roles and risks
- Clarify expectations, needs and schedules
- Negotiate agreements for services and payments
Sofia’s (Dennis’ Option Counselor) Description
Sally’s (Dennis’ daughter’s) Reflections
Dennis’ Experience
# Action Planning to Meet Goals & Commitments

<table>
<thead>
<tr>
<th>Routine</th>
<th>Examples of family commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning paper</td>
<td>- Sally and Home Care Worker (HCW) will monitor Dennis’ ability to understand sign on the door&lt;br&gt;- Sally and Fred will make sure there is extra reading material at the breakfast table</td>
</tr>
<tr>
<td>Walking</td>
<td>- HCW to walk with Dennis when she arrives&lt;br&gt;- Lola will get a device to attach to Dennis’ watch so his location is known&lt;br&gt;- Sally will ask neighbors to watch for Dennis</td>
</tr>
<tr>
<td>Lunch</td>
<td>- Sally will continue to prepare meals for Dennis when she cooks for her household&lt;br&gt;- Sally, Keisha, Fred, HCW will take turns coming to lunch; Sally will eat with Dennis and reduce the number of housekeeping tasks</td>
</tr>
<tr>
<td>Housework, chores</td>
<td>- HCW will do laundry, housework; in the future help with ADLs</td>
</tr>
<tr>
<td>Cards, visiting</td>
<td>- Fred will continue providing rides to Saturday breakfast, will take Dennis shopping</td>
</tr>
<tr>
<td>Planning</td>
<td>- Lola to take the lead in following up on resources provided by options counselor; will arrange transportation to community center. Focus on advance planning needs&lt;br&gt;- Lola and Sally will communicate</td>
</tr>
</tbody>
</table>
Supporting Martha

- Recorded importance of calling her “Martha,” not “Mary”
- Consulted with APS (judged not a threat to self)
- Contacted DMV
- Gave physician algorithm for diagnosing dementia*
- Obtained short-term support from former colleagues
- Enlisted the help of other neighbors
- Added Martha to wait list for Senior Companions
- Helped Martha hire homecare worker (HCW)
- Arranged Meals on Wheels
- Set up reminder calls for medication
- Posted medical, ADRC, APS, HCW, neighbor’s and his own contact information in multiple places throughout the house

*Currently in development by SPADO, 2.b
Use the “what’s working” “what’s not working” in a staff meeting.
• Can you help people feel listened to?
• Find common ground?
• Be unconditionally constructive?

Use the “Timeline” with a colleague – get to know each other better!
Consider:
• Significant life events, milestones
• Relationships and social networks
• Accomplishments, contributions
• Important traditions
• Consider asking about: places lived, schools attended, jobs held, important people
Recap, Module 6

- **Tools of Inquiry**
  - Routines
  - Timeline
  - Working/not working

- **Planning: Decision Making Tools**
  - Identify goals, shape outcomes

- **Implementing: Strategic Tools**
  - Action planning
  - Changing roles and responsibilities (who does what)
Common care transitions experienced by persons living with dementia (psychological and physical transitions)

The intersection of dementia with depression, and delirium

Risks associated with care transitions.

Supporting families through transitions.
Thank You!

www.HelpforAlz.org
Feedback Survey

https://www.surveymonkey.com/s/Dementiamodule6

This training was developed by Portland State University on behalf of Oregon Department of Human Services – Aging & People with Disabilities. Funding for this project was provided by an Administration for Community Living grant (#90DS2001) and funding provided by the Oregon Legislature for mental health training.