**Module 3: What Happens During Options Counseling?**

**Slide 1**

Welcome to Module 3 of Virginia’s Options Counseling Statewide Standards Information Session. Module 3, which examines the standards relating to delivering Options Counseling, will take approximately one hour and 30 minutes to complete.

Prior to proceeding to Module 3, please make sure that you have completed Modules 1 and 2, as they provide information which will not be repeated in Module 3. You can find Modules 1 and 2 on the same web page as this Module.

As a reminder, completion of Modules 1, 2, 3 and 4 is a prerequisite to delivering Options Counseling. After you have completed Module 3, you will be asked to take and submit a post-quiz to certify that you completed the Module.

Please note that you have online access to materials that will be referenced. There are many interactive parts of the information session so that you can practice the skills that you will be reviewing. These include “quiet time” exercises that allow you to apply what you have learned, and there will also be role plays along the way.

**Slide 2**

Section 3.2 of the Statewide Standards covers how Options Counseling is actually delivered once someone is referred. In this presentation, we will cover:

* Who participates in Options Counseling
* Providing and obtaining initial information
* Understanding the individual
* Providing information on options
* Decision-making
* Developing the individual action plan and
* Documentation

We will also have additional roles plays and an exercise to help you apply what you have learned.

**Slide 3**

Imagine now that someone has been determined to need Options Counseling and has been referred to you.

* How do you actually engage the individual and his or her supporters in Options Counseling?
* How do you really understand the individual and his or her preferences, values, needs, and circumstances?
* What information will you be providing?
* How are decisions made and by whom?
* How do you support the decision-making process?
* What is an Individual Action Plan and how do you help the individual develop it?
* What should you document along the way?

We hope you will gain a clear understanding of:

* How to deliver Options Counseling according to the Options Counseling Standards and
* How to develop an Individual Action Plan as part of the Options Counseling process.

We will also talk a bit about documentation.

Just as in Module 2, all references to the Standards themselves will be in orange, and the slide will display the “star” symbol in the bottom right hand corner.

**Slide 4**

So let’s get started. What are the very first things an Options Counselor needs to do?

**Slide 5**

Before Options Counseling can begin, the Options Counselor needs to determine who will be participating throughout the Options Counseling process. At a minimum, Options Counseling will of course involve the Options Counselor and the individual who has sought Options Counseling. But it can involve others, too.

* If the individual has a surrogate decision-maker, that person MUST be involved in every phase of Options Counseling (and actually makes the decision or decisions following Options Counseling). We will talk more about this in a minute.
* If there is no surrogate decision-maker, the individual can choose to include others in any -- or all -- of Options Counseling: family members, friends, caregivers –anyone of **the individual’s** choosing.

**Slide 6**

In fact, under Section 3.2(A) of the Standards, all individuals should be strongly encouraged to include supporters in Options Counseling because they can help the individual in a variety of ways. The presence of trusted family members, friends or caregivers in Options Counseling has many advantages:

* They may help the individual to be more comfortable talking to the Options Counselor—after all, he or she is a stranger at first.
* They may be able to help the individual express and focus on his or her preferences, values and needs, and explain current circumstances.
* They may be able to help the individual identify goals and offer ideas about how the goals can be reached.
* They may be a responsible party in implementing action steps in the Individual Action Plan.

But remember: In the absence of a surrogate decision-maker, it is **the individual’s decision** as to who participates—not the Options Counselor’s!

**Slide 7**

If an Options Counseling session starts with others present, and the individual later decides to go it alone, the individual’s wishes must be respected.

**Slide 8**

Exactly what is a surrogate decision-maker? (It’s often also referred to as a “substitute” decision-maker). It is a person **legally** authorized to make decisions on behalf of an individual who has been declared **legally** unable to make their own decisions.

In Virginia, there are only two types of surrogate decision-makers**:** guardians or conservators, and individuals named in a Power of Attorney (POA) that has become active.

It is extremely important to remember that everyone is presumed to have the capacity to make their own decisions unless there has been a **legal determination otherwise**.

* This means that if the Options Counselor has proof in writing that an individual has a surrogate decision-maker you MUST INVOLVE the surrogate decision-maker in every aspect of Options Counseling.
* It also means that UNLESS you have proof in writing, you CANNOT REQUIRE that anyone else be present during Options Counseling. And this is true no matter how the individual appears to you. An Options Counselor should never be placed in the position of determining that any individual cannot make their own decisions—that is something Options Counselors are not necessarily trained to do nor would they be comfortable doing. This could also create a “slippery slope,” whereby individuals who can make their own decisions are wrongfully determined not to be able to make their own decisions.

This raises the issue of how to involve individuals with Alzheimer’s/Related Dementias or other cognitive disabilities who do not have a legally-authorized surrogate decision-maker. As mentioned before, the standards provide that Options Counselors should strongly encourage these individuals to involve their caregivers or friends or family members in Options Counseling. Experience has shown that most people will want to involve them. But what happens in the rare case that the individual does not want to involve anyone? The individual should not be excluded from services, and should always be offered available services, however Options Counseling is not appropriate for them.

Remember: Never take surrogate decision-maker information verbally; always ask for proof in writing, in other words a copy of the Power of Attorney, or a copy of the guardianship order. You need to also verify that the person present with you is in fact the same person named in the Power Of Attorney or guardianship order.On the webpage with Module 3 are three documents to which you may want to refer: Guardianship and Conservatorship in Virginia, a sample guardianship order, and a sample Power of Attorney. We will not be covering these documents in this presentation.

A document called “The Importance of Person-Centered Practices for Substitute Decision-Makers” is also on the webpage with Module 3. This document addresses the need for surrogate decision-makers to use person-centered practices to the maximum extent possible when exercising their decision-making authority. You should give any surrogate decision-maker a copy of this handout and review it with him or her before Options Counseling begins.

**Slide 9**

So let’s briefly review. Under Section 3.2(B)(2) of the Standards:

* + 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 the individual has no legal right to make his or her own decisions. It is NOT because the individual cannot participate in Options Counseling or have input into the decision-making process!!! The individual should always be allowed to participate to the maximum extent possible.
* If the individual has no surrogate decision-maker, the Options Counselor encourages the participation of others, but the **individual alone** decides.

**Slide 10**

Options counselors are often faced with conflicts within a family about the appropriate decisions to make.This can present a challenge in supporting decision making. Perhaps as with Nancy in Module 2, an adult child calls for assistance and has an idea of what is needed to “solve” his or her parents’ issue, but the parent sees no problem or need to change the status quo. What can an Options Counselor do to support the adult child, but also respect the older adults’ right to make his or her own decisions?

Or perhaps as with Joe, an adult with a disability feels stifled by the well-intended attention of his parent. What can an Options Counselor do to support the parent, but also respect the adult child’s right to make his or her own decisions?

Joe lives with his mother and wants to move out. They’ve gotten along okay so far, but tensions started when he turned 22 last year and now are increasing between them. It seems that Mom does not see him as an adult and still wants to take care of him and make decisions for him. Joe is ready to sprout his wings and fly, but he doesn’t know where to start, and Mom doesn’t think he can make it on his own. After all, he uses a wheelchair and can’t get around very easily. Who would be there to make sure he gets into bed at night and up in the morning if not her?

Joe found out about Options Counseling through a friend and thought it would help him decide how to plan his getaway. He told his Mom he was going, and Mom pleaded to go with him. He agreed. After all, maybe she could LEARN something and stop bugging him about wanting to move!

Let’s watch as Joe and Mom meet with the Options Counselor.

**OC welcomes Joe and Mom:** Hello. My name is Amanda, and I am the Options Counselor at the Apple Valley CIL **(pronounced “SILL”**). It’s nice to meet you Joe, and you must be Mrs. Allen, Joe’s mother.

**Mom:** I am. And I don’t understand why we are even here. I can take care of Joe just fine.

**OC:** Well, I’m very happy that you are both here. Joe, can you tell me a little about yourself?

**JOE:** Well I am 22 years old. I’m not in school anymore and I would like to move out on my own like all my friends have.

**MOM:** Joe, I’ve taken care of you all your life. If you move out, who will get you out of bed in the morning? How will you get dressed, shower. It’s unrealistic to think you can live on your own.

**OC:** I understand that you are concerned Mrs. Allen; are you Joe’s guardian or power of attorney?

**MOM:** No but that doesn’t mean Joe knows what is best for him. And I have a legal document that says I get to decide.

**OC:** Let me see that (looks at paper). Well Mrs. Allen, it appears that what you have is an advanced medical directive. What this says is that if Joe gets sick and he’s not able to make decisions regarding his health care, that you are able to make those decisions on his behalf. But an advance directive does not give you the authority to make decisions for Joe in his every day life. Since Joe is an adult, he has the right to make his own decisions.

**OC:** Joe, my job is to help you look at different options and resources so that you can pursue your goals. And if snags come up down the road, I can help you navigate those as well. And Mrs. Allen, I know you are Joe are very important to each other and hopefully we can all work together so that Joe can lead the life he envisions.

**JOE:** That’s great. I want to live in an apartment of my own and have a dog.

**MOM:** You can’t even take care of yourself; how are you going to take care of a dog?

**JOE:** You never think I can do anything but I can do this. My friend Chris uses a wheelchair and he lives in an apartment and his mother doesn’t constantly tell him what he can’t do.

**OC:** Tell me about your friend Chris, Joe.

**JOE:** Chris has a spinal cord injury just like I do. He lives on his own and he has someone come in and help him a few times a day. Why can’t I do that?

**OC:** Let’s look at ways that we can make that happen Joe. Can you tell me how you would like to live? By yourself, with a roommate?

**JOE:** I think I’d live alone with a dog.

**MOM:** There he goes with the dog idea again.

**JOE:** Mom, why don’t you just leave. I didn’t want you here with me to begin with.

**OC:** Joe, maybe you and I could talk alone for a few minutes and then you can decide if you want your mom to rejoin us after we’ve figured out some options for you.

**JOE:** That sounds fine. Mom, I love you but I need to do this on my own.

**MOM (leaving the room in a huff…):** Fine, it’s not like this is going to work out anyway.

**OC:** Based on what you’ve told me today, it looks as if you would like to move into an apartment and be able to get personal care services to help you with some of your daily activities, like getting up, dressing, bathing.

**JOE:** That sounds great. How do I go about getting someone to help me and what if I don’t like that person?

**OC:** Personal assistance is available under a program called the Elderly or Disabled with Consumer Direction (“EDCD”) Waiver. I can help you arrange for an assessment to see how many hours of help you need and then you would be able to choose whether you wanted consumer-directed services where you would choose the person who helps you, or have an agency deliver these services.

**JOE:** Well I would rather have someone I know do it, but not my mom. And I want to live in the city near my friends not in the suburbs.

**OC:** I understand. We can develop an action plan where we can write down all of the steps needed that will allow you to become more independent and live on your own. You said you wanted a dog and I’m wondering if you can tell me more about that.

**JOE:** I’ve just always wanted a dog to keep me company. Not a service animal, just a pet.

**OC:** I love dogs myself. They do require a lot of care and exercise. I wonder if you may want to put that further down in the action plan. That way you could make sure that you were getting the supports you need first.

**JOE:** That sounds like a good idea as long as we don’t forget about it. I guess we should invite my mom to come back in.

**MOM reenters.**

**MOM:** Have you gotten this silly idea out of your head?

**JOE:** No mom, I’m going to move out and Amanda is going to help me.But I’m going to wait on the dog for awhile.

**OC:** Mrs. Allen, I know how difficult this must be for you, but Joe has very realistic goals and really wants to be on his own. We can help him find an accessible apartment and obtain personal assistance services so that he has the help he needs. Maybe you could tell Joe what some of your specific concerns are about his plan.

**MOM:** Well he’s just never been on his own. I’ve always done everything for him and what if he gets hurt or someone takes advantage of him.

**JOE:** Mom, I know you are worried. But I’m not a kid anymore and I need to be able to live my life. And you need to let me try.

**MOM:** Maybe you ‘re right. I’m not getting any younger and I won’t be around forever. You do need to learn to take care of yourself.

**OC:** Okay, it sounds like we have a consensus that we will put together a plan to help Joe move out on his own into an accessible apartment with personal assistance services. And then Joe, I know you want to work as well and so we’ll talk more about what you are interested in doing and get you linked up with agencies that can help you get a job.

**JOE:** Okay. I’m psyched to start. I hope it doesn’t take too long.

**MOM:** Well, I’m still not happy about it but I guess it’s not really my decision. I can visit you right?

**JOE:** Yes, mom…..but call first!

That is the end of this role play. We will ask a series of questions and pause a few seconds between them so you can think about them.

* How was Joe feeling throughout this session? How was Mrs. Allen feeling? (***Pause 10 seconds)***
* What family dynamics were at play? (***Pause 10 seconds)***
* Did the Options Counselor do a good job of establishing rapport? Getting information about Joe’s goals? Honoring Joe’s wishes? Acknowledging Mrs. Allen’s concerns? Explaining why Joe alone had to make the decisions? (***Pause 10 seconds)***
* What might you have done differently (if anything) and why? (***Pause 10 seconds)***

You may want to refer to the webpage link with the Module 3 materials entitled “Holding a Family Meeting” for tips on dealing effectively with family dynamics.

**Slide 11**

In Module 2 you also met Nancy, who is concerned about her mother Sarah. Let’s listen as they meet with the Options Counselor.

This is Scene 1:

**OC (alone on phone) calls Sarah; Nancy answers:** Hello. My name is Cory, and I am the Options Counselor at Mountain Lake AAA **(pronounced “Triple A”)**. Am I speaking with Sarah?

**Nancy:** No. I’m her daughter though. I’ve been expecting you to call me.

**OC:** I understand you called and talked with someone here about some assistance that you believe your mother might need. I am calling to make an appointment to meet and talk with her. Is she available?

**Nancy:** Oh, there’s really no need to talk with her. She’s had some problems lately managing her own place and I’m afraid she is going to fall again. I was wondering if you can help me get her moved into an assisted living facility. I can make that decision for her.

**OC:** Are you Sarah’s legal guardian, or do you hold her Power of Attorney that gives you the decision- making authority for her?

**Nancy:** Well, er, no. But why would that matter? She needs to get out of here.

**OC:** Well, unless she has a guardian or active power of attorney, then she can make her own decisions, and that’s very important in Options Counseling. So I need to meet directly with her since she would be the one making any decisions about her future. I will certainly encourage her to involve you, though. You seem to care a lot about her. If Sarah agrees, I can meet with both of you. May I please talk with Sarah now?

**Nancy:** Okay, but she doesn’t know that I called you all so I need to let her know. Hold on a minute.

**Nancy to Sarah:** Mom, this lady is calling from the Local AAA (**pronounced “Triple A”**). She wants to talk with you about how you might be able to get some help since you’re having some problems doing all the things you used to do. Please come talk to her—she won’t talk with me!

**Sarah:** Whatever do you mean, you called to get help for me? I am managing just fine!

**Nancy:** Mom, you know you’ve been having a hard time doing housework, and you fell getting out of the shower last week. You even told me you couldn’t do your yard work anymore—and your grass is getting really high.

**Sarah:** For goodness sake, Nancy. Why didn’t you tell me you were calling them?

**Nancy:** You can be a little stubborn Mom, so I wanted to see if they could help since I work full time and you wouldn’t let me help you anyway. Please—will you talk with this nice lady?

**Sarah:** I don’t want to, but oh—all right--I will. It’ll be a short conversation, though.

**Sarah gets on the phone; Nancy goes back to pick up an extension phone to listen.**

**Sarah:** Hello?

**OC:** Hello. My name is \_\_\_\_\_\_\_\_\_\_\_, and I am the Options Counselor at the Local AAA (**pronounced “Triple A**”). Am I speaking with Sarah?

**Sarah:** Yes, this is she. But I think there’s been some mistake. I’m doing just fine and I don’t need any help.

**OC:** Are you aware your daughter called us because had some concerns about your safety?

**Sarah:** Well, she just told me she had called you . . . But what do you mean, she had concerns about my safety!?

**OC:** She’s concerned with your living situation. I understand that you live alone and perhaps you can’t do as much housework and yard work as you used to. She said that she works full time so she can’t be there to help you do those things.

**Sarah:** I don’t need **her** help. I don’t need **your** help. I don’t have any problems—I’m doing okay right here on my own!

**Nancy:** Now Mom you KNOW you aren’t able to keep this house up. I’m so worried you are going to fall again. You haven’t been able to do your own shopping or much cooking lately, and the city’s going to fine you if your grass doesn’t get cut soon. I want you to live somewhere where you will have people around all the time.

**Sarah:** I’m not leaving my house.

**OC**: I’m not asking to you to leave your house, Sarah. I just want to meet with you to see if there is anything we can think of that would help you.

**Sarah:** I don’t like this one bit, but okay—I’ll talk with you.

**OC:** That’s great. Where would you like to meet and when?

**Sarah:** Well, I don’t drive anymore, so I guess you will need to come here. Is tomorrow afternoon all right?

**OC:** Yes that would be fine. Do you want Nancy to be there when we talk?

**Sarah:** Not really. Well, maybe that’s OK. She can be here, but I’m telling you--I’m not leaving my house.

**OC:** I am not trying to get you to leave your house. I want to work with you to see what you want and see what choices you might have. What time can Nancy meet with us?

**Nancy:** I get off at 5:00 every day. Let’s make it 5:30 tomorrow.

**And this is Scene 2:** The Options Counseling session is scheduled. Now it’s the next day. Let’s see what happens.

**OC:** Hello again, Sarah and Nancy. It’s nice to meet you. I’m Cory, the person you spoke with yesterday. Thank you for arranging to meet with me today.

**OC:** Based on our conversation yesterday, Sarah, I’d like to learn a little more about you and talk with you about some options you might have to continue living in your own home.

**Nancy:** She can’t keep living at home—she just can’t manage by herself any more.

**OC:** Let’s sit down and talk—maybe there **is** a way she could stay here if she gets some help.

**OC:** Sarah, what is your day like usually?

**Sarah:** I get up around 8 a.m., take a shower, and eat some cereal. Then I usually watch TV, read the paper and work the crossword puzzle. I like to stay up late and watch the 11 news before I go to bed.

**OC:** How about lunch and dinner?

**Sarah:** I usually microwave a frozen dinner. Sometimes Nancy brings me dinner, and my neighbor shares things out of his garden.

**OC:** Do you do your own grocery shopping?

**Sarah:** No—I can’t drive any more. My neighbor picks up things for me when she goes shopping.

**Nancy**: Mom, tell her about not being able to do housework anymore, or take care of your yard. And also tell her that it’s hard for you to get in and out of the shower and you fell last week.

**OC:** Sarah, do you want to tell me about those things?

**Sarah:** No. That’s ridiculous. I have no problems, I’m doing just fine.

**Nancy:** You know you almost broke your leg.

**Sarah to OC:** Can I please talk with you alone?

**OC:** Sure, that’s up to you. Nancy, would you mind if I spoke with Sarah alone?

**Nancy, leaving:** Okay. I’ll go into the kitchen. Mom, please tell her the truth!

**OC to Sarah:** Did you really have a fall getting out of the tub?

**Sarah:** Well, I did, but I didn’t hurt myself. Everybody falls occasionally. I’m no different.

**OC:** Well did you go to the emergency room or see a doctor?

**Sarah:** No I didn’t go because I wasn’t hurt that bad.

**OC:** Oh that’s good. Nancy thinks you need to move somewhere else. What do you think about moving somewhere else?

**Sarah:** Nancy means well, I know, but I do NOT want to move anywhere else. I am very happy where I am! Maybe if I could get a little help with my chores, that would make Nancy happy. She does worry about me a lot.

**OC:** Well, we can certainly talk about what help might be available to you stay here.

**Sarah:** That’s great, but I need to think about all of this awhile—can you plan to come see me again?

**OC:** Sure—let’s set a date and time.

We’ll be hearing the next Options Counseling session a little later. For now, let’s think about what has just happened. Just as before, we will pause a few seconds after each question to give you some time consider the answers.

* How was Sarah feeling throughout this session? How was Nancy feeling? ***(Pause 10 seconds)***
* What family dynamics were at play? ***(Pause 10 seconds)***
* When Sarah asked her daughter to leave, Nancy got on the phone and listened to the conversation without Sarah knowing. How did this affect Sarah’s confidentiality and privacy? ***(Pause 10 seconds)***
* Did the Options Counselor do a good job of establishing rapport? Getting information about Sarah’s current circumstances? Honoring Sarah’s wishes? Acknowledging Nancy’s concerns? Explaining why Nancy could not make the decision for her mother? ***(Pause 10 seconds)***
* What might you have done differently (if anything) and why? ***(Pause 10 seconds)***

**Slide 12**

Once it has been established who will be participating, the Options Counselor then:

* Explains and clarifies the roles of the Options Counselor, the individual and others in the Options Counseling process. It’s also important to give the individual an idea of what will be happening throughout the counseling.
* Reviews with the surrogate decision-maker (if any)*The Importance of Person-Centered Practices for Surrogate Decision-Makers,* and gives him or her a copy to take home.
* Under Section 3.1 (D)(3) of standards, “Agencies shall assure that individuals receive and have access to the agency’s existing bill of rights and grievance procedures.” Be sure to give copies of your agency’s bill of rights and grievance procedure to the individual or surrogate decision-maker, explain them and answer any questions that may come up.

**Slide 13**

For Options Counseling to be effective, communication is key, and the Options Counselor must fully understand:

* How the individual prefers to communicate and
* The environment for Options Counseling that the individual prefers.

Not everybody speaks the same language. Not everybody communicates in the same way. Options Counseling will be only as effective as your ability to communicate with the individual, using *his or her communication preferences.* This can present challenges for you, since you are used to communicating in *your* own way. You may have to get a sign language interpreter. You may have to get a foreign language interpreter. You may have to learn to use a special communication device, such as a TTY, if you don’t already know how to use it. Cultural competence is also important for you to achieve. All communications contain words and phrases that may have different meanings to different people, depending on their cultural background.

And remember--your body language also communicates messages without your saying a word! Do you maintain eye contact? Fold your arms in front on you when talking with someone? Make facial expressions that convey your thoughts and feelings about what someone says? Use hand gestures? Always be aware of the messages you may be conveying unintentionally.

The environment for Options Counseling is ideally in person and/or over the telephone, depending on the individual’s preference. After all, it’s much easier to establish rapport and trust when engaging in a personal conversation. However, some individuals may want other environments, such as exclusively via the computer. The environment in which Options Counseling is conducted should be what **the individual prefers--not what you might prefer, or what might be most convenient to you.** This can also present challenges to you. You might have to drive farther than you would prefer to meet with someone. You might think a home visit is the only way Options Counseling can occur, but the individual might not want to meet with you in his or her home. If the individual does not want you to come to his home and can’t or won’t come to your office, you may want to suggest a neutral location, such as a restaurant or library, where you can meet face-to-face with the individual. Have any of you provided any type of counseling on-line? Now that most of us are electronically connected through e-mails, chat rooms, and other media, you very well may have someone who prefers to have Options Counseling delivered exclusively on-line. Are you ready for that?

**Slide 14**

Understanding the individual is the heart of Options Counseling. If the individual is *misunderstood in any way*, everything that follows will be a waste of the individual’s time—not to mention the Options Counselor’s. It seems simple, but it can be very difficult!

**Slide 15**

Each of us is unique. We all have our own likes and dislikes. We have different strengths and skills, and we experience different challenges in our lives. Each of us has our own values and opinions as well.

**Slide 16**

Each of us comes from a different culture and a unique living situation. We each have talents and interests acquired over our lifetime that may be different than others’ talents and interests. People with disabilities and older adults are certainly no different in their uniqueness than anyone else. It is very important to remember each person’s uniqueness in the process of Options Counseling—and to never impose your own values, likes, culture and so forth onto other individuals.

**Slide 17**

OK. Now we are ready for Sarah’s next Options Counseling session a week later. Let’s see what happens this time.

**OC knocks on door; Sarah meets OC at the door**

**OC:** Hello, Sarah. It’s good to see you again.

**Sarah:** Hello, Cory. I’m really anxious to talk about what help I might be able to get to stay here.

**OC:** We can talk about that, but we can also talk about the possibility of your moving somewhere else. Can Nancy join us?

**Sarah**: I guess that’s OK, but I am NOT going to agree to move ANYWHERE. (Calls Nancy into the room; Nancy comes in)

**OC:** Hello Nancy. How are you today?

**Nancy:** Fine thank you. How are you?

**OC (talking to Nancy):** I’m fine, thanks. I have some information about some services available that might be of assistance to your mother to keep her in her home. But I also brought information about a wonderful assisted living facility nearby. Has Sarah had any more problems since we first met?

**Sarah:** No I have not.

**Nancy:** Yes you have, Mom. You told me you are having trouble getting to the bathroom on time. There’s nobody here to help you with that!

**OC:** Well, my own mother was having trouble getting out of the bathtub. I found a wonderful place and took her for a visit. She decided to move there Monday. She still has privacy, but there’s someone around all the time to help her. I’m so happy! Here’s some information about the place she lives. I think Sarah might like it, too.

**Nancy to OC:** I’m so glad you agree with me!

**Sarah:** I don’t care what either of you want, but you’d better figure out some way for me to stay here--I’m NOT leaving my home.

**OC:** Well, if you don’t like this other place, then where else could you go, Sarah?

**Sarah:** I do not want to go ANYWHERE else.

**Nancy:** She couldn’t move in with me—I work and she needs someone with her all day.

**OC to Nancy**: My mother didn’t want to move, either, but after I took her to visit, she was ecstatic.

**Sarah:** Even if I wanted to go—which I definitely do NOT-- who would pay for it? I’ve lived in this home all my life and I am not leaving now for anybody.

**OC:** Sarah, there may be a way for the state to pay for it. Why don’t we just make a date to visit? After I show you the place then you can make up your mind. You can even talk with my mother—she’s so happy there.

**Nancy**: Before you take Mom there I’ll go talk with the admissions coordinator to see if she can be admitted when we visit. I will be back in touch with you.

**Sarah:** But wait! I never agreed to visit that place. Nancy, I’m going to talk to your brother about all of this.

That’s the end of the role play. Let’s think about what has just happened. Take the few seconds following each question to see how you would answer it.

* How was Sarah feeling throughout this session? How was Nancy feeling? ***(Pause 10 seconds)***
* What family dynamics were at play? ***(Pause 10 seconds)***
* Did the Options Counselor do a good job of honoring Sarah’s wishes? Acknowledging Nancy’s wishes? ***(Pause 10 seconds)***
* Did the Options Counselor follow the standards? If not, what did she do incorrectly? ***(Pause 10 seconds)***

**Slide 18**

It should be clear at this point that the Standards require Options Counselors to make every possible effort to understand the individual’s unique preferences, needs, values and circumstances. But how exactly can you do that?

**Slide 19**

Section 3.2(C) of the standards can help!

* Develop rapport and trust with the person
* Actively listen to the individual
* Understand that no two people have exactly the same preferences, needs, values or circumstances
* Use person-centered practices and
* Use a series of questions and scenarios that assist the individuals in evaluating options.

**Slide 20**

Many people do not plan for the future, or find it challenging to think ahead. The Options Counseling process offers an opportunity to customize support to a specific individual’s situation in the context of a relationship of trust. This trust makes difficult conversations about the future possible. Options Counselors can help individuals weigh the pros and cons of different choices by asking questions such as “What might happen if you take no action?” or “What might happen if you tried a homemaker twice a week?” Options Counselors can also assist families to anticipate and plan for future needs by presenting questions to consider such as “What would you like to do when your daughter (caregiver) goes back to work full-time?” and “Where would you like to be living in five years? Ten years?”

Techniques of motivational interviewing can also be helpful in exploring the future with individuals. For example, for an individual who expresses a desire not to move, has some functional limitations, but will not accept help in the home, an options counselor might explore with the individual the importance of staying at home on a readiness scale from 1-10. These conversations about importance level can then lead into what it would take to accomplish staying in one’s own home. Using these techniques to tap into internal motivation rather than rationalizing with individuals about how they should accept help so that they can stay in their home longer will go much farther in moving people toward change.

There is a link to a document on the webpage with Module 3 materials called “UNDERSTANDING THE INDIVIDUAL: SUGGESTED QUESTIONS AND SCENARIOS.” This document was developed by the Statewide Options Counseling Standards Work Group and contains additional questions and scenarios you may find helpful.

**Slide 21**

By getting to know the individual’s circumstances, preferences, values and needs, you now have a good idea of what type of information would be most helpful to the individual. At this point you should be able to clearly understand the individual’s goals. Be sure to articulate the goals back to the individual to make sure that you understand them. Then begin documenting the individual’s goal as the first step in the individual’s’ action plan. Some people may need extensive information in order to weigh options and make decisions; others may need less information. Let’s look at some types of information that Options Counselors should be prepared to provide.

**Slide 22**

It is critically important to remember that the options presented to an individual can go far beyond the options any particular agency has to offer. The information given individuals about options should always take into consideration ALL OPTIONS AVAILABLE IN THE INDIVIDUAL’S COMMUNITY. So the information provided during Options Counseling is always *dependent upon the individual’s unique needs, values and circumstances, and the availability of supports in the individual’s* ***entire*** *community.* And that’s because each person has unique needs, values and circumstances! The following three slides contain the five types of information that most people will want and need; each also references resources that you can use. You should become familiar with all of these resources and offer them to individuals to use as well.

**Slide 23**

1--**Existing long-term support options tailored to individual.** Again, “options” means the **entire range of possible options available in the individual’s community, not just those offered by a particular agency**. “Existing” means options that currently exist for the individual. An Options Counselor may be well aware of many local supports, but may not be aware of others. Three websites can help:

* **Virginia Easy Access**, a secure and confidential connection to community resources for older adults and individuals with disabilities
* **VirginiaNavigator,** a website that allows you to do quick searches, guided searches, and locate resources by topic and community or zip code
* **Call 2-1-1 Virginia,** an easy to remember phone number connecting people with free information on available community services or **visit the 2-1-1 Virginia website** to search for services.

We have included with the Module 3 materials on the webpage a listing of these website URLs as well as all the other websites that will be covered here and on the next two slides.

2--**Planning ahead for long-term support.** What options may be available to the individual in the future? Depending on the choices made now, what would the long-term support look like in the future? It is important to talk about this while an individual still has the capacity to do so.

* Be sure to cover legal decision making tools, e.g., power of attorney, advance directives. Advance directives provide for substitute medical decision-making, while powers of attorney can cover much broader decision-making. A Virginia advance directive form and Power of Attorney form are included with the Module 3 materials on the webpage. We will not cover them in the presentation.
* There is a great toolkit for Own Your Future at the longtermcare.gov website (the URL is contained in the list that was referenced earlier).
* If appropriate, you may want to include information on insurance. If the individual has long-term support insurance, you need to know what it covers and when. If the individual wants insurance, be able to refer them to several choices they might have. We have included a good website resource for this in the list that was referenced earlier.

**Slide 24**

3--**Understanding self-directed and agency-directed supports and the differences between them.** People also need to understand what agency-directed and self-directed mean, and how they are different. In agency-directed supports, an agency hires, supervises and schedules an individual’s personal assistant, respite worker or companion worker. In self-directed supports, the individual hires, trains, supervises and fires a personal assistant, respite worker or companion worker of his or her own choosing. Several Medicaid waivers permit self-direction of personal assistance, respite and companion supports, and is has become the model of choice for most people, particularly those using the Elderly or Disabled with Consumer Direction (“EDCD”) Waiver. The Department for Aging and Rehabilitative Services (“DARS”) also offers self-directed personal assistance to individuals who do not qualify for Medicaid. There are links to two excellent guides posted on the webpage with the Module 3 materials:

* *A Guide to Directing Your Own Supports in Virginia* actually written by people who use self-direction and
* DMAS’ *Consumer-Directed Employer Services Manual*, written by the Department of Medical Assistance Services (DMAS, **pronounced “D-MASS”)**

4--**Medicare and Medicaid Benefits and Options.** You can never know too much about Medicare and Medicaid! You should make full use of the resources on this slide to learn about both programs and share relevant information with individuals participating in Options Counseling. We have included in the website listing with your materials a link to the Medicaid Waivers Guide that is a tremendously helpful resource on all Medicaid Waivers.

**Slide 25**

Information about other supports and benefits is also important to share with individuals during Options Counseling:

* Housing resources
* Transportation resources
* Opportunities for employment or volunteering
* Social and recreational resources
* Communication and assistive technology resources
* Informal supports – those that exist naturally in an individual’s environment, such as friends, family members and neighbors
* Social security benefits
* Financial and legal planning resources, including Veterans benefits
* Older adult or disability rights resources and
* Caregiver support resources

Again, you can find a variety of websites for these resources in the listing referenced earlier.

**Slide 26**

So far we have covered what Options Counselors do initially, ways to understand an individual, and information that should be shared with the individual. Now let’s talk about decisions themselves.

**Slide 27**

Supporting individuals in the process of weighing their options and making decisions is key to Options Counseling, and it is one thing that distinguishes Options Counseling from some other types of support. Let’s take a look at what this means.

Sorting through new information (and possibly a lot of it!) can be difficult for anyone. Relating that information to one’s own options can be even more difficult. Here are some ways in which you can help someone weigh their options and make decisions tailored to their own preferences, values and needs:

* Honor requests for additional information
* Provide Options Counseling in the environment that the individual chooses
* Use the method or mode of communication that the individual uses and prefers
* Explain potential risks, consequences and costs of each available option
* Explore alternatives and arranging on-site or virtual tours—when someone’s goals are not realistic or attainable (e.g., When I win the lottery I want to build a mansion)
* Coordinate transportation or giving the individual the information to coordinate transportation
* Help the individual articulate his or her own values, needs and preferences
* List options, as requested, and their consistency with the individual’s stated goals
* Clarify roles of the individual and the Options Counselor and
* Provide information and facilitate decision-making at a pace appropriate to the individual.

You probably can think of more ways to support decision-making as well!

**Slide 28**

The individual or surrogate decision-maker is in charge of decision making--**preferably (but not necessarily)--**with family members and supporters reaching consensus and the Options Counselor concurring. Under the Standards, **all** decisions made as a result of Options Counseling are made by the individual or the individual’s surrogate decision-maker.

**Slide 29**

Under Section 3.2(F) of the Standards, the Options Counselor must respect the individual’s right to make decisions that entail a certain amount of risk.

In Options Counseling, the individual--not the Options Counselor or the service system--decides where he or she will live, and with whom; what type of supports he or she requires, and who will provide them; how he or she will spend his or her time, which may include the type of employment, vocational or educational opportunities he or she wishes to engage in, and how he or she will relate to the community, which may include joining in community events, taking part in civic groups, and developing and maintaining relationships with others in the community. The individual’s right to make decisions is sometimes called “self-determination.”

As an Options Counselor, it will be easy to accept the person’s decision when it seems right to you. It becomes more difficult when your own personal opinions clash with what the individual chooses. You may even consider the individual’s decision too “risky.” But it is important to realize that you come to this conclusion based on your own life experiences—NOT based on the individual’s life experiences. For example, wouldn’t an individual who has made a career as a fighter pilot have a completely different context for riskiness than you or I do (assuming you were never a fighter pilot!)?

Self-determination is a process that differs from person to person according to what each person determines is necessary and desirable to create a satisfying and personally meaningful life. Options Counselors should provide individuals with opportunities for involvement and control in selecting the types of supports they receive. Asking, “what do you need to help you make this decision better?” can be helpful.

An important tenet that originated in the disability community is the “right to fail,” which captures the spirit of self-determination. It may be difficult to let go of the need for individuals to do the “right thing” or the “safe thing” in the opinion of the Options Counselor. However, if individuals have no legally authorized surrogate decision-maker, they have the right to chose their own options and then revise those based on personal experience—just like we all do.

**Slide 30**

So when would a decision be considered “too risky?” The Standards provide that the Options Counselor must “take action to prevent an individual from engaging in risky behavior consistent with **legal requirements**.” So let’s look at the legal requirements.

As employees of the CILs **(pronounced “SILLS”)** and AAAs (**pronounced “Triple As”),** in certain specified situations you are legally required to report to Adult Protective Services or Child Protective Services. What are those situations? Suspected abuse or neglect (of children and adults) or exploitation (of adults).

The reporting requirement for adults comes from Virginia Code Section 63 point 2 dash 1606: “Matters giving reason to suspect the abuse, neglect or exploitation of adults shall be reported immediately upon the reporting person's determination that there is such reason to suspect…. Reports shall be made to the local department or the adult protective services hotline in accordance with requirements of this section…”

These three terms are defined in Virginia Code Section 63 point 2 dash 100:

* "Adult abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult.
* "Adult neglect" means that an adult is living under such circumstances that he is not able to provide for himself or is not being provided services necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is a written or oral expression of consent by that adult.
* "Adult exploitation" means the illegal use of an incapacitated adult or his resources for another's profit or advantage.

**Slide 31**

Let’s revisit Joe and his Mom for a moment. This time, we have two scenarios that illustrate the difference between a decision that may trigger an Adult Protective Services report and a decision that may not.

**Here is Scenario Number 1.** Joe has moved out into an accessible apartment and is currently receiving personal assistance. His mother comes to visit him on a Monday morning.

**Mom knocks on the door; Joe lets mom in.**

**Mom:** Good morningJoe! It looks like you guys cleaned up your apartment, looks nice. It is so hot outside, I’m going to get a drink. How are you doing honey?

**Joe:** I’m doing ok.

**Mom:** Is Amanda coming over this morning?

**Joe:** Yes mom, she should be here pretty soon.

**Mom (opening refrigerator door):** Joe you have hardly anything in your refrigerator to eat or drink. Is your personal care assistant going to the grocery store today for you?

**Joe:** He went the other day for me and got a bunch of frozen meals, pizza, chips and soda. We invited friends over yesterday for a little apartment warming party, so I guess most of it got eaten.

**Mom:** Honey I know it’s nice to have friends over but you can’t afford for them to eat you out of house and home. You have so much money each week for food in your budget. Are these new friends you have made here at the apartment complex?

**Joe:** No. They are friends of my personal assistant, John. They are all really cool. We had a great time watching movies, listening to music--and I learned a new game, beer pong.

**Amanda knocks on the door, and Joe lets her in.**

**OC:** Hello, Joe and Ms. Allen nice to see you. How are things going?

**Joe**: I really like it here and have lots of new friends.

**Mom:** I’m a little concerned. Joe’s personal assistant John went to the grocery store 2 days ago and now there’s hardly any food in the refrigerator. Joe says that John’s friends came over for a party--look for yourself.

**Joe:** Come on mom, it was just a little party. Last time everyone came over I didn’t have enough for everyone to eat. They said they wanted to hang out but needed some munchies. They brought their own drinks, it’s no big deal.

**OC**: Joe, I think it’s nice you are making new friends, but you can’t be expected to feed everyone. If you spend more on food each week or month, you may be short on some of your other bills. How are you doing on your budget for this month?

**Joe**: I have all the bills paid for this month except the cable bill. John was short on cash so I loaned him $50 bucks, but he’s going to pay me back end of this week. He paid me back last time I loaned him money.

**Mom**: I don’t like the sound of this John character. I’m very concerned you are being taken advantage of, Joe.

**Joe:** Mom, I don’t want you coming over here criticizing John and my new friends when you haven’t even met them.

**OC:** Joe, I appreciate that you and John are getting along well and you are becoming friends. As a paid personal care attendant, John is the employee and he should not be borrowing money from you. This is a professional relationship.

**Joe:** But if I didn’t loan him the money he wouldn’t have been able to make his car payment and then he wouldn’t have transportation to help me.

**Mom:** What if he doesn’t pay you back and you don’t have enough money for rent?

**Joe:** Yes mother, I know but he will pay me back.

**OC:** Joe have you loaned John money other times?

**Joe**: Well he did pick up some groceries for himself while he was shopping for me.

**OC**: Do you have the receipt? I’d like us to go through the receipt together and look at your checkbook.

**Joe**: Okay. Receipts are over on the table with my checkbook and bills.

**OC**: Joe, I know you don’t smoke or drink, but there is about $40 towards those items. It also looks like several pizzas were purchased. Looking at your bank statement, you have a money machine withdrawal for $100. Is that to help pay your transportation and/or spending money for the month?

**Mom:** What do you need with $100 cash???

**Joe**: I didn’t get $100 out of the money machine! And I didn’t realize beer and cigarettes cost that much.

That ends Scenario number 1. Please think about answers to the following questions during the brief pause following each question:

* Do you consider Joe’s decisions to be too risky? ***(Pause 10 seconds)***
* Are you legally required to report this situation to Adult Protective Services? If not, why not? If so, why? ***(Pause 10 seconds)***
* If you report it, how would you involve Joe in the reporting? ***(Pause 10 seconds)***

**Now let’s listen to Scenario number 2.**

**Mom knocks on the door; Joe lets mom in.**

**Mom:** Joe! When are you going to have your apartment cleaned? Just look at this place!! You have trash everywhere! You say you want a dog, but it already looks like pigs live here!

**Joe:** Mom, don’t start. What is wrong with my apartment? I like it the way it is! If I cleaned it, I would not know where to find anything.

**Mom:** Where is your personal assistant Isn't he supposed to be here by now?! What time are Amanda and that other person supposed to be here? Let’s just get this nonsense over with.

**Joe:** Amanda and the benefits planner are going to be here in about 20 minutes.

**Mom:** What are you doing with all these newspapers spread out all over the floor?

**Joe:** I'm trying to find a job!

**Mom:** You are going to mess around and lose all of your benefits if you get a job! You're just going to ruin yourself financially, and then what will you do to pay your bills?!

**Joe:** Mom, that is why we are meeting with Amanda and the benefits planner. They can tell me how working might affect my benefits and can explain all my options to me.

**Mom:** I still think it won't work. Look at the dishes that are in your sink and the clothes on your floor! What temperature do you have that heat on anyway?

**Joe:** Mom, did you come over here to support me in this meeting, or to just criticize the way I live? You know I have to have the heat turned up a little higher to stay warm.

**Mom:** Where is your personal assistant? Isn't he supposed to be here by now?

**Joe (in a huff):** Yes, Mom! He was here a few minutes ago, but I sent him to the store pick up the grocery order I called in.

**Mom:** All this arguing is giving me a headache! Do you have any water so that I can take this aspirin?

**Joe:** Yes, mother. Here, let me get that for you. (*Joe gets a glass of water for his mother so she can take her medicine.)*

**Mom:** Well, I still don't like your apartment! If you keep this up, you will have bugs in here! You know the Department of Social Services could be called in on an apartment that looks like this!

***Amanda knocks on the door, and Joe lets her in.***

**OC:** Hello, Joe. Hello Ms. Allen. Is the benefit planner here yet?

**Joe:** No, you're a few minutes early.

**OC:** Good. I wanted to be early so that I see how everything was going before the benefits planner got here.

**Mom:** Well, as you can see from the mess, things are not going well at all for Joe! This apartment is completely trashed! I can't seem to get Joe to understand the importance of cleaning up after himself! I am concerned that the Department of Social Services could be called on an apartment like this!

**OC:** I see. Joe, how are things going with you?

**Joe:** I'm learning to manage my money. I have paid my utility bills, and you would not believe how the heat bill has increased!

**OC:** The power company does like getting its paycheck. What did you think of the water bill?

**Joe :**That's expensive stuff, too! But the water department got paid, too!

**OC:** How are your personal assistant services going with John?

**Joe:** Great! Thanks so much for setting this up for me. He has made a run to grocery store for me. We get along great.

**Mom:** Is anyone outside of me concerned that this apartment looks like a war zone!?

**OC:** Mrs. Allen, Joe has just stated that he is up to date on his power and water bills and that has enough food to eat. He appears to be safe in his environment, even though you or I might not choose this décor. Remember: The most important thing is that he is safe, his basic needs are being met, and he seems to have a good relationship with John. Just like you, me, or anyone else, Joe has the right to live in his apartment the way he likes it. And, he also has the right to make his own decisions – even if he doesn’t always make the best decisions or even decisions that you, me, or anyone else agrees with or understands.

**(Turns to Joe)** I will say, this, though, Joe: You do need to be aware that your landlord may evict you if bugs and other rodents start to come to visit you. So, maybe you and John might think about paying a little more attention to cleaning up around here.

**Joe** : Well, I guess I don't need to leave food out. You’re right! When John gets back from the grocery store, I’ll get him to help me organize this mess and clean up a little bit.

That is the conclusion of Scenario number 2. Again, think about the answers to these questions in the few second pause following each.

* Do you consider Joe’s decisions to be too risky?
* Did the Options Counselor make the right decision, or was she legally required to report this situation to Adult Protective Services? If not, why not? If so, why?
* If you report it, how would you involve Joe in the reporting?

**Slide 32**

Now that the individual has gotten information, weighed options, and made decisions, it’s time to develop an action plan. In this part of the presentation we will cover all elements that must be contained in the action plan: goals, decisions, action steps, resources, timelines for each action step, and the parties responsible for following up in each action step.

**Slide 33**

Under the Standards, the Options Counselor works with the individual to develop an action plan for implementing the decisions made as a result of Options Counseling.

The action plan is a critically important document for both the Options Counselor and the person.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 he or she wishes, and that he or she is taking the steps needed to help the individual reach those goals. And it also has an important role in evaluating the success of Options Counseling for the individual.

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**Slide 34**

Let’s look in more detail at the elements each Action Plan contains.

* THE INDIVIDUAL’S GOALS AND DECISION/S: Why? *Making decisions and setting goals is a planned way to make a dream come true!*
* THE ACTION STEPS NEEDED TO REACH THE GOALS, INCLUDING RESOURCES NEEDED FOR EACH STEP: Why? *Goals are more attainable if the steps and the resources needed to take each step are identified.*
* A TIMELINE FOR EACH ACTION STEP: Why? *Without time limits, progress might not be made, and it’s a lot harder to start.*
* WHO IS RESPONSIBLE FOR EACH ACTION STEP: *Let the individual do as much as possible, but others can and should assist as needed.*

A sample ACTION PLAN TEMPLATE is included in the Module 3 materials on the webpage.

**Slide 35**

Here’s the action plan that led to Joe being able to meet his goal of living by himself.

* An apartment and personal assistance were critical to Joe meeting his goal.
* Personal assistance was available under the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and the eligibility assessment for that waiver in Joe’s case came as a part of the action plan. But assessments can also be made during Options Counseling if an individual needs eligibility information to make decisions about what options they want to pursue.
* Joe also needed a housing voucher.
* He planned to get on the waiver within 2 months, then secure his housing voucher within a month after that.
* The Options Counselor was made responsible for the waiver screening referral, and Joe himself pursued his housing voucher with the assistance of his CIL **(pronounced “SILL”)**.

**Slide 36**

And now back to Sarah. Here is the action plan that allowed Sarah to get the help around her house that she needed to avoid having to move to an assisted living facility:

* The plan involved seeing if her neighbor could do her yard work, using her own mower and garden tools, and she and Nancy agreed to call him within the week.
* The plan also involved securing chore supports and meals on wheels from the local AAA **(pronounced “Triple A”**), which the Options Counselor agreed to secure even sooner.

**Slide 37**

Now that we have gotten to know a little about Joe and Sarah, let’s go back assume that their plans didn’t work out as they wished. Is there any information about them that we still don’t have that would be helpful for the Options Counselor to know? Has the Options Counselor in either Joe’s or Sarah’s situations covered all of the options that could have or should have been explored?

Let’s take Joe first. He still wants to live by himself, but can he do that without the Elderly or Disabled Consumer Direction (EDCD) Waiver and a housing voucher? Again, we will pause briefly following each question to give time to think about the answer.

* Does Joe have any income? Has the Options Counselor asked anything about his desire to work?
* Have non-Medicaid alternatives for personal assistance been discussed with Joe?
* Could Joe afford to rent an apartment if he was willing to have a roommate to share the rent?
* Are housing vouchers the only way Joe can get an apartment subsidy?

Ok, now let’s look at Sarah. She still refuses to move and still needs help around her house. If she can’t get her neighbor to mow the yard and the AAA **(pronounced “Triple A”)** cannot offer chore supports and meals on wheels, will she have any choice but to move? Think about the answers to these questions:

* Do we know anything about Sarah’s and Nancy’s financial situation? (We only know that Nancy works full time). If that is explored, could it lead to other options such as hiring their own housekeeper? Paying somebody to mow the yard? Building Sarah a walk-in shower? (***Pause 10 seconds)***
* What do we know about Sarah’s family? We know Nancy, and we know Nancy has a brother. Could her brother help in any way? Do we know if there are there any other family members who could assist? (***Pause 10 seconds)***
* What do we know about Sarah’s neighbors? We now know she has a neighbor who won’t mow her yard, but she also has a neighbor who does her grocery shopping. Is the neighbor willing to continue doing that? Instead of buying frozen dinners could the neighbor buy fresh prepared meals at the supermarket? (***Pause 10 seconds)***

**Slide 38**

As we wind up this section of Module 3, we will review what the Standards say about documentation by a staff member who delivers Options Counseling. Again, we will be talking about the data that is collected as per the Standards, but we will not be covering the means by which it will be collected: that is up to each individual agency. For those agencies that use the electronic Communication, Referral, Information and Assistance (CRIA, **pronounced “CREE-AH”)** there is an Options Counseling screen specifically designed for the collection of Options Counseling data. Aggregate reports for Options Counseling feed off of this data as well. Information regarding the use of CRIA **(pronounced “CREE-AH”)** and/or the use of Options Counseling in CRIA **(pronounced “CREE-AH”)** is available by contacting the Department for Aging and Rehabilitative Services (DARS).

**Slide 39**

As a part of the Options Counseling process, the standards provide for documentation of the following:

* The date the initial contact was made by the Options Counselor
* Whether the individual is new to Options Counseling or is reengaging in Options Counseling and if reengaging, the reason why
* Others involved in Options Counseling, their relationship to the individual and contact information and
* The individual’s preferred method or mode of communication and preferred environment for Options Counseling

**Slide 40**

Also documented are the individual’s relevant current circumstances, including:

* Paid and informal supports
* Employment/ financial resources and benefits
* Financial/legal plan for future
* Housing
* Transportation
* Social and recreational activities and
* Assistive technology

**Slide 41**

Finally, the Options Counselor documents:

* The options discussed with the person, including alternative supports, and (if the individual requests it, the risks and benefits of each)
* The action plan including:
  + The individual’s preferences, needs, values, personal goals/desired outcomes, and definition of success
  + The decision or decisions made by the individual or the surrogate decision-maker
  + Referrals made by name, date and type of support and
  + Confirmation of implementation of the plan, including enrollment or other evidence of actual receipt of any support to which the individual was referred.
* Finally, the Options Counselor documents progress notes referencing each interaction, including the date of contact with the individual.

Options Counselors are also encouraged by the Standards to document the individual’s future projected immediate, intermediate and long term support needs.

**Slide 42**

This completes Module 3. Please complete and submit the Module 3 post-quiz before proceeding to Module 4.