**Module 1: What Is Options Counseling And**

**How Is It Similar To What We Already Do?**

**Slide 1**

Welcome to this information session on Options Counseling and Virginia’s Options Counseling Standards. This presentation was prepared by the Virginia Department for the Aging and the VCU Partnership for People with Disabilities, working closely with seven CILs and seven AAAs who have been participating for the past two years in a grant that Virginia was awarded in 2010. Under the grant, a statewide workgroup developed Virginia’s Standards, and the local CILs and AAAs co-employed Options Counseling Coordinators to begin offering Options Counseling under the Standards. You can find the Standards themselves on the webpage with the link to this presentation.

This module, Module 1, has been prepared to give you an overview of Options Counseling and how it is different from—or similar to—supports that you and your agency might currently offer. We will also cover the statewide Options Counseling Standards and discuss how they were written.

This presentation is designed to give you background information that will be helpful as you complete other modules.

It should take about 45 minutes to complete.

**Slide 2**

The term Options Counseling has sometimes been abbreviated “OC” in this slide show.

 Let’s look briefly at the goals for today’s presentation. We will:

* Learn how the statewide Options Counseling Standards were developed and why they are important;
* Review the Options Counseling philosophy, guiding principles, terminology, and eligibility;
* Examine the components and features of OC in a little more detail – but still at a birds-eye view.
* Determine how OC is different from or similar to other services and supports offered by your agency; and
* Review the mission and roles of Virginia’s Aging and Disability Resource Connection (ADRC or No Wrong Door) and learn how OC fits into the ADRCs.

We will also let you know how you can get answers to your questions about the material in this presentation and ask for your evaluation of the information session.

**Slide 3**

Let’s start by learning a bit about the Standards -- and how and why they were developed. Again, you can find the Standards themselves on the webpage that links to this session.

**Slide 4**

Options Counseling is a new name to some, and a new approach to others. The essential components of OC are the same components that the CILs have used for many years in their “Peer Counseling” program. In Peer Counseling, a person with a disability assists other persons with disabilities to achieve the independence **they** desire by taking time to get to know the person, sharing experiences, providing information and resources, and giving support. One critical aspect of the Independent Living philosophy is a conversion from the “Medical Model” to the “Independent Living Model” (or “Social Model”) of understanding disability. This model gives people with disabilities a new way to explain their identities as people with disabilities and also helps providers and supporters embrace a support model (paradigm) for assistance and interaction.

Options Counseling is one way that is helping make the same conversion for older adults: from a Medical Model to an Independent Living Model. Some of Virginia’s AAAs have been incorporating some of the elements of OC into the supports they currently offer, and the grant has enabled them to also deliver OC as a stand-alone support.

Through working together under the same Standards, the CILs and AAAs have learned much from each other, with the result that the supports now being offered to both people with disabilities and older adults are serving them better than ever. In other modules, you will learn more about how people are supported through options counseling.

**Slide 5**

So why do we now have “Standards?”

Options Counseling is national in scope, and national draft Standards have been developed in cooperation with the states receiving grants. Standards provide a framework for consistency, ensuring that similar descriptions and practices are used across the country. Virginia is pleased to have had maximum input into the development of the national Standards. It is very clear that OC is becoming an important element of ensuring people with disabilities and older adults can remain in their homes and communities.

The recent grants to the states required the development of state-specific Options Counseling Standards.

The Standards developed assure individuals with disabilities and older adults receive the same support regardless of their geographical residence and regardless of the agency providing OC.

Standards also contain minimum requirements that add a level of professionalism to any support or service being provided by an agency.

In the future, “fully functional” Aging and Disability Resource Centers (ADRCs; in Virginia Aging and Disability Resource Connections or No Wrong Door) will provide Options Counseling under statewide Standards, and it is very likely that future funding may depend on the degree to which OC has been integrated into the ADRC—making it clear that OC is here to stay. Later in this Webinar we will cover ADRCs in more detail.

**Slide 6**

Virginia’s Standards were developed by the aging and disability communities working closely together. A large and diverse work group representative of individuals who use aging and disability services and agencies that work with each of these populations came together. All seven of the CILs and all seven of the AAAs participating in the grant, as well as the seven co-employed Options Counseling Coordinators hired under the grant, actively participated in this work group.

The state agencies represented on the work group included the Department of Behavioral Health and Developmental Services, the Department of Medical Assistance Services, the Department of Social Services, the Department of Rehabilitative Services, the Department for the Blind and Vision Impaired, the Department for the Deaf and Hard of Hearing, and the Virginia Board for People with Disabilities in addition to the Virginia Department for the Aging and the Partnership for People with Disabilities at VCU. The Virginia Office for Protection and Advocacy (VOPA) also participated, as did the Office of the Secretary of Health and Human Resources.

Three sub groups worked over several months to develop the “meat” of the Standards. Although there were differing opinions on some issues, the work group resolved them all, and the final product represents a consensus of everyone participating.

**Slide 7**

Before we take a closer look at OC under the Standards, let’s reflect on a few important reasons for OC in the first place.

Many agencies have historically considered only the services and supports that that particular agency offers. While these services and supports are critical, they rarely represent the entire range of options available to an individual IN THE COMMUNITY AT LARGE. OC opens doors to consideration of ALL available options—not just those the agency happens to provide.

Through agencies working together and learning from each other, the range of options suddenly increases.

All of you are familiar with the many issues surrounding the provision of long-term supports:

* + Institutional placements too frequently occur without consideration of available community options;
	+ Institutional placements are generally more expensive than community options;
	+ In increasing numbers, people want to stay at home or “age in place”—they DO NOT want to be institutionalized;
	+ Lots of information is available on-line, but it can be complex, contradictory, and confusing; and
	+ Few people plan ahead for long term support needs

Options Counseling—because it is focused on what individuals want, not what agencies can provide-- can go a long way toward addressing all of these issues.

Just as importantly, OC honors individual choice. None of us wants to lose control of our decision-making—or our lives. OC allows people to retain that control!

**Slide 8**

With that background and context, let’s now turn our attention to what the Standards cover. We have tried to make it easy for you to identify the content of the Standards: all references to the Standards appear in orange and light blue and display the “star” symbol at the bottom right.

This module presents some important basics – and more specific information is in other modules.

**Slide 9**

These are the basic elements of OC in the “official” definition in the Standards. Note first how the terms “individuals,” “they,” and “their own” appear in bold. This is because OC is focused exclusively on individuals and what THEY want for THEIR future. It is NOT focused on what we or anyone else THINKS the individual wants or what we THINK is best for the individual. Through interacting with an Options Counselor, individuals decide how much support they want and who participates with them in OC. Based on the individual’s own preferences, strengths, needs, values and individual circumstances—and presented with a range of options available to help them meet their own goals—individuals themselves decide what they want for their own future.

Many people refer to this process as “person-centered.” While we will not be covering person-centered practices in the recorded part of this Webinar, if you are interested in learning more about them, you can find material at the end of this slide show.

**Slide 10**

There are three guiding principles that frame how we view OC in Virginia:

* Options Counseling involves respecting the right of individuals to control and make choices about their own lives.
* Relationship-building and establishing trust are essential to understanding individuals’ preferences and needs; options counselors must take time to listen and use culturally competent, person-centered approaches.
* Options Counseling is a process, not an event. It may include many contacts with an individual over a short-term period, or it may be ongoing over a longer period of time—the pace and length are up to the individual.

**Slide 11**

Under the Standards, all individuals age 18 and over with a disability and all adults age 60 and over who request long-term supports and/or who are planning for the future regarding long-term supports are eligible for OC. Importantly, individuals are eligible for Options Counseling regardless of their ability to pay. As a matter of fact, another section of the Standards (3.1(D)) prohibits any eligible individual from being excluded from OC.

Many AAAs and CILs are contacted by caregivers wanting options for their family member. While giving them the information is an extremely important service we can offer to caregivers, as it always has been, this is not considered to be OC under Virginia’s Standards. Why? Because individuals themselves MUST be the center of OC so that THEY are making decisions about THEIR own lives—not having someone else make decisions for them. There is only one exception to this, and that is if an individual has a LEGALLY AUTHORIZED surrogate decision-maker. More on that later.

**Slide 12**

NOT EVERYTHING WE DO IS OPTIONS COUNSELING.

This slide and the following slide contain the essential components (distinguishing features) of OC. You will see many individual components that are essential to the supports your agency currently delivers—for example case management, service coordination, communication, referral, information and assistance. However **all** of the elements **must** be present for the support to be considered OC. If one or more is missing, it is something else, but it is **not** OC:

* First (and you will hear this time and time again)—OC focuses on **the individual-**-not on the caregiver, not on the agency or what the agency provides, not on the staff, not on anyone or anything else except the individual.
* Two examples of how OC focuses on the individual are that he or she controls the time spent in OC and whether anyone else participates in OC. Not everyone moves at the same pace! The time spent with an individual in OC is totally dependent on what the individual needs and wants. Unless the individual has a legally authorized surrogate decision-maker, the individual alone –not the Options Counselor--decides whether anyone else participates in OC.
* The individual—NOT the Options Counselor or anyone else--weighs the pros and cons and potential implications of the various options available.
* When the individual has made decisions, the Options Counselor assists him or her to develop an individual action plan identifying goals, action steps needed to reach the goals, time lines and responsible parties.

**Slide 13**

* Relationship-building is a critical OC component. OC is not just a 1 or 2-time chance encounter with someone—it is an ongoing process by which an Options Counselor and an individual develop a trusting relationship and rapport.
* The Options Counselor gathers information about individuals’ current circumstances—what they want, need and prefer—then shares information about the entire range of long-term support options available in the community to help them get where they want to go.
* The Options Counselor also offers whatever “decision support” the individual may need in order to make informed decisions.
* The Options Counselor then follows up with the individual, including assisting with enrollment in publicly funded services and supports, but also importantly-- connecting the individual to privately purchased and/or informal supports. The Options Counselor also tracks the individual over time to make sure that his or her goals are being achieved.

**Slide 14**

Let’s now look at the essential components of Options Counseling in more detail, and in sequence.

Again, from the very start to the very end of OC, the individual is the focus of everything that happens. We all have unique preferences, strengths, values, needs and individual circumstances. Older adults and individuals with disabilities are certainly no different!

As an Options Counselor, it is very important to be aware of your own uniqueness and separate that entirely from the individual’s. This seems simple, but it can be very difficult, especially when you have strong opinions or you might make a different decision than the individual makes. The Options Counselor’s own opinions are NOT a part of Options Counseling.

**Slide 15**

As OC starts, it’s important to understand two basic concepts:

1—As we mentioned before, the amount of time spent in the entire process of OC is dependent solely upon how much time the individual wants to spend. It can be several brief encounters, or fewer longer encounters—whatever the individual wants. Time is not controlled by the OC, by the clock, or by anything or anyone else!

2—It is critically important to identify who, if anyone else in addition to the individual, will be participating in the OC process. Under the Standards, the Options Counselor, the individual, and any other person the individual wants to involve (for example a family member, caregiver or close friend) are the participants in OC.

There are two exceptions to this basic rule:

* + If the individual declines to have other individuals present--at any point in the counseling-- the Options Counselor must respect the individual’s wishes.
	+ If the individual has a legally authorized surrogate decision-maker, the Options Counselor must require that the surrogate decision-maker be present through all phases of Options Counseling. This is because only that person is legally authorized to make decisions as a result of OC.

**Slide 16**

Again, if the individual has a legally authorized surrogate decision-maker, that person **must** participate in OC because they must make the decisions that result. So what is a surrogate decision-maker? This is the definition in the Standards: a person legally authorized to make decisions on behalf of an individual.

It is important to note that in Virginia, there are only two types of **legally authorized** surrogate decision-makers: a court-appointed guardian, and a power of attorney that has become active (in other words has been triggered) due to an individual’s inability to make his or her own decisions.

**Slide 17**

If an individual does not have a legally authorized surrogate decision-maker, Section 3.2(A) of the Standards calls on the Options Counselors to actively encourage the individual to involve others, who provide support to him or her, in the Options Counseling process. The presence of trusted family members, friends or caregivers in Options Counseling may have many advantages for the individual:

* It may assist the individual be more comfortable talking to the Options Counselor – who is, after all, a stranger at first.
* It may assist the individual to express and focus on his or her preferences, values and needs, and explain his or her current circumstances.
* It may assist the individual to identify and articulate goals and offer ideas about how the goals can be reached.
* Lastly, others may have some role in assisting the individual to implement certain action steps in the Individual Action Plan.

But remember: It is the individual’s decision—not the Options Counselor’s!

**Slide 18**

Because Options Counseling is an interactive process, the Options Counselor builds rapport and a trusting relationship with the individual participating in OC. Some things that need to be considered may be sensitive for the individual to talk about. Without a basic trust, very little can be accomplished.

Because the options available to an individual depend upon the individual’s unique circumstances, desires and needs, the Options Counselor actively listens to what the individual says. There is no place in Options Counseling for any assumptions or preconceptions of what an individual wants or needs.

We are all unique, so Options Counselors always understand –and respect—individual differences.

Using “person-centered practices” is simply another way of saying the focus is always on the individual and these practices are at the core of OC. Again, there are several slides at the conclusion of the Webinar if you wish to learn more about person-centered practices.

**Slide 19**

Only through relationship building, active listening and information gathering is the Options Counselor is in a position to know what options may be available to the individual.

These options might include long-term support that is available in the individual’s community, or planning ahead for long-term support if it is not needed currently. If agency-provided supports are an option, the individual needs to understand how they work, whether self-direction is available and the differences between agency-directed and self-directed supports. Any Medicare or Medicaid options that might be available to the individual are also shared. Last but not least, there may be other supports and benefits available to the individual including:

* + Informal supports;
	+ Social security benefits;
	+ Financial and legal planning resources;
	+ Older adult or disability rights resources;
	+ Housing and transportation resources;
	+ Opportunities for employment or volunteering;
	+ Social and recreational resources;
	+ Communication and assistive technology resources; and
	+ Caregiver support.

Note that “available in the individual’s community” is underlined twice. This helps us remember that the range of options available to an individual’ can go far beyond the options available through any particular agency.

**Slide 20**

Under Section 3.2(F) of the Standards, all decisions made as a result of Options Counseling are made by the individual or the individual’s surrogate decision-maker. While it’s always a nice thing if everyone else, including the Options Counselor, concurs, no one else has any decision-making role.

**Slide 21**

Support plays a very important role in OC, on three different levels:

1. The individuals’ supporters are involved in OC as the individual wishes, which we just talked about.

2) Here we want to focus on the second type: decision support which is provided to the individual during OC. This includes things like:

* Honoring requests for additional information
* Providing Options Counseling in the environment that the individual chooses
* Using the method or mode of communication that the individual uses and prefers
* Explaining potential risks, consequences and costs of each available option
* Exploring alternatives and arranging on-site or virtual tours, for example when someone’s goals are not realistic or attainable (e.g., “When I win the lottery I want to build a mansion”)
* Coordinating transportation or giving the individual the information to coordinate transportation
* Helping the individual articulate his or her own values, needs and preferences
* Listing options, as requested, and their consistency with the individual’s stated goals
* Clarifying the roles of the individual and the Options Counselor
* Providing information and facilitating decision-making at a pace appropriate to the individual

3) Lastly, connection with supports and support systems in implementing the individual action plan that results from OC, which we will examine in a minute, is an important part of Options Counseling.

**Slide 22**

The Standards define Individual Action Plan as a documented plan developed by the individual with the support of the Options Counselor as a result of Options Counseling that contains the individual’s goals, along with the action steps, resources needed, time lines and responsible parties to achieve the goals. The action plan includes all of the decisions the individual makes as a result of Options Counseling, but it is a flexible document that can be adjusted as the individual works to reach his or her goals.

The Individual Action Plan is a critically important document for both the Options Counselor and the individual. It is something that the individual can take home, study, and use to implement and measure progress in meeting his or her goals. The Options Counselor will also be using it to make sure that the individual’s plan is being implemented as intended, and that the Options Counselor is taking the steps needed to help the individual reach those goals.

It also has an important role in evaluating the success of OC for the individual.

**Slide 23**

This is a graphic representation of the elements that each Individual Action Plan contains.

**Slide 24**

The Options Counselor arranges for delivery of the supports chosen by an individual as a result of Options Counseling, involving others as needed to get the supports fully in place by:

* Assisting with referrals; and
* Conducting follow up to assure referrals are in place and adequate for the individual’s support

The Options Counselor also assists the individual to make an effective transition to the supports that the individual has chosen by:

* Contacting the individual and conducting other follow-up as necessary to verify referrals made;
* Determining whether the referrals were implemented effectively; and
* If adjustments are needed, supporting the individual in determining the best alternative course of action.

Once the supports are in place, the Options Counselor follows up to determine the extent to which the individual’s goals have been met. A uniform instrument, administered in the method or mode of communication that the individual uses and prefers, is used to measure individual’s satisfaction with the Options Counseling process and the choices the individual has made.

Options Counseling may be terminated when an individual:

* Is no longer seeking support;
* No longer has unmet goals;
* After six months has not responded when contacted;
* Has exhausted an appeals process and there is a finding that termination is necessary; or
* Is dissatisfied and the Options Counselor has no further alternatives available to the individual.

**Slide 25**

Let’s now turn our attention to examining more closely how OC is similar to and different from the services and supports your agency currently provides.

**Slide 26**

First, let’s look at what OC is NOT.

As we mentioned before, OC certainly involves identifying and offering options available to an individual, but that’s only a part of OC. With OC, options are not even considered until there is a clear understanding of the individual’s current circumstances, preferences and needs. Let’s look at an example: A 75-year-old man contacts your agency looking for energy assistance. With some initial questions, your agency may begin to assess his situation and collect some information to determine if he may be eligible for an assistance program offered by DSS, your agency, or a local organization. Options presented to him may in large part be driven by the programs for which he qualifies. If the same individual were to engage in OC, however, many additional options might become evident as you get to know the individual. Let’s say you learn that the individual is extremely unhappy having to live with his daughter—she never pays the bills even when he chips in his part—and his real goal is to move out of her home. The options—and really what the individual wants—suddenly shift from energy assistance to finding appropriate housing. Or let’s say the individual doesn’t want to move out, but complains that his daughter likes the house a lot colder than he likes it. The individual’s goal is not really energy assistance, but rather staying warm. Options might suddenly include a family meeting with the daughter to see if the issue can be resolved. Or perhaps you may discover that the reason he can’t stay warm turns out to be a longstanding medical condition that he has neglected. Visiting the doctor again would be another option.

OC is also not CRIA, although the elements of CRIA are definitely a part of OC. If someone contacts your agency and wants to know how to get on a Medicaid waiver, you would likely give them the information they need in order to apply for the waiver, and even make a referral for screening. But what if you found out through OC that the real goals of the individual are not going to be attained by getting waiver supports? Or what if you discover through OC that the individual has some means for purchasing services but did not know that services were available on a fee-for-service basis?

As we mentioned before, OC is also not caregiver assistance or support--although certainly support for the caregiver or family member may be a result of OC. Technically, if you are working only with the caregiver, it is not considered OC. In order to be considered OC, the individual himself or herself must be directly involved. During the process of OC with the individual, however, one of the things the Options Counselor may discover is that the individual’s caregiver desperately needs respite or another type of support. The caregiver’s needs can hopefully be met as an adjunct to OC, but caregiver support in and of itself, is not OC.

OC is also not case management—and while OC may lead to a referral for case management, it is not meant to take its place. Alternatively, case management is also not OC. Case management is designed to follow an individual on a longer-term basis, requires the development of a service plan for providing formal and informal supports, and requires the Service/Support Coordinator to maintain regular contact with the individual. OC is designed to support individuals as they explore all of their options and make decisions, formulate a plan of action and access identified supports in order to meet their goals. There is a beginning, middle, and end to the process and although it does not have to be accomplished within a determined timeframe, generally speaking, it is relatively short-term compared to case management.

**Slide 27**

Assessments (sometimes called screenings) serve the purpose of determining unmet needs and eligibility for a variety of supports, including certain types of publicly-funded supports such as a Medicaid Waiver and some AAA services. Individuals engaged in OC may have had an assessment prior to beginning OC and therefore know their eligibility status, while others may not have been through this process AND may not want or NEED to go through eligibility screening. But if an individual **does** want to know whether he or she is eligible for a certain support for which an assessment is required, then the OC can refer the individual for that assessment during the OC process itself, then assist the individual in setting goals based on the information obtained as a result of the assessment. Referrals for assessments can also occur as a part of implementing the individual’s action plan.

We have already covered the difference between an individual action plan resulting from OC and a service or support plan. Depending on the individual’s wishes (and perhaps the results of an assessment), the OC can refer the individual to the provider responsible for developing a service or support plan.

Simply providing information to someone is not the same thing as delivering OC. Simply providing referrals for someone is not the same thing as delivering OC. If you are simply providing information and making a referral, you are not delivering OC. Why? Because many of the essential components of OC are not present.

**Slide 28**

This simple diagram provides a snapshot for the progression of supports offered through No Wrong Door/ADRC in Virginia. The bullets are core components of each support and help to clarify the difference among supports by length of time, eligibility requirements, interaction, individual participation, assessment requirements, planning documents, and method and location of contacts.

**Slide 29**

As we mentioned at the beginning of this Webinar, OC is very similar to Peer Counseling, an Independent Living Model developed and provided by the CILs. The two basic differences between Peer Counseling and Options Counseling are:

* Peer Counseling is provided by a peer
* OC is provided by any practitioner who has been trained in the Statewide Standards for Options Counseling and agrees to adhere to the Standards in the delivery of the support. This requirement has been established to ensure that individuals may access Options Counseling with the same level of quality, regardless of the agency and/or the geographic region in which it is offered.

**Slide 30**

Now that we have explored some of the basics of OC, let’s look at how OC fits into the bigger picture. As you probably know, for some time efforts have been underway both nationally and in Virginia to transform the health and human service system so that it is more person-centered and efficient. Traditionally, both nationally and in Virginia, the system has been disjointed and ineffective, containing silos and barriers to supporting individuals, especially in the community.

One of the transformation initiatives that has been underway in Virginia is No Wrong Door (NWD), Virginia’s approach to ADRC. No Wrong Door is designed to offer a **virtual** single point of entry for accessing public and private health and human supports for older adults and adults with disabilities in Virginia. No Wrong Door is both the **philosophy** that drives the initiative and the **name** that Virginia has given to the Federal initiative called Aging and Disability Resource Connections (ADRC). At times the terms are used **interchangeably**, but most often, when **No Wrong Door** is used, it is referencing **Virginia’s initiative** and when **ADRC** is used, it is referencing the **federal perspective**.

Culture change helps pave the way for more qualitative approaches, such as options counseling, that recognize individuals are in charge of their own choices. Working more efficiently is necessary to focus more time and attention on the individual rather than on paperwork and processes.

Several years ago, Options Counseling was added to the criteria that make up a “Fully Functional” ADRC. More recently, additional language has been added which increases the emphasis upon Options Counseling, calling for “Options Counseling [to] be incorporated into all state and local rebalancing efforts, systems integration activities, transition supports activities, and participant-directed programs.”

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No Wrong Door/ADRC has been influenced by three separate yet related perspectives: Federal, state and local.

**On the Federal level,** AoA (now ACL or Administration for Community Living) and CMS came together to create grant opportunities like the Aging and Disability Resource Center (ADRC) Grant and Systems Transformation Grant (STG). The Federal push was initiated to address the increasing drain on Medicaid and Medicare because of the age wave. This initiative was designed to increase access to services on the community level to keep people out of nursing homes. **It also was the prompt to begin to look at serving several populations through one system.**

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**Virginia’s efforts were also prompted by the Legislature** – through mandated studies to determine the benefits of No Wrong Door and/or Single Point of Entry approaches to long term support. Virginia legislators have been supporting the idea of a No Wrong Door system for years for two main reasons: money that will be saved by reducing or eliminating duplication of effort; and because it is our best opportunity for getting good data with unduplicated counts and a picture of where the gaps in supports are occurring.

**On the Local level,** providers within a community have a tradition of working together on behalf of individuals. Some communities have been trying to create a No Wrong Door approach to long term supports for years because organizations on the grassroots level see frustrated individuals having to tell their story over and over again. In many ways, they have worked together to try to coordinate supports. No Wrong Door has given these communities the tools and protocols to more formally help agencies securely share personal data that is unique to the individual.

**Slide 33**

Today, a network of thousands of public and private organizations in Virginia serve adults with disabilities and older adults, creating a sometimes disjointed delivery system that can confuse individuals and can be equally challenging for providers. While an individual may receive most supports through one agency, often a person may also qualify for and seek supports from other providers, both public and private. In this case, as people bounce from one agency to another, they are often required to repeat the same information over and over again. Additionally, opportunities for continuing and/or increasing independence and autonomy can be missed.

At the same time, providers are asked to do more with less. Resources are limited, and the number of older adults and individuals with disabilities seeking support is growing. It has never been more important to maximize efficiencies, with less time spent on administration and more time providing direct support to individuals.

“The Case for Inclusion,” a recent study by the United Cerebral Palsy organization on the use of Medicaid dollars in supporting individuals with disabilities in community settings, lists Virginia as one of the 10 most deficient states in the country. Virginia ranked poorly because of the high number of people who live in state institutions, long waiting lists and the percentage of dollars spent on institutions rather than community supports. Now it is more imperative than ever that we work together toward a solution!

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In Virginia, ADRC is a **virtual**, single point of entry **system**, rather than a physical place. But No Wrong Door/ADRC is more than the technology. It is also a philosophy of providing supports to individuals, a concept of building collaborative partnerships to bridge barriers and work more effectively together.

These are 8 goals that serve as the foundational blocks for the No Wrong Door/ADRC initiative:

* Streamline access to information and supports;
* Leverage technology to gain efficiencies;
* Assist with Support Coordination;
* Support individuals In avoiding and leaving institutions;
* Strengthen Home and Community-Based Supports;
* Serve multiple populations in one system across agencies;
* Empower individuals to self-direct; and
* Prevent and/or self-manage chronic disease.

**Slide 35**

No Wrong Door/ADRC takes a three-pronged approach: partnering relationship;, collaborative protocols, processes and policies; and an integrated referral system.

Public agencies and private providers form a web-based community offering integrated supports to older adults and adults with disabilities. This model compliments independent living, individual control, and person-centered practices. Home and community-based options are presented, and choice, independence and self-direction are emphasized to support individuals in the environment of their choice, regardless of where they originally seek help.

**Slide 36**

Why did the Feds decide that the first and foremost partnership should begin with CILs and AAAs, and why are they also focused on serving veterans through ADRC?

According to the 2008 American Community Survey, 54 million people in America have a disability, representing nearly one fifth of all people in the community (civilians not in an institution). By age, people with disabilities are 5 percent of children age 5 to 17, 10 percent of adults age 18 to 64, and 38 percent of adults age 65 and older.

Beyond this, now is the time to act as we recognize that the number of individuals with a disability is rapidly rising. There is a 25% jump in the number of veterans with a disability, and there is a growing number of individuals with a developmental disability who are also older adults. Overall, the number of individuals with disabilities continues to increase. With these common threads among people seeking supports, it makes sense to start where the greatest opportunities to strengthen partnerships exist.

**Slide 37**

Options Counseling was not designed to stand alone but rather be a support that is integrated into the array of supports offered by critical pathway partners in the ADRC. Ultimately, the goal is not only for OC to be offered by these partners, but for it to always be offered according to the statewide Standards. This will help individuals better understand the support and what it entails. In Virginia, the current grant has enabled CIL, AAA, CSB and MFP representatives to come together through a statewide work group and develop the Standards. They are first being implemented in the seven CILs and AAAs participating in the grant; we are now positioned to focus on implementing the Standards beyond the agencies involved in the grant. Ultimately, OC may be offered by a wide variety of public and private providers with the same components and by the same Standards.

**Slide 38**

OC is being fully integrated into No Wrong Door and will be required to be a support offered by all ADRC communities.

OC is being integrated into MFP in two ways:

1—Individuals can be referred to Transition Coordination Providers (TCPs) and Case Managers (CMs) as a result of OC; and

2—Options Counselors can serve as MFP “champions” and a “resources point of contact” for TCPs and CMs

OC is the very essence of the Community Living Program which was really the first funding stream for AAAs to help provide OC for older adults. CLP is based on person-centered practices and self-directed supports.

Care Transitions focuses primarily on the process of an individual moving from an acute care facility to home and community-based supports. Historically, the approach was securing services for individuals as they leave the hospital, but more recently, discharge planning begins when a person is admitted and is much more focused on the individual lending itself to OC.

Systems Transformation is a paradigm shift from a model that fits people into service slots to a model that considers each individual’s preferences and life situation. It is a change that will take place over time but the development of statewide Standards for OC is a great step forward.

Other statewide programs such as the Chronic Disease Self Management Program and Lifespan Respite provide opportunities for referrals to OC and vice-versa.

Ultimately, the most important thing is to ensure that any and all individuals who may benefit are given the opportunity to engage in OC.

**Slide 39**

Throughout this Webinar, we have mentioned “person-centered practices” and its importance to OC. While we will not be addressing this as a topic in this Webinar, we have provided slides at the end of this presentation that you can review if you would like. The slides also contain additional resources on person-centered practices.

**Slide 40**

This completes the Module 1 narration. Slides on the importance of person centeredness follow this slide. Please complete and submit the Module 1 post-quiz before proceeding to Module 2.