

# ADRC Dementia Care Training

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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

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## ➤ 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

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- 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:

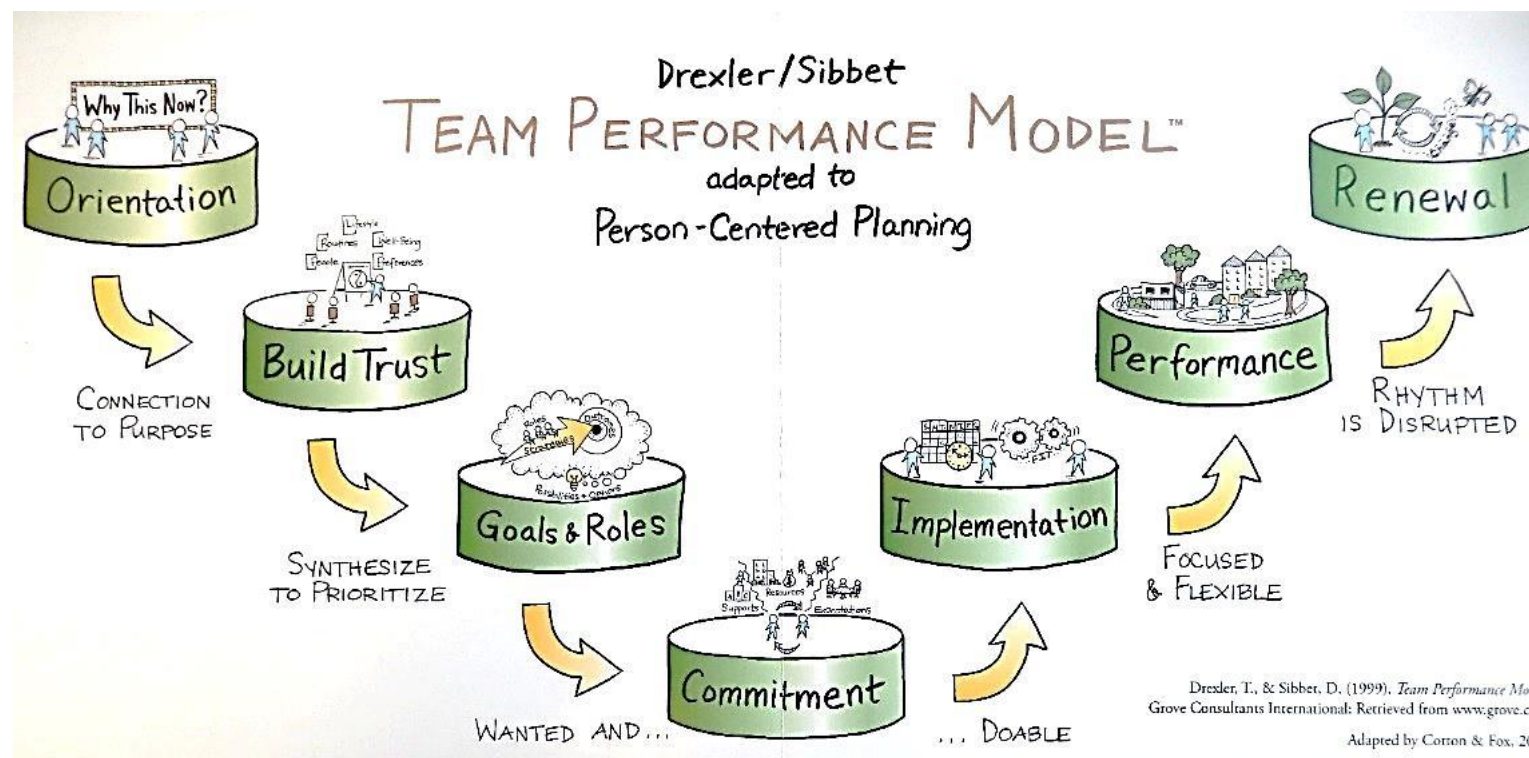
1. Facilitate person-centered planning
2. Collaborate with people with dementia and their families to locate and access public and private resources
3. Assist families in implementing and evaluating their person-centered plans



# Module 5 Review

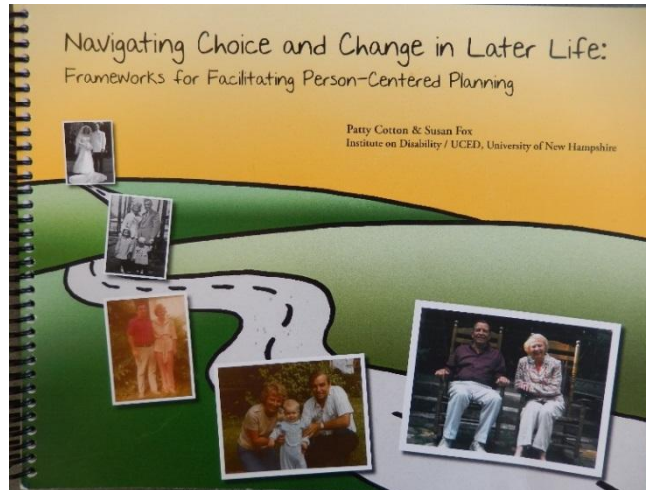
## ➤ Team Performance Model

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



# Review: Tools & Approaches Used

## Daily Routines - Dennis



## Timeline - Margaret



# Visual Tools

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- 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

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## What's Working and Not Working



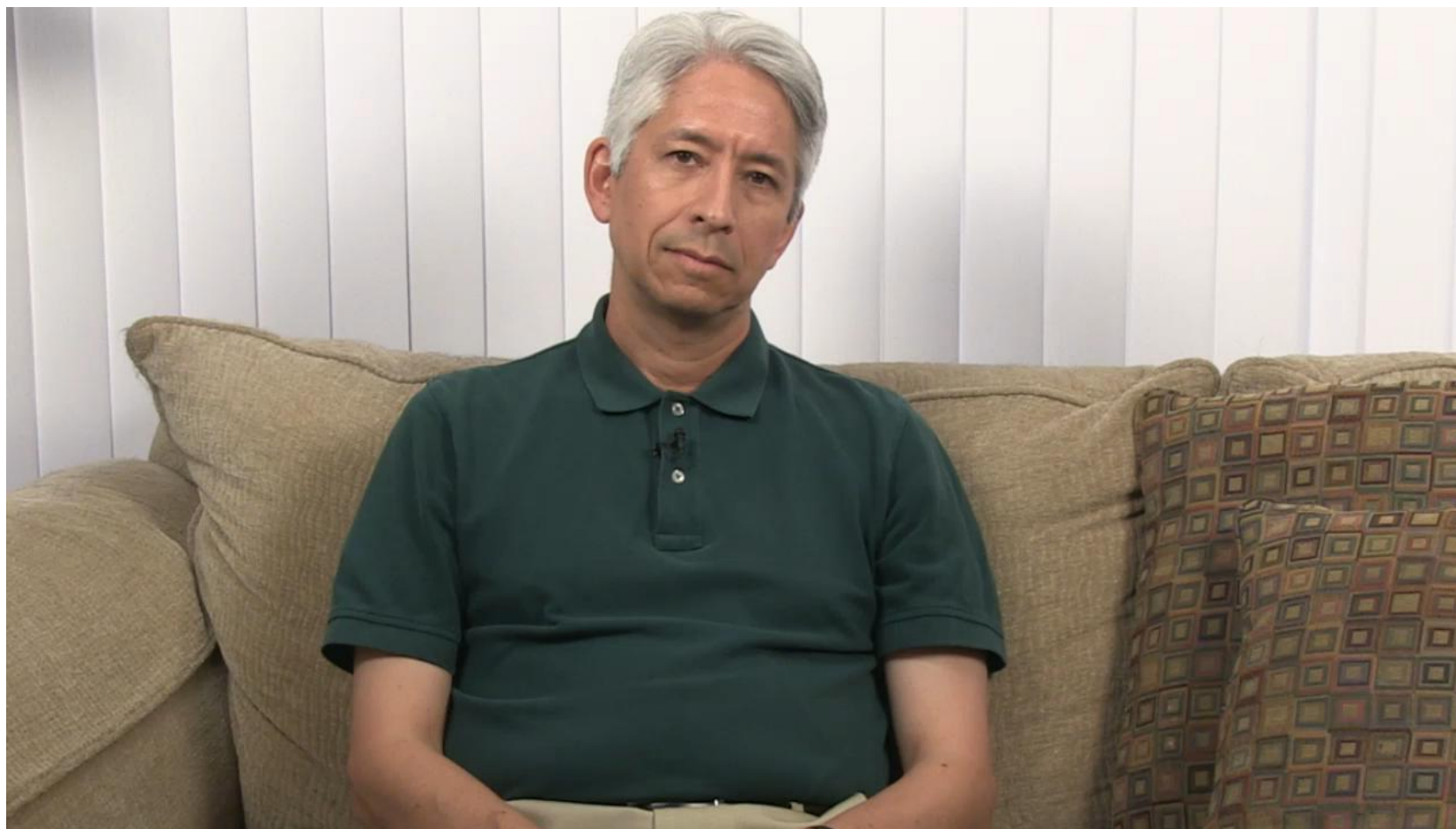
# What's Working/Not Working: Principles of Negotiation

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- 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

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# What's important to Sarah?



# Sarah's Preferences (What's Working/Not Working)

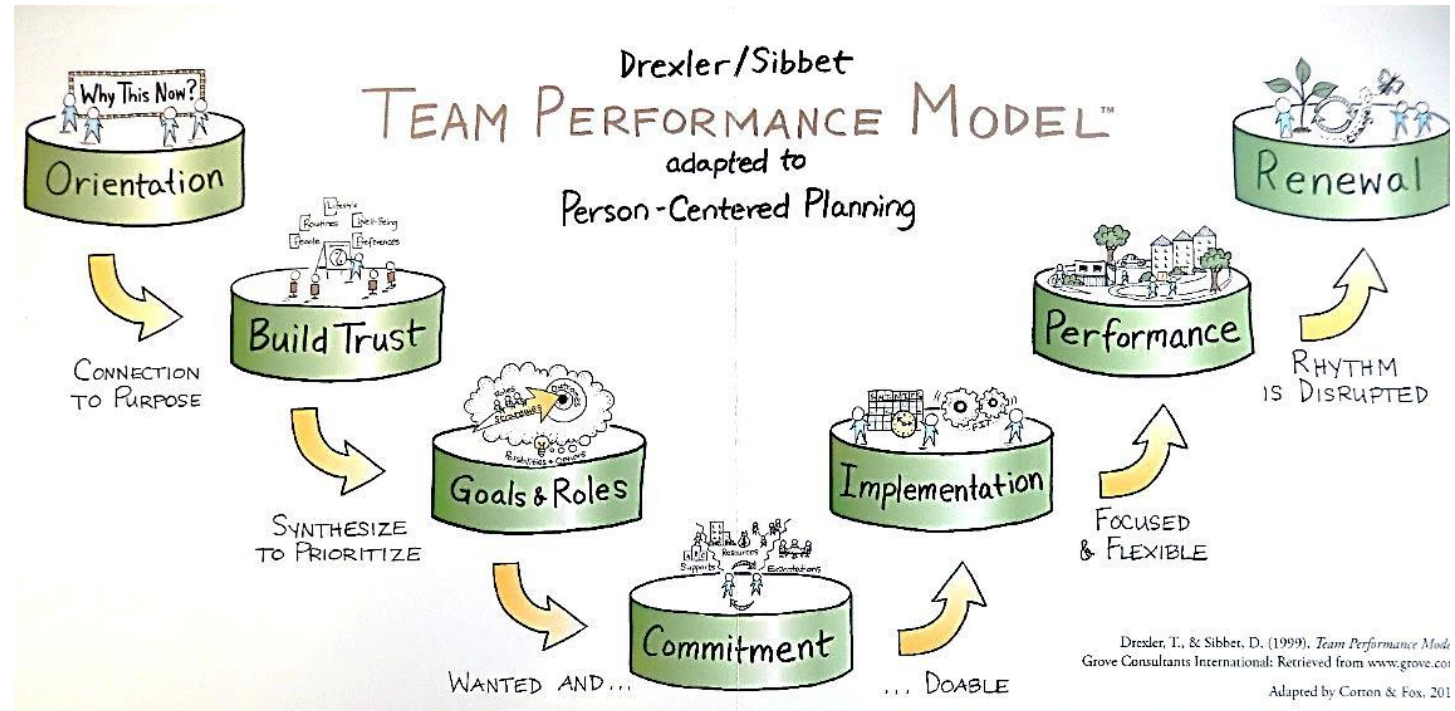
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# Module 6

## ➤ Team Performance Model

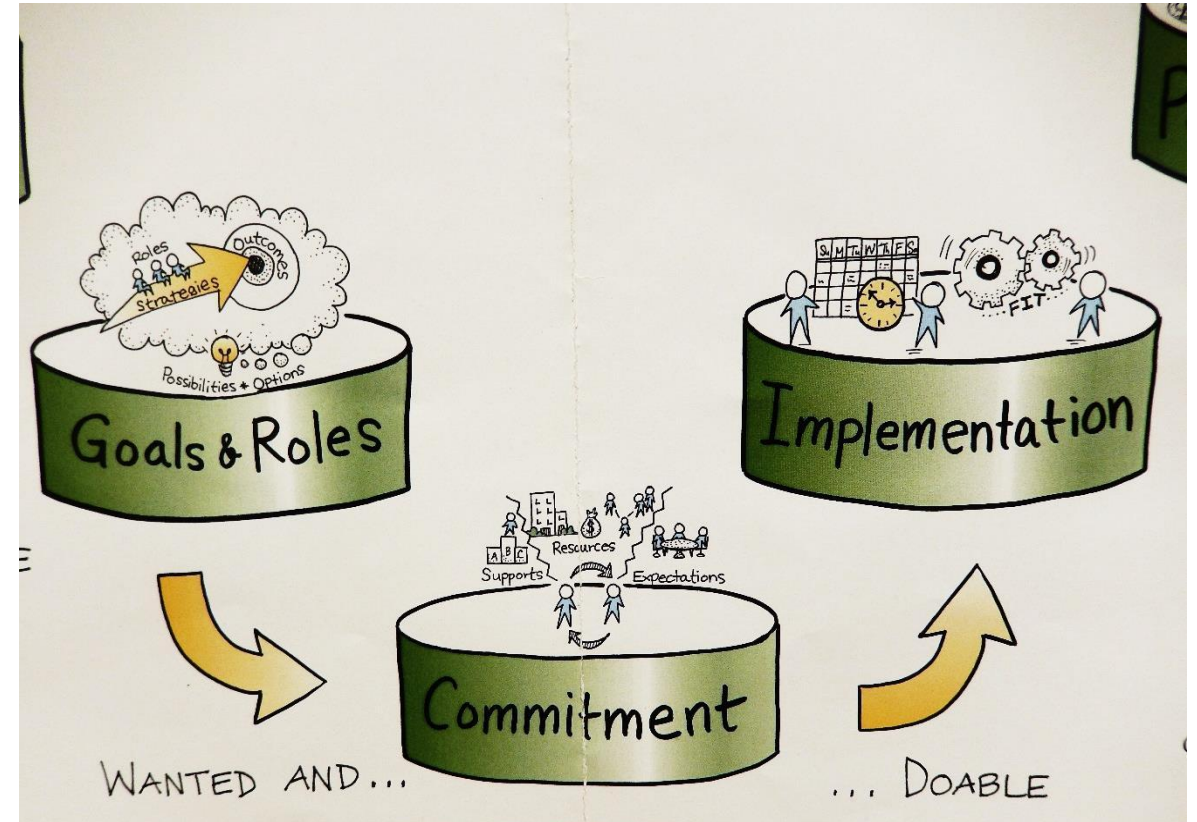
- Orientation
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- **Identify goals and roles**
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# Goal Clarification

## Decision Making Tools

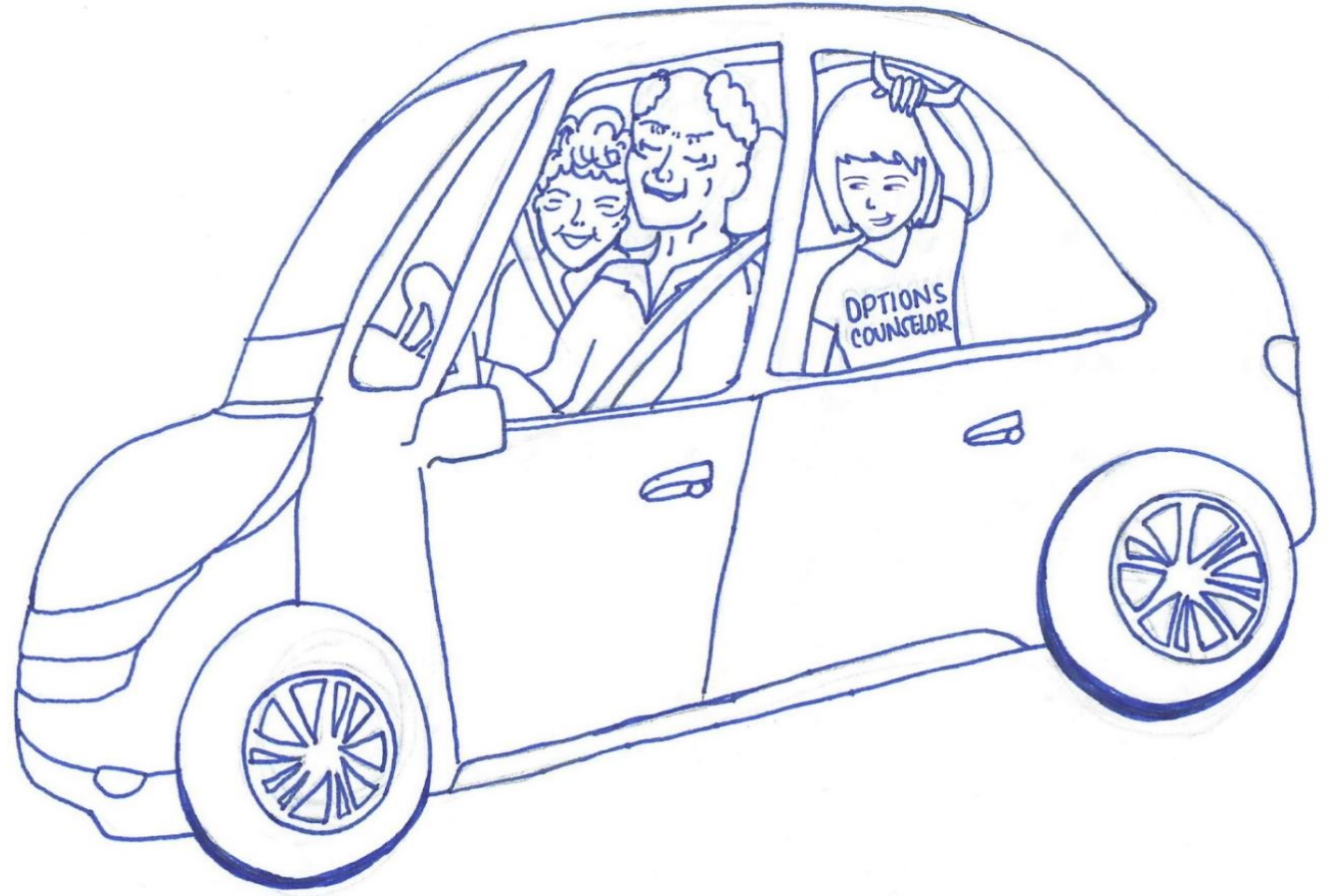
- Envision Success (Outcomes)
- Explore Possibilities (Opportunities)
- Understand Choices



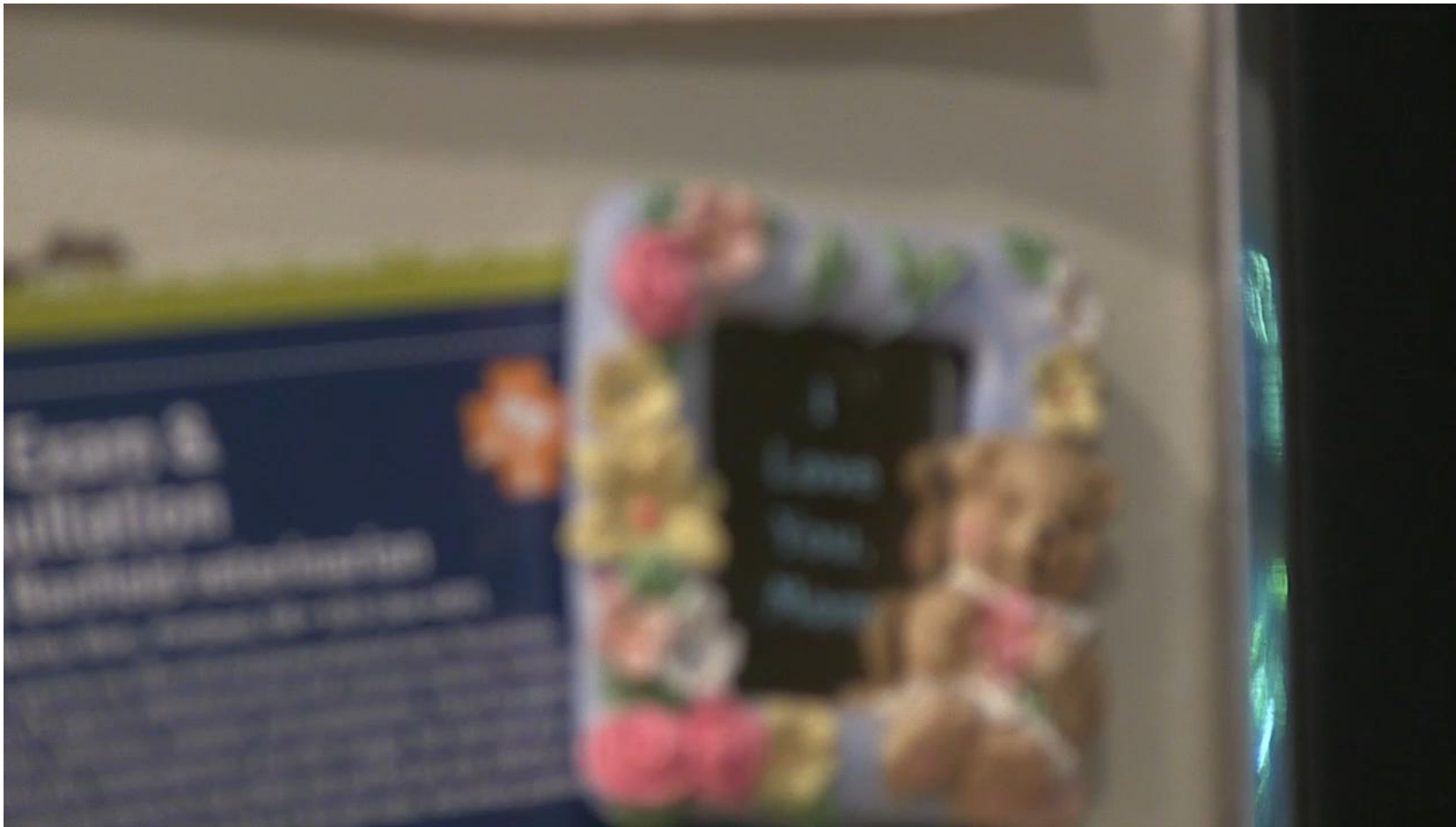
# Goal Clarification

## 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

<u>Sarah</u>	<u>Bill</u>	<u>Joyce (Daughter)</u>	<u>Jon (son)</u>	<u>OC</u>
COMMUNICATE DESIRED VOLUNTEER/ COMMUNITY PARTICIPATE	Talk to hospital coordinator Take Sarah to concerts	Talk to friends about taking Sarah to activities.	VOLUNTEER WITH SARAH FOR MEALS ON WHEELS	Provide resources to promote involvement

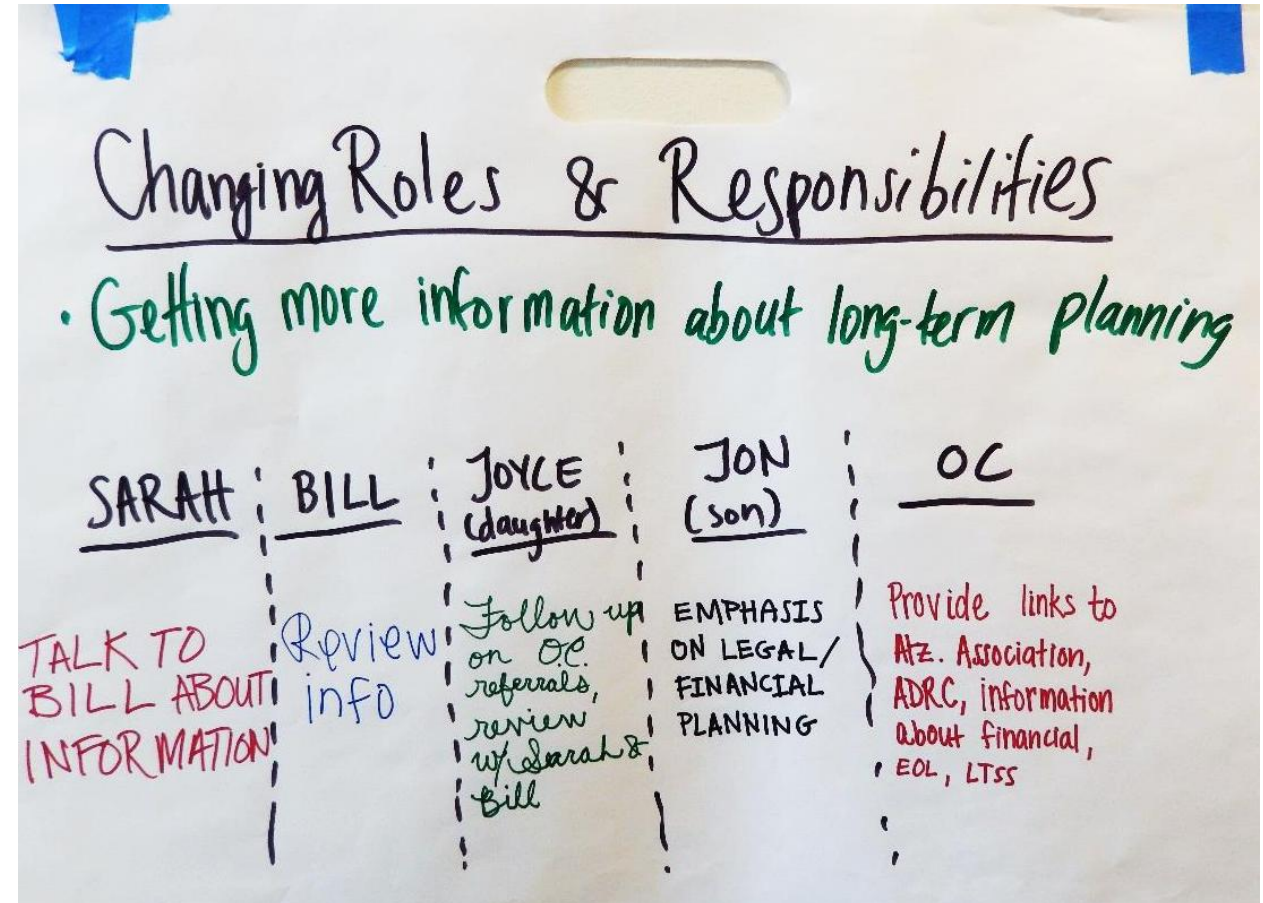
# Implementing Sarah's Plan

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

Support Roles	Descriptors	Details
<b>Morning routine</b>	<ul style="list-style-type: none"> <li>• Reading the paper</li> <li>• Taking a daily walk</li> <li>• Meeting friends for breakfast on Saturday mornings</li> </ul>	<ul style="list-style-type: none"> <li>• Dennis needs a daily paper to have a good start to the day</li> <li>• Walking in the neighborhood helps keep Dennis healthy and involved with people, but it puts him at risk as dementia progresses</li> <li>• Eating lunch with golfing friends is a long-standing routine enabling him to reminisce and joke with old friends</li> </ul>
<b>Daytime supports</b>	<ul style="list-style-type: none"> <li>• Eating a hot lunch</li> <li>• Going to the community center</li> <li>• Spending quality time with Sally</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to work the microwave leads to anxiety and frustration</li> <li>• Sally and Dennis have their best times over lunch</li> <li>• Sally values time with Dennis, but can't be there every day. Completing tasks for Dennis takes away from quality time with Dennis</li> <li>• Playing cards lifts Dennis' spirits – he seems to be happier and less confused afterward</li> </ul>
<b>Evening routines</b>	<ul style="list-style-type: none"> <li>• Talking with Lola</li> <li>• Watching news</li> </ul>	<ul style="list-style-type: none"> <li>• Dennis and Lola enjoy shared time, especially talk of sports</li> </ul>
<b>Errands &amp; chores</b>	<ul style="list-style-type: none"> <li>• Assistance with housekeeping, Laundry, grocery shopping, meal preparation</li> </ul>	<ul style="list-style-type: none"> <li>• Household chores are taking time away from Sally's personal time with Dennis</li> <li>• Meal preparation for Dennis is part of Sally's own family routine</li> <li>• Grocery shopping with Dennis is increasingly challenging for Sally but enjoyable for Dennis</li> </ul>

# Dennis' daughters



*Sally*



*Dennis*



*Lola*

# Commitment & Implementation

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- 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

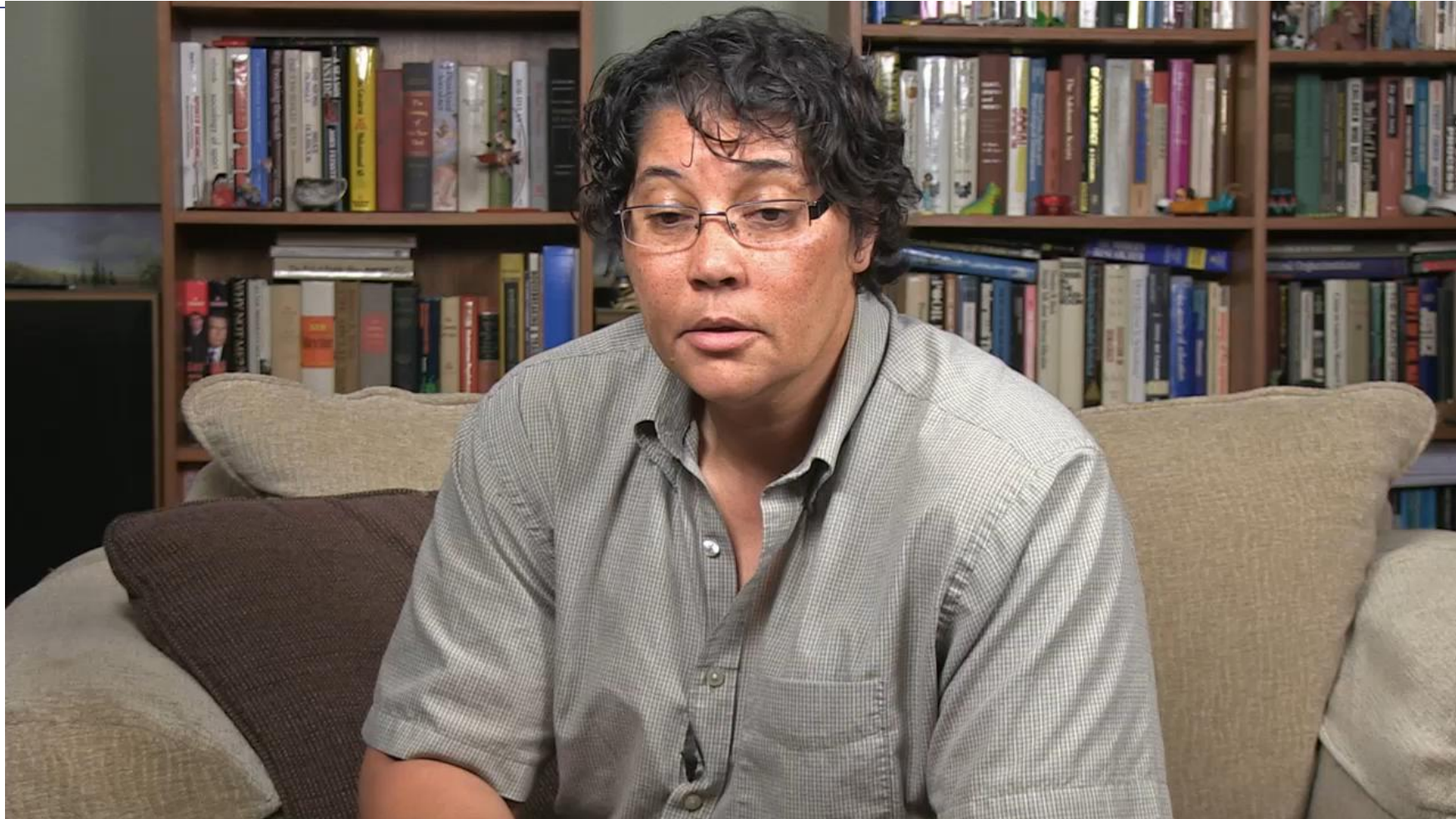


# Sofia's (Dennis' Option Counselor) Description

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# Sally's (Dennis' daughter's) Reflections



# Dennis' Experience



# Action Planning to Meet Goals & Commitments

Routine	Examples of family commitment
Morning paper	<ul style="list-style-type: none"> <li>• Sally and Home Care Worker (HCW) will monitor Dennis' ability to understand sign on the door</li> <li>• Sally and Fred will make sure there is extra reading material at the breakfast table</li> </ul>
Walking	<ul style="list-style-type: none"> <li>• HCW to walk with Dennis when she arrives</li> <li>• Lola will get a device to attach to Dennis' watch so his location is known</li> <li>• Sally will ask neighbors to watch for Dennis</li> </ul>
Lunch	<ul style="list-style-type: none"> <li>• Sally will continue to prepare meals for Dennis when she cooks for her household</li> <li>• Sally, Keisha, Fred, HCW will take turns coming to lunch; Sally will eat with Dennis and reduce the number of housekeeping tasks</li> </ul>
Housework, chores	<ul style="list-style-type: none"> <li>• HCW will do laundry, housework; in the future help with ADLs</li> </ul>
Cards, visiting	<ul style="list-style-type: none"> <li>• Fred will continue providing rides to Saturday breakfast, will take Dennis shopping</li> </ul>
Planning	<ul style="list-style-type: none"> <li>• 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</li> <li>• Lola and Sally will communicate</li> </ul>

# 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

# Visual Tools: Suggested Learning Activities

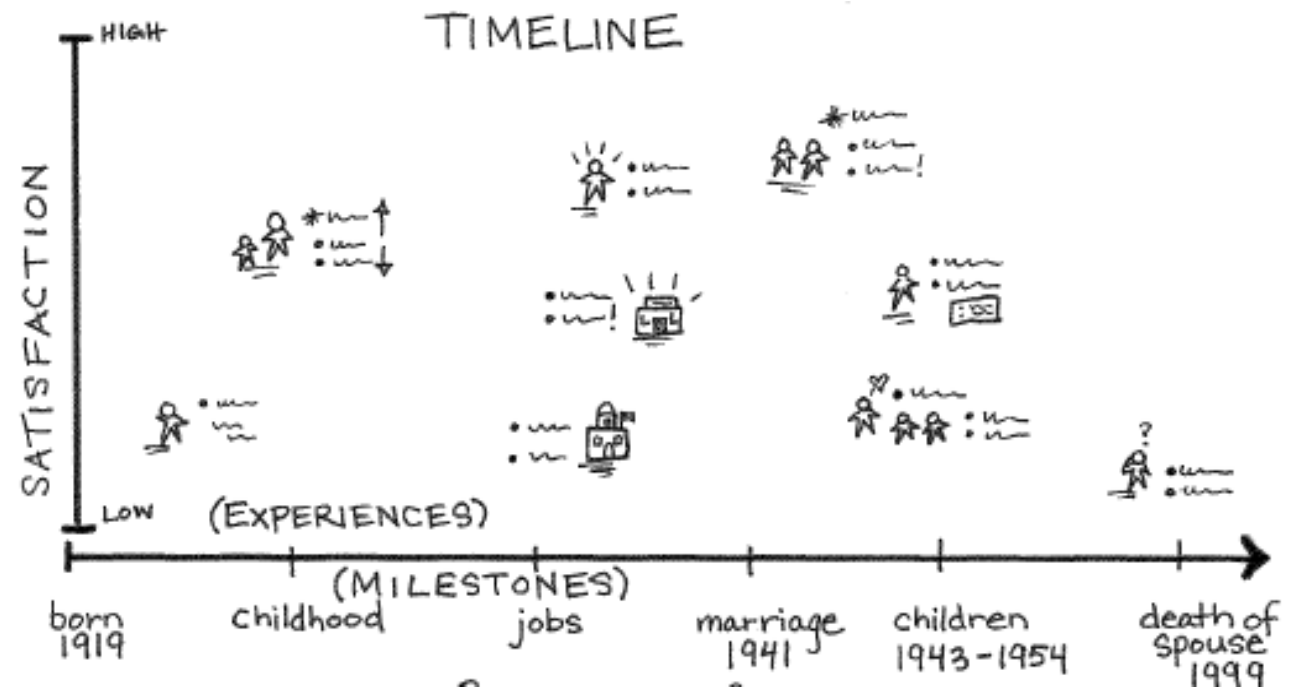
➤ **Use the “what’s working” “what’s not working” in a staff meeting.**

- 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)



# Preview, Module 7

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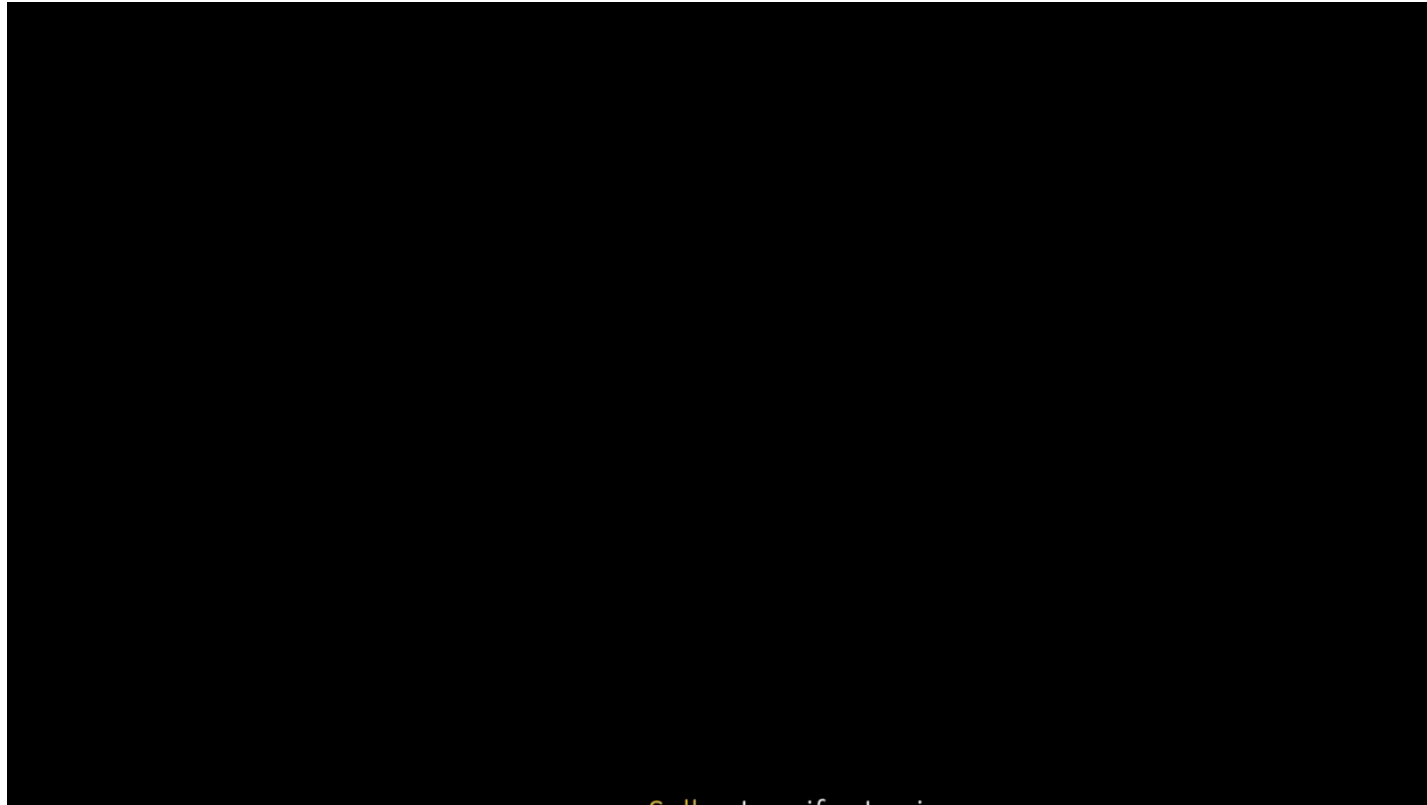
- Common care transitions experienced by persons living with dementia (psychological and physical transitions)
- The intersection of dementia with depression, and delirium
- Risks associated with care transitions.
- Supporting families through transitions.



# Thank You!

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[www.HelpforAlz.org](http://www.HelpforAlz.org)



# Feedback Survey

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<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.