

Welcome to Session 31: Advancing Interoperability in Home and Community Based Services (HCBS)

Guest speakers:

- » Shawn Terrell, Administration for Community Living
- » Arun Natarajan, ONC
- » Liz Palena Hall, ONC



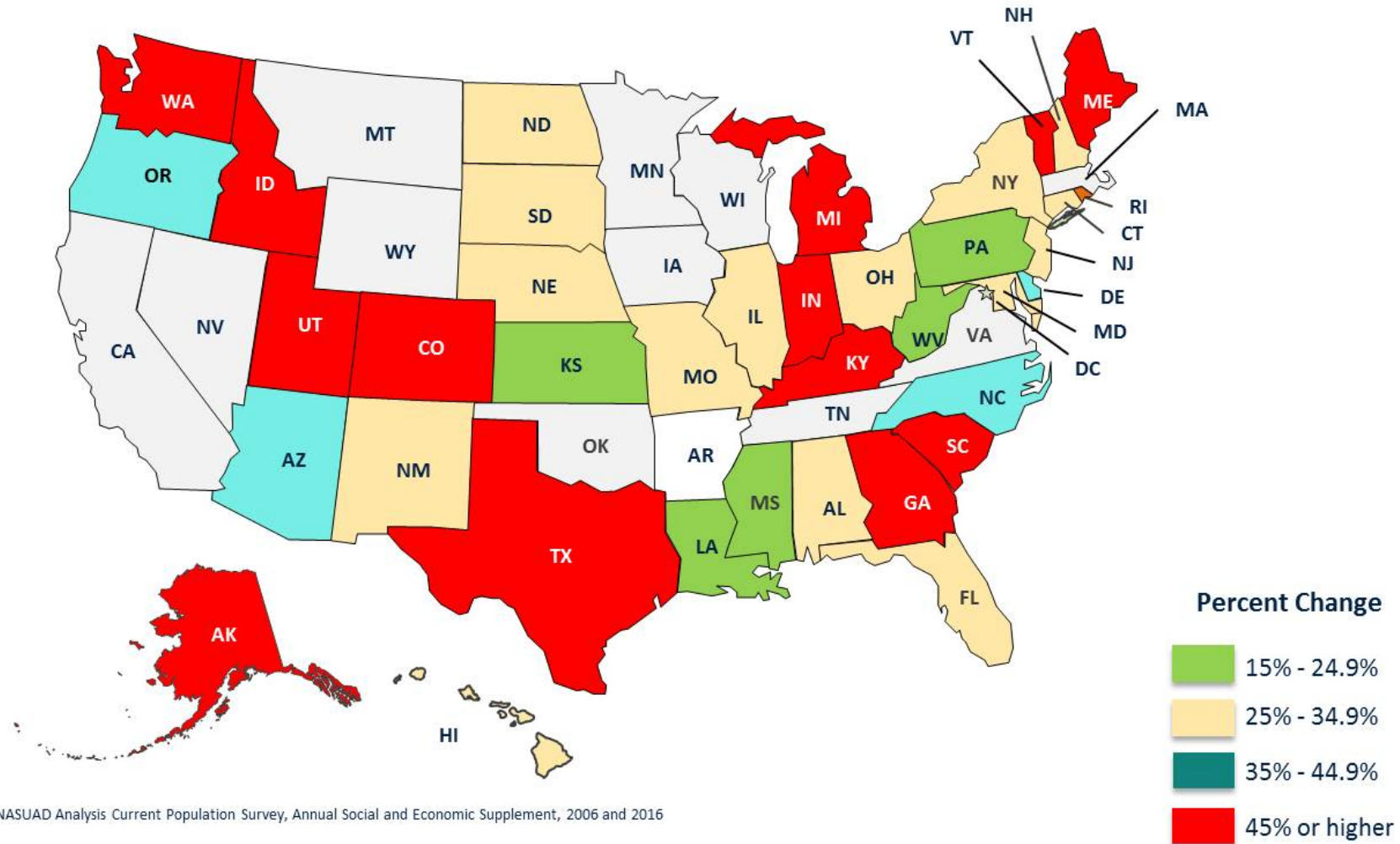
Advancing Interoperability in Home and Community Based Services

Introduction to the HCBS Health IT Toolkit

Arun Natarajan, Sr. Policy Analyst | November 30, 2018

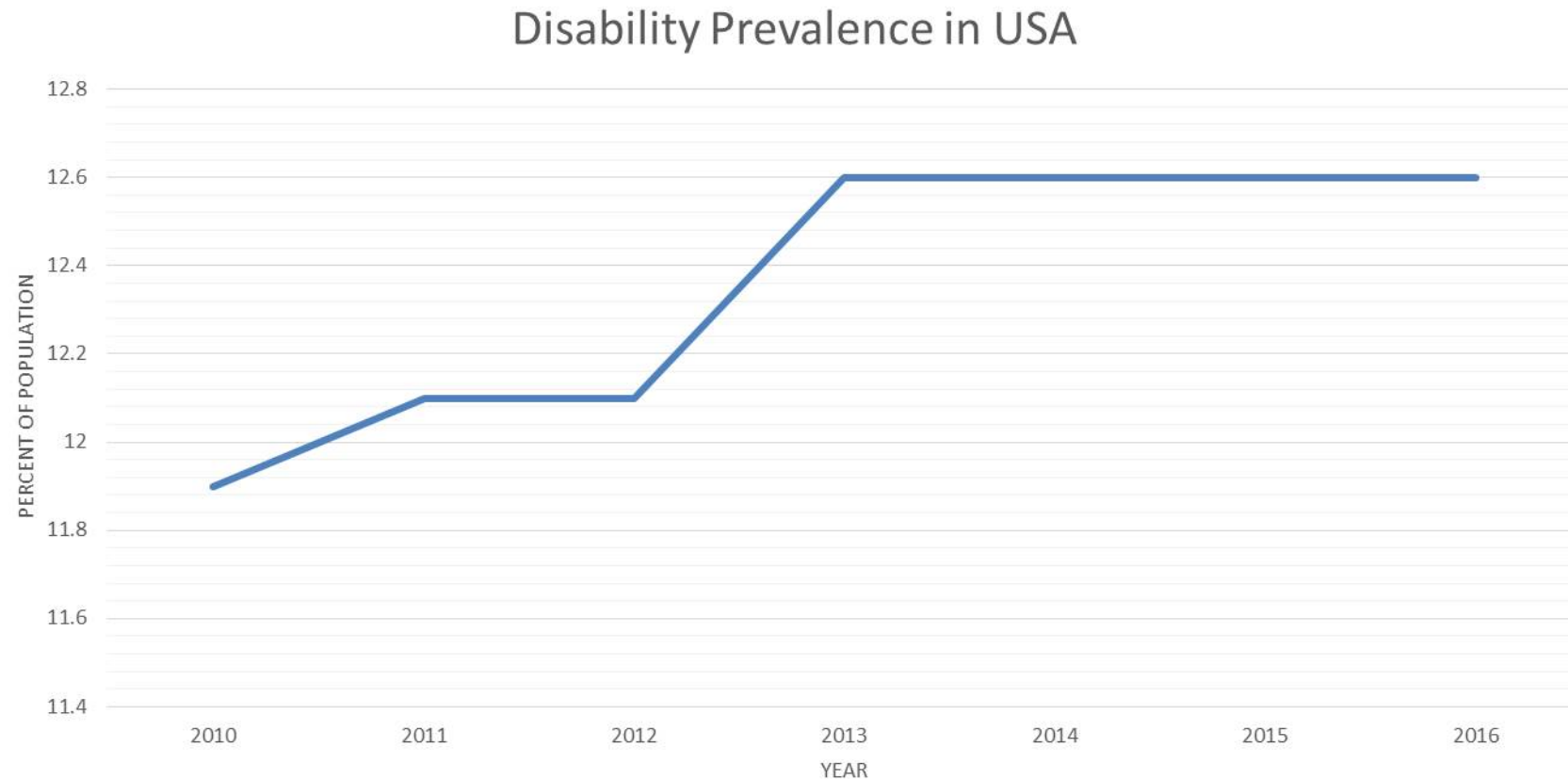


Percentage Increase in the Number of Older Adults Age 60 or above from 2006 to 2016



Source: NASUAD Analysis Current Population Survey, Annual Social and Economic Supplement, 2006 and 2016

Increasing Prevalence and Incidence of Disability Also Driving State Policy Decisions

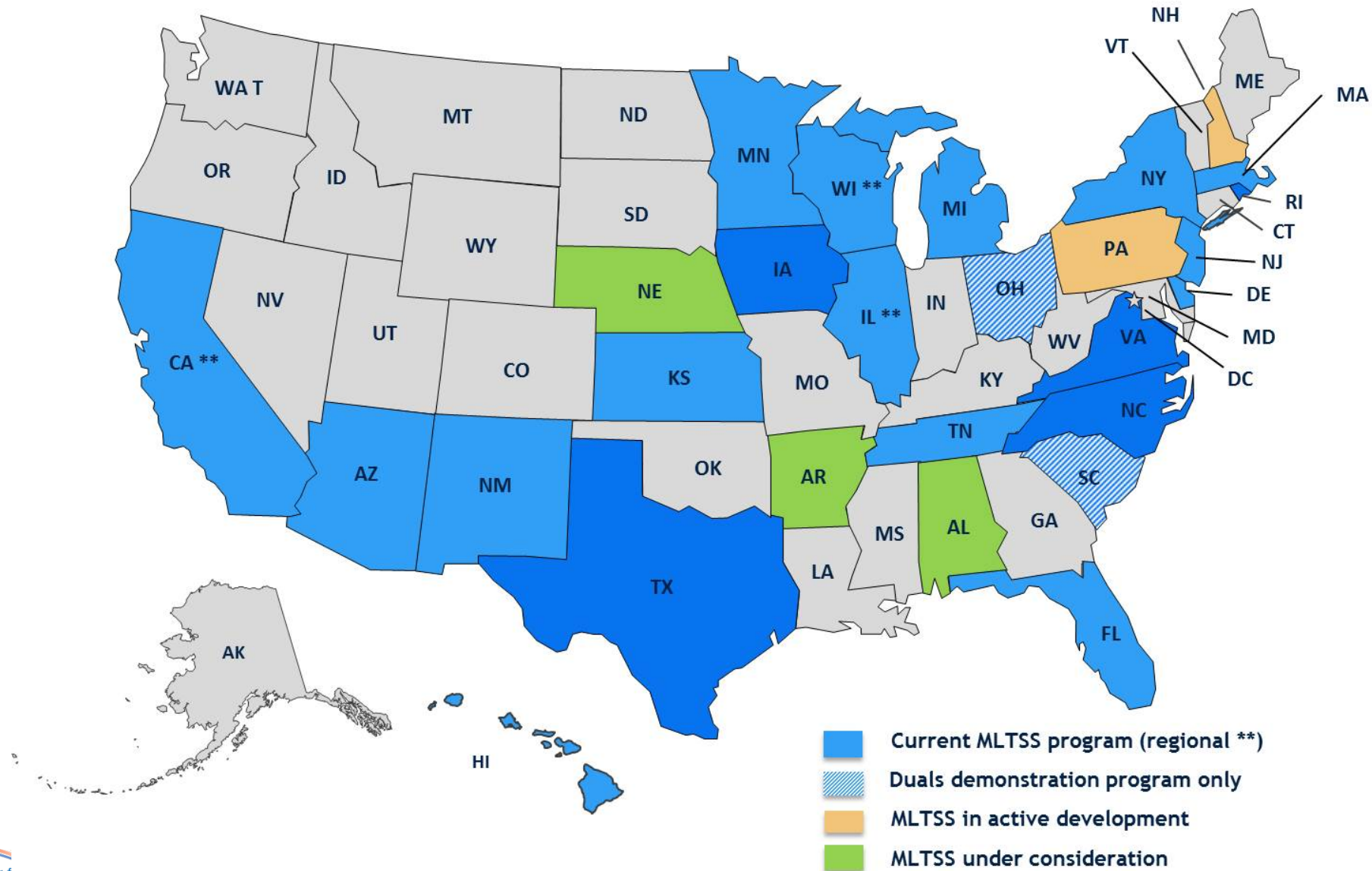


Sources: <https://disabilitycompendium.org> & <http://www.disabilitystatistics.org>

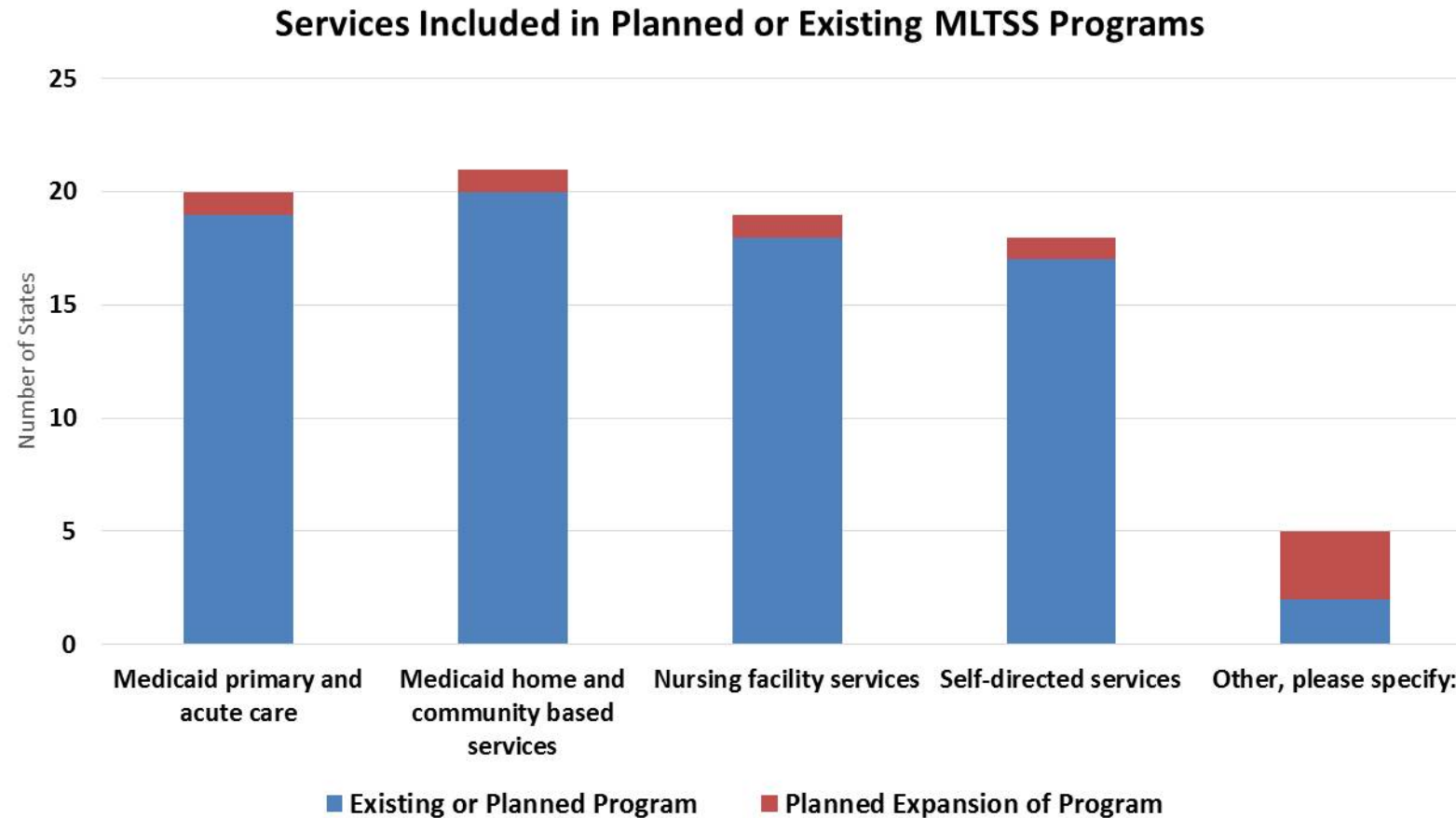
The Intersection of Health and Social Services

- Especially for older adults, there is a significant overlap between primary/acute care and LTSS:
 - » Hospitalization (example: broken hip) -> post-acute rehabilitation -> personal care and chore services
- Fractured eligibility & payment systems, particularly Medicare and Medicaid, can lead to disconnects between settings of care, treatment goals, and desired health/social outcomes
 - » However, eligibility, payment, and quality management can be fractured inside of Medicaid too
- Interoperable systems have the promise of improving coordination and keeping LTSS person-centered

Changing Delivery Systems Impacting Services – MLTSS Programs 2017



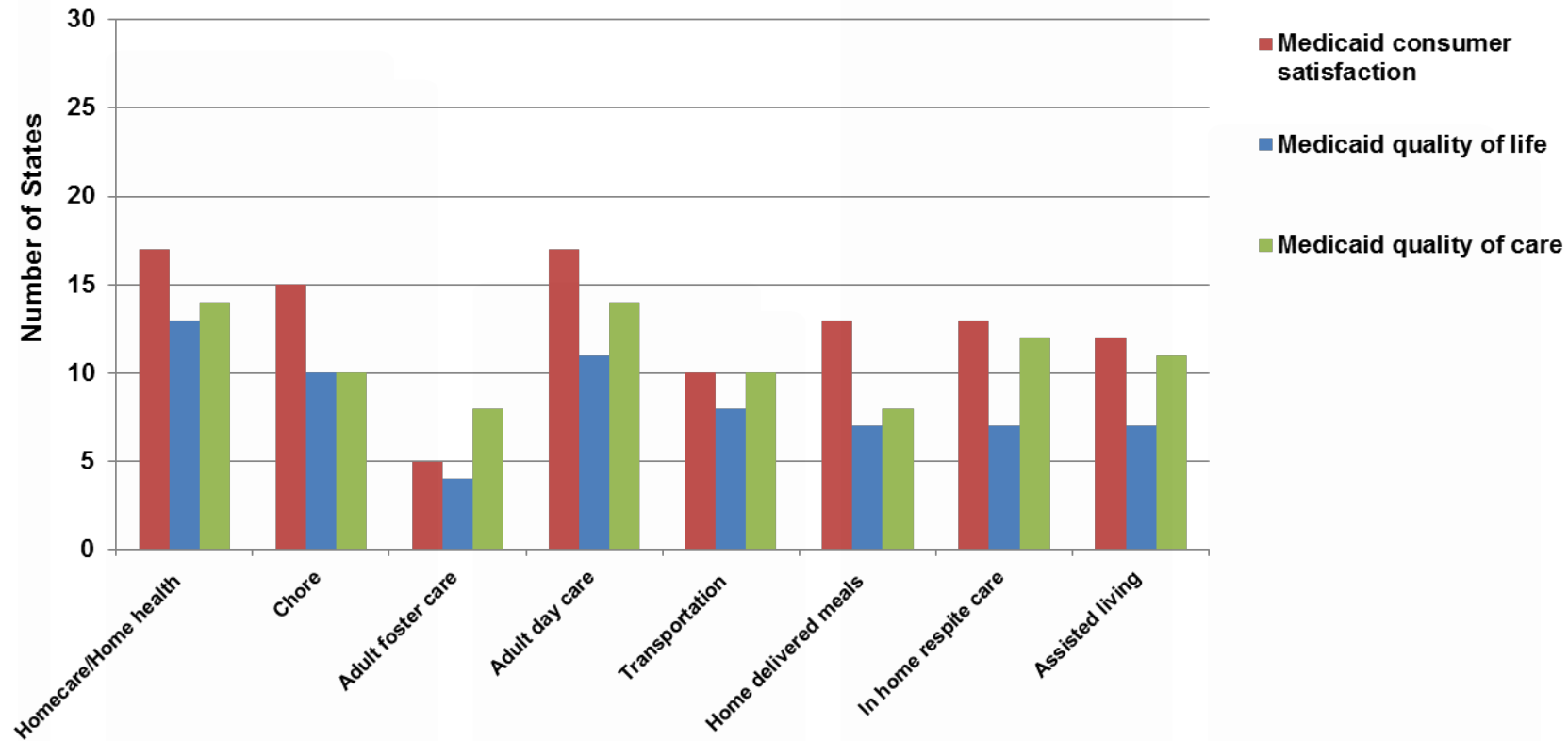
Services Included in Planned or Existing MLTSS Programs



Source: NASUAD 2017 State of the States report (Published: August 2017)

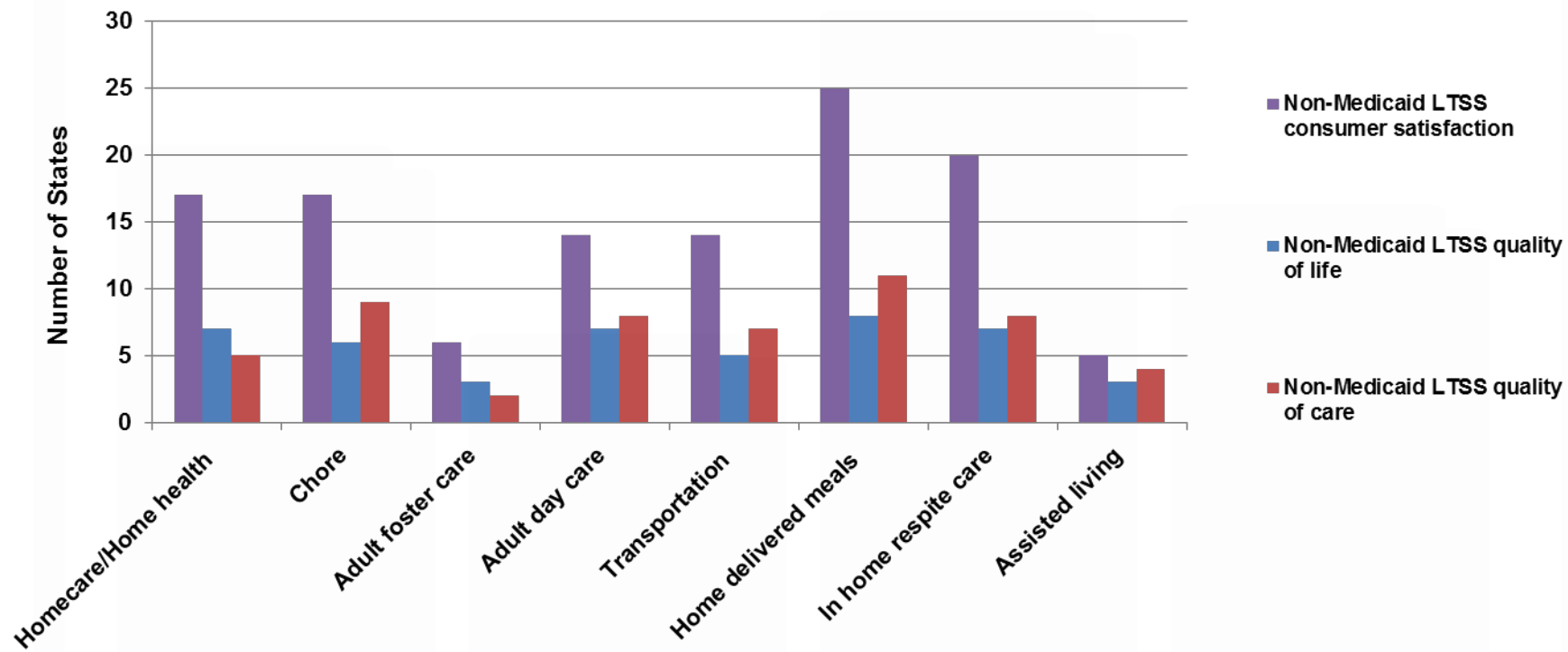
Consumer Surveys: Medicaid Supports

States Collecting Data on Medicaid Consumer Satisfaction, Quality of Life, and Quality of Care by Service



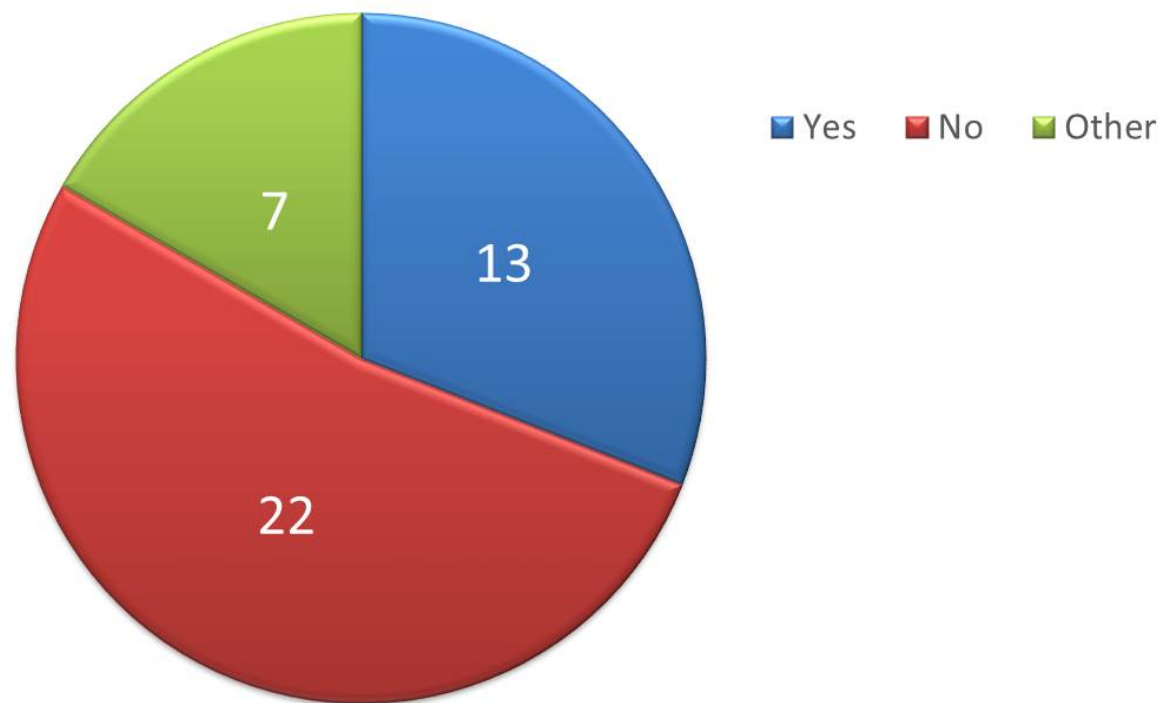
Consumer Surveys: Non-Medicaid LTSS

States Collecting Data on Non-Medicaid LTSS Consumer Satisfaction, Quality of Life, and Quality of Care by Service

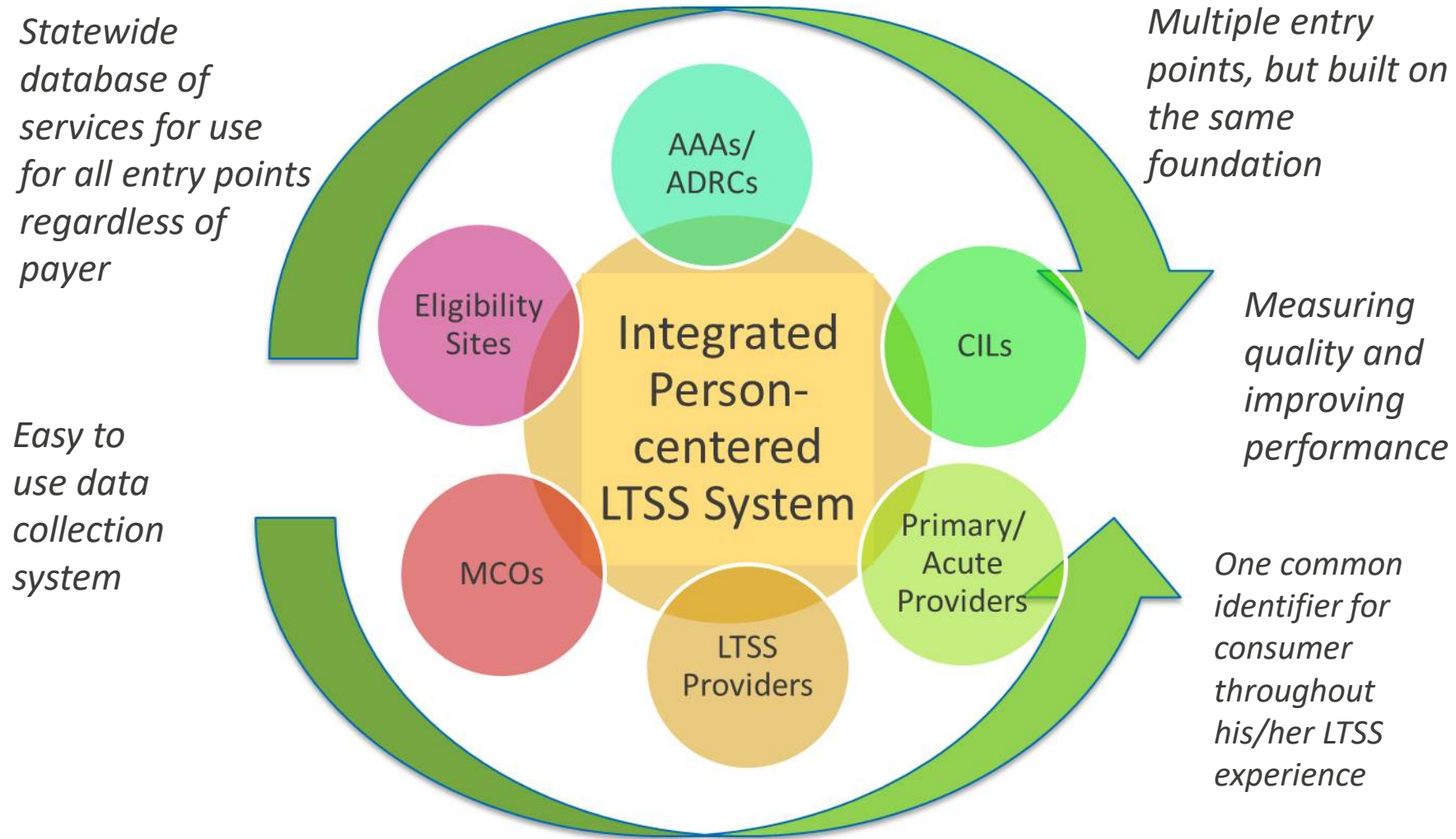


State Aging/Disability Information Sharing

Does your information system share data with other HHS data systems?



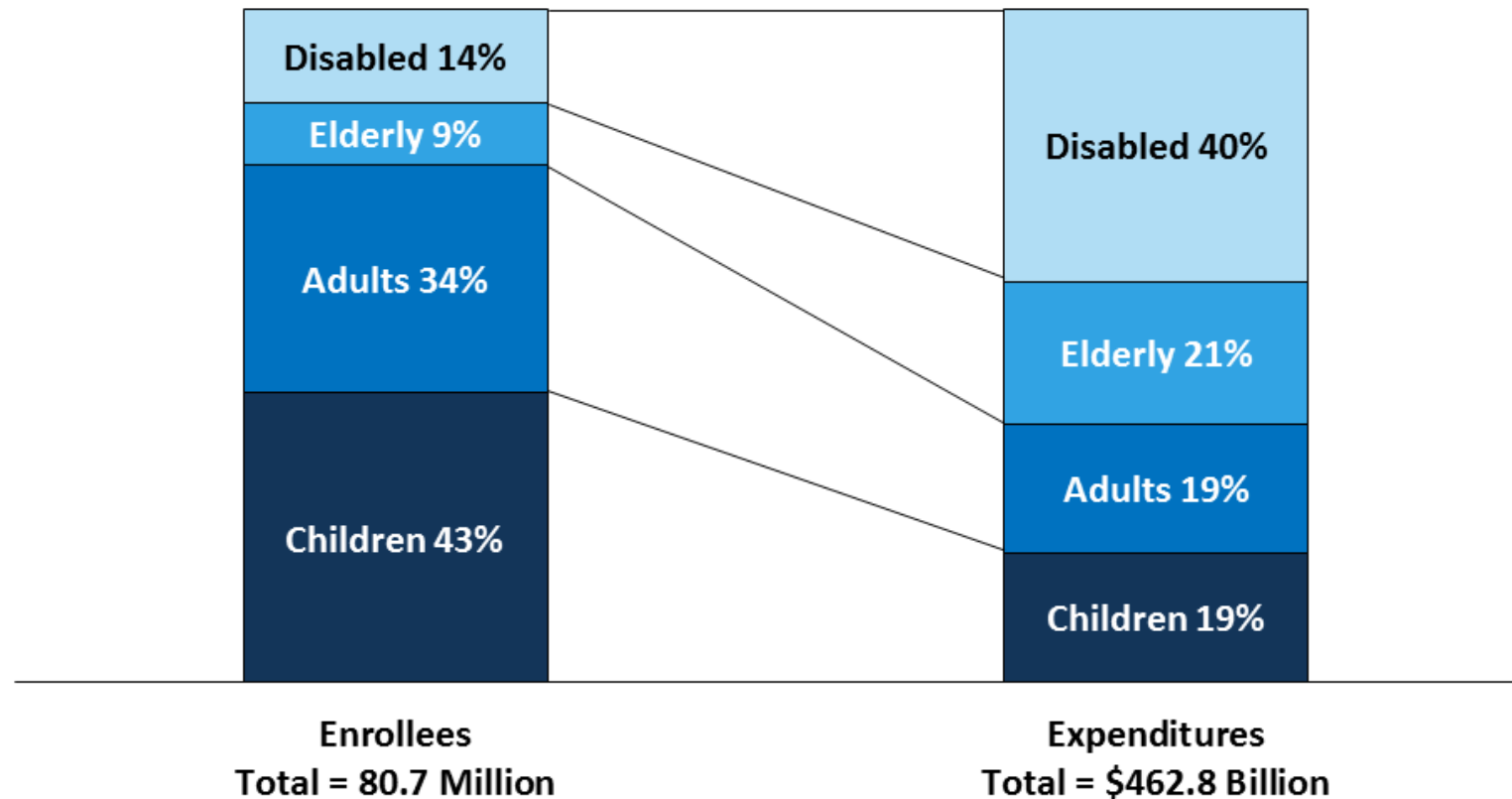
The Goal: LTSS Integrated System



LTSS Beneficiaries are Driving the Medicaid Spending

Figure 1

Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.



NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.

Health IT and Medicaid

- CMS and ONC are committed to ensuring that we are supporting states to develop a health IT infrastructure able to sustain and deliver on our shared Medicaid program objectives.
- To this end, HHS has developed a series of state facing program authority specific health IT toolkits. States can use these toolkits as they are designing their Medicaid programs.

Toolkits and Resources

- Use of these tool kits will help states:
 - » Ensure they have the health IT capacity and infrastructure to accomplish their Medicaid program goals.
 - » Identify and adopt a common set of health IT standards (where federally recognized standards exist) among states to promote information sharing (interoperability).
 - » <https://www.healthit.gov/providers-professionals/advancing-interoperability-medicaid>
 - » <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>

Key health IT considerations to include in an HCBS health IT, HIE and interoperability toolkit

1. Care Plan Exchange
2. Real time access to Admission/Discharge/Transfer notifications
3. Inclusion of 45 CFR 170 Standards and as applicable other federally recognized standards identified in the Interoperability Standards Advisory (ISA) within RFPs for LTSS MCO contract procurements
4. Connecting LTSS Providers to local/state's HIE – requirement to send in and/ or receive information
5. HCBS (1915(c)) Quality Framework – using electronically specified measures

How are HCBS Programs Fitting into a SMAs Larger HIT, HIE, and Interoperability framework?

1. Plan to support HCBS providers for their health IT, HIE and interoperability needs (Regional Extension Center like services)
2. Leveraging states 90-10 funding per SMD 16-003 for HCBS providers.
 - Registries
 - Funding Connections
3. SMAs Governance plan- what is the role for including HCBS services/providers? Are the HCBS programs represented in these State discussions
4. Are HCBS considerations included in the State's Master Data Management (MDM) strategy
 - Provider Directory strategy
 - Identity Management
5. Role of PHRs – Can the HCBS Medicaid program encourage/fund or support HCBS individuals access to a PHR for their human and health care services?

Indiana – Using AAA to capture SDOH for Medicaid Bene's and Provide Services

- Aging and In-Home Services of Northeast Indiana, a federal and state designated Area Agency on Aging, the Aging and Disability Resource Center (ADRC), and the Central Indiana Council on Aging (CICOA) have leveraged technology to integrate HCBS provider data with Indiana's existing Health Information Exchanges. Use of technology has allowed both Aging and In-Home Services and CICOA to negotiate with accountable care organizations to contract for provision of HCBS services that address the social determinants of health, which in turn help achieve the triple aim.

NY Grant Program for EHR Adoption to HCBS Providers

- In order to assure that Adult Behavioral Health HCBS providers are ready for and can succeed in the transition to Medicaid Managed Care under the New York State 1115 waiver program, New York State created a Behavioral Health Information Technology Grant Program (BH-IT) to support these providers. The grants provide assistance with: Health Information Technology (HIT) scoping and vendor qualifications and initial purchase of licenses, system upgrades, and/or implementation and technical assistance for Electronic Health Records (EHR) and/or Electronic Billing Systems (EBS).

Use of the 2015 Standards Advisory: Health Home Examples – Clinical Decision Support

Washington's Medicaid Health Home SPA targets individuals with one chronic condition and at risk for developing a second, defined as a PRISM risk score of 1.5 or greater. Chronic conditions may include cancer, dementia, Intellectual disability or disease, HIV/AIDs as well as others. The State integrates fee-for-service claims data, managed care encounter data, eligibility, and enrollment data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM.

(the Monitoring Section)

Use of the Interoperable Standards Advisory: Health Home Examples – Admit, Discharge, Transfer Sets

WASHINGTON: The State has developed an HIT pilot for Health Action Plans through OneHealthPort, an entity contracted with HCA to also consult on building a statewide health information exchange. HCA has developed the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets.

(the Monitoring Section)

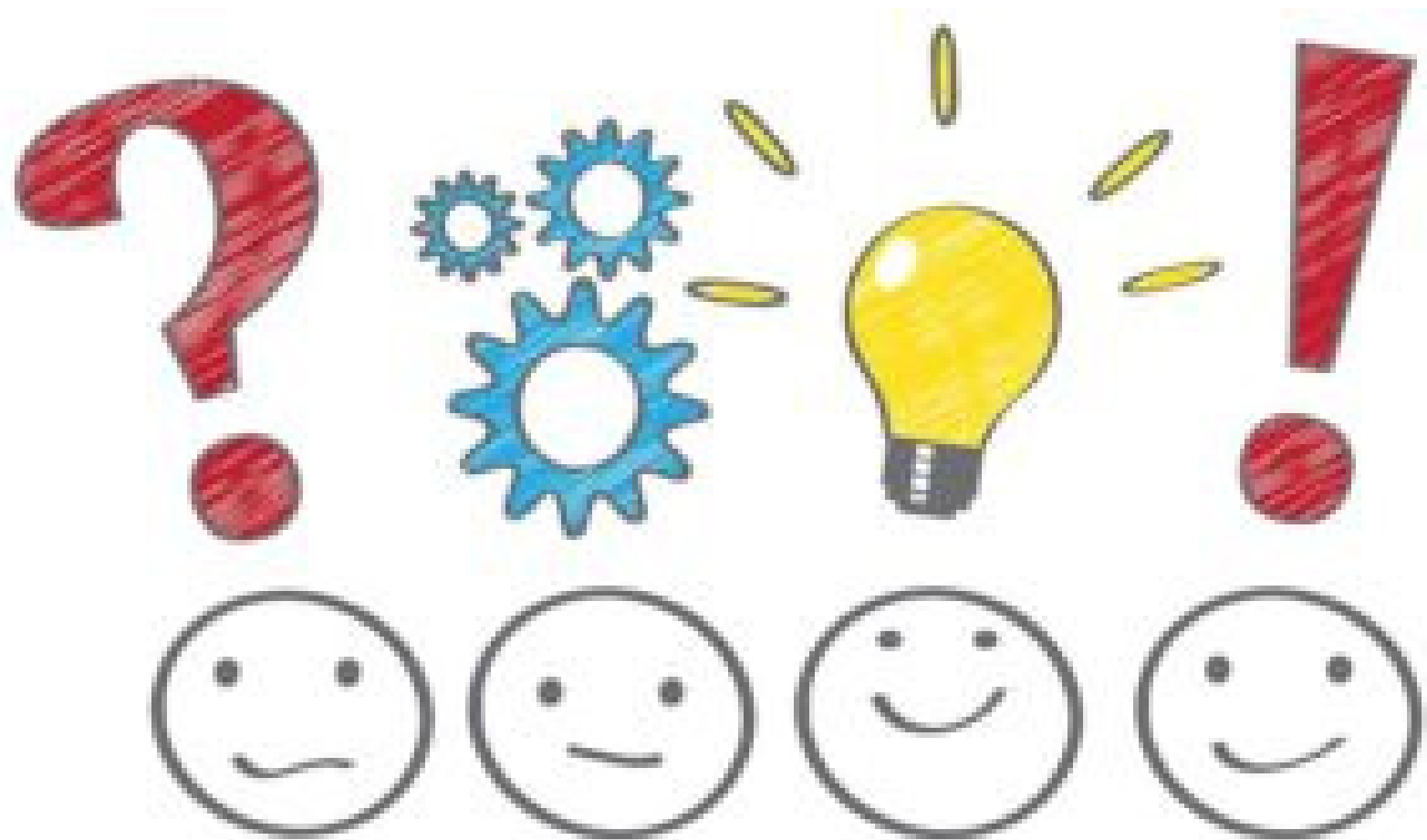
Use of the Interoperable Standards Advisory: Health Home Examples – Care Planning

MAINE: Over 24 months all BHHO will be expected to have implemented certified EHR systems. BHHO will be expected to share health information including care planning documents to and from other treating providers/organizations and across the team of BHH professionals. (the Provider Section)

IDAHO: The final standards require that designated providers use HIT for the following processes:

1. Have a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's care plan;
2. Utilize HIT allowing the patient health information and care plan to be accessible and allow for population management and identification of gaps in care including preventive services; and
3. Is required to make use of available HIT and access members' data through the IHDE to conduct all processes, as feasible. (the Provider Section)

Questions





ONC Annual Meeting 2018 electronic Long-Term Services & Supports (eLTSS)

November 30, 2018

Liz Palena Hall, LTPAC Coordinator, ONC



Agenda

- Background and Project Overview
- Working with a Standards Development Organization – HL7
- eLTSS Informative Document
- eLTSS FHIR Implementation Guide
- eLTSS Community Engagement

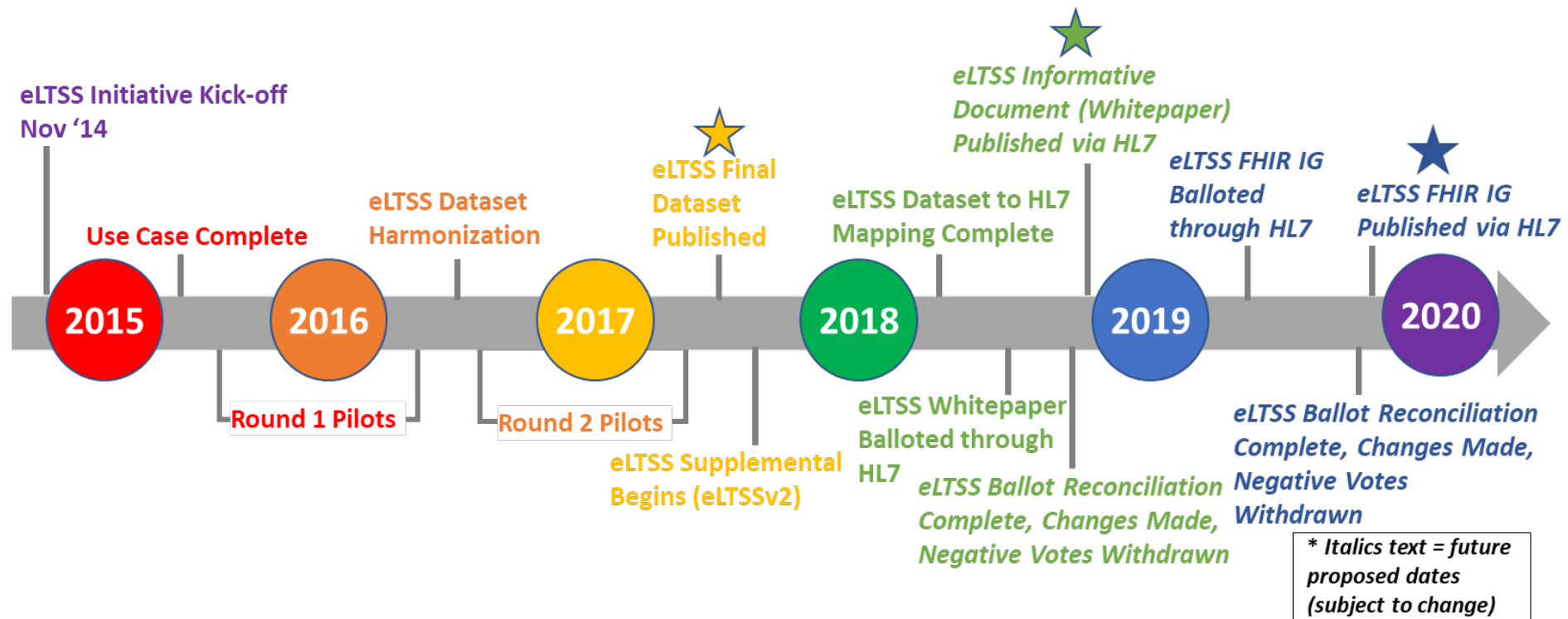
Background and Project Overview

eLTSS Project Background

- The eLTSS project is a joint project between CMS and ONC, established to advance data-level interoperability for the home and community-based services (HCBS) community.
 - » The project aim is to advance data-level interoperability for the Home and Community-Based Services (HCBS community) and to facilitate the identification and validation of a data standard for capturing and exchanging person-centered LTSS service plan data.
- Key Accomplishments
 - » eLTSS Dataset Published: Collaborative requirements gathering, and harmonization efforts have culminated in the publication of the eLTSS dataset and supporting documentation (e.g. use cases, etc.).
 - The eLTSS dataset contains data items commonly found on LTSS Service Plans and serves as the groundwork for developing electronic means for exchanging LTSS data.

To track and review eLTSS Artifacts including the published dataset please see the eLTSS wiki:
<https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home>

eLTSS Initiative At-A-Glance



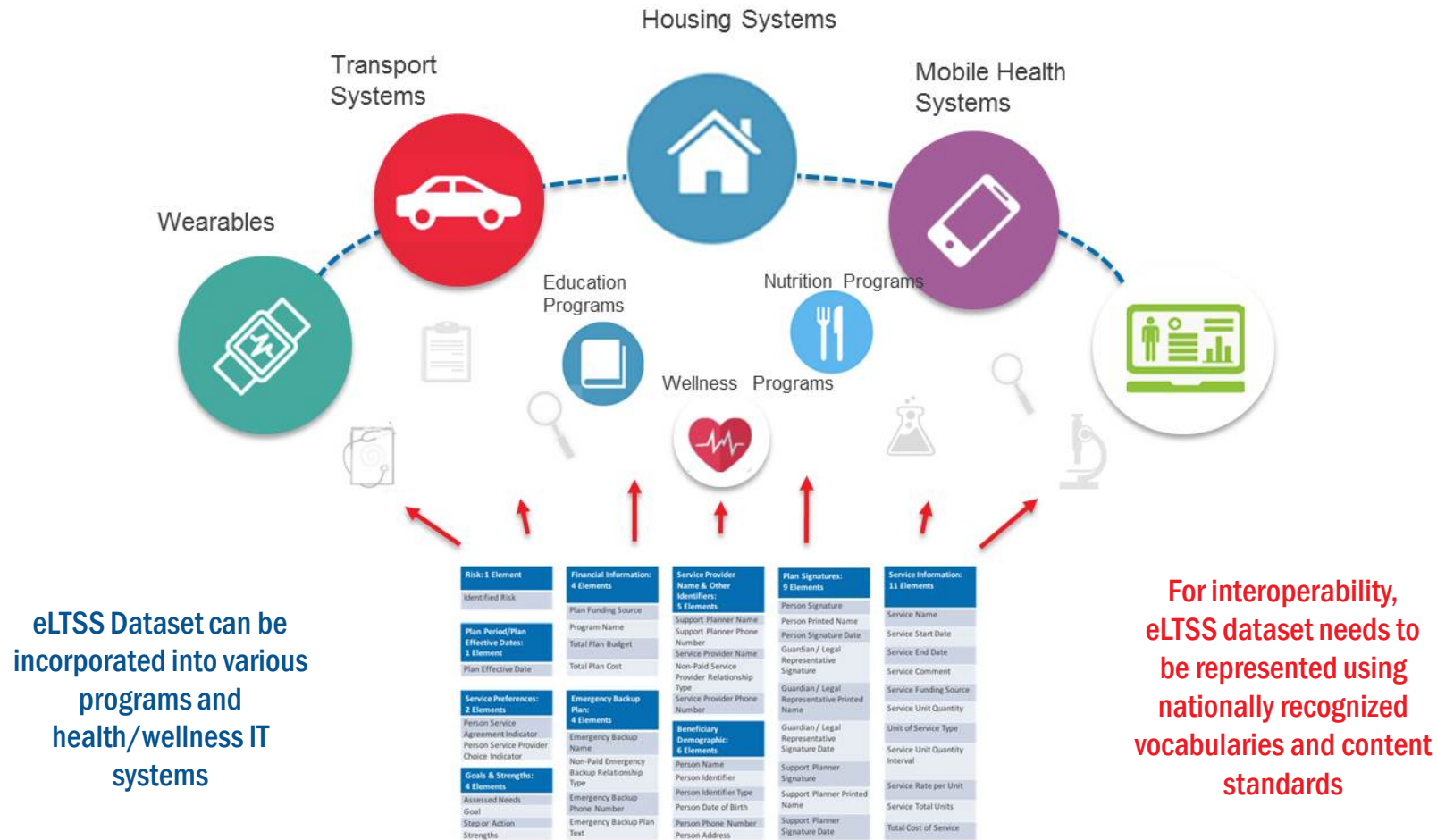
eLTSS Final Dataset

- Total Number of Elements: 56

Beneficiary Demographics: 10 Elements	Person Centered Planning: 11 Elements	Plan Information: 1 Element	Risks: 2 Elements	Service Provider Information: 5 Elements
Person Name	Assessed Need	Plan Effective Date	Identified Risk	Support Planner Name
Person Identifier	Preference		Risk Management Plan	Support Planner Phone Number
Person Identifier Type	Person Setting Choice Indicator			Service Provider Name
Person Date of Birth	Person Setting Choice Options			Service Provider Phone Number
Person Phone Number	Service Options Given Indicator			Non-Paid Provider Relationship
Person Address	Service Selection Indicator			
Emergency Contact Name	Service Provider Options Given Indicator			
Emergency Contact Relationship	Service Provider Selection Agreement Indicator			
Emergency Contact Phone Number	Service Plan Agreement Indicator			
Emergency Backup Plan	Plan Monitor Name			
	Plan Monitor Phone Number			
Goals & Strengths: 3 Elements	Plan Signatures: 12 Elements	Service Information: 12 Elements		
Goal	Person Signature	Service Name		
Step or Action	Person Printed Name	Self-Directed Service Indicator		
Strength	Person Signature Date	Service Start Date		
	Guardian/Legal Representative Signature	Service End Date		
	Guardian/Legal Representative Printed Name	Service Delivery Address		
	Guardian/Legal Representative Signature Date	Service Comment		
	Support Planner Signature	Service Funding Source		
	Support Planner Printed Name	Service Unit Quantity		
	Support Planner Signature Date	Unit of Service Type		
	Service Provider Signature	Service Unit Quantity Interval		
	Service Provider Printed Name	Service Rate per Unit		
	Service Provider Signature Date	Total Cost of Service		

Final dataset and information on HL7 engagement available at:
<https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home>

Vision for eLTSS Dataset Integration



eLTSS Current and Future Plans

- **September – December 2018**

- » **September – October:** Initial Implementer Guidance (eLTSS Informative Document) balloted by HL7:
 - The eLTSS Informative document serves as the initial technical specification for leveraging FHIR and C-CDA Health IT Standards for exchanging eLTSS Dataset items.
 - It served to introduce LTSS needs to the HL7 community.
 - This informative document may be used to support LTSS solution provider pilots who want to electronically exchange a service plan.
- » **November – December:** Republish final Informative Document prior to January HL7 meeting

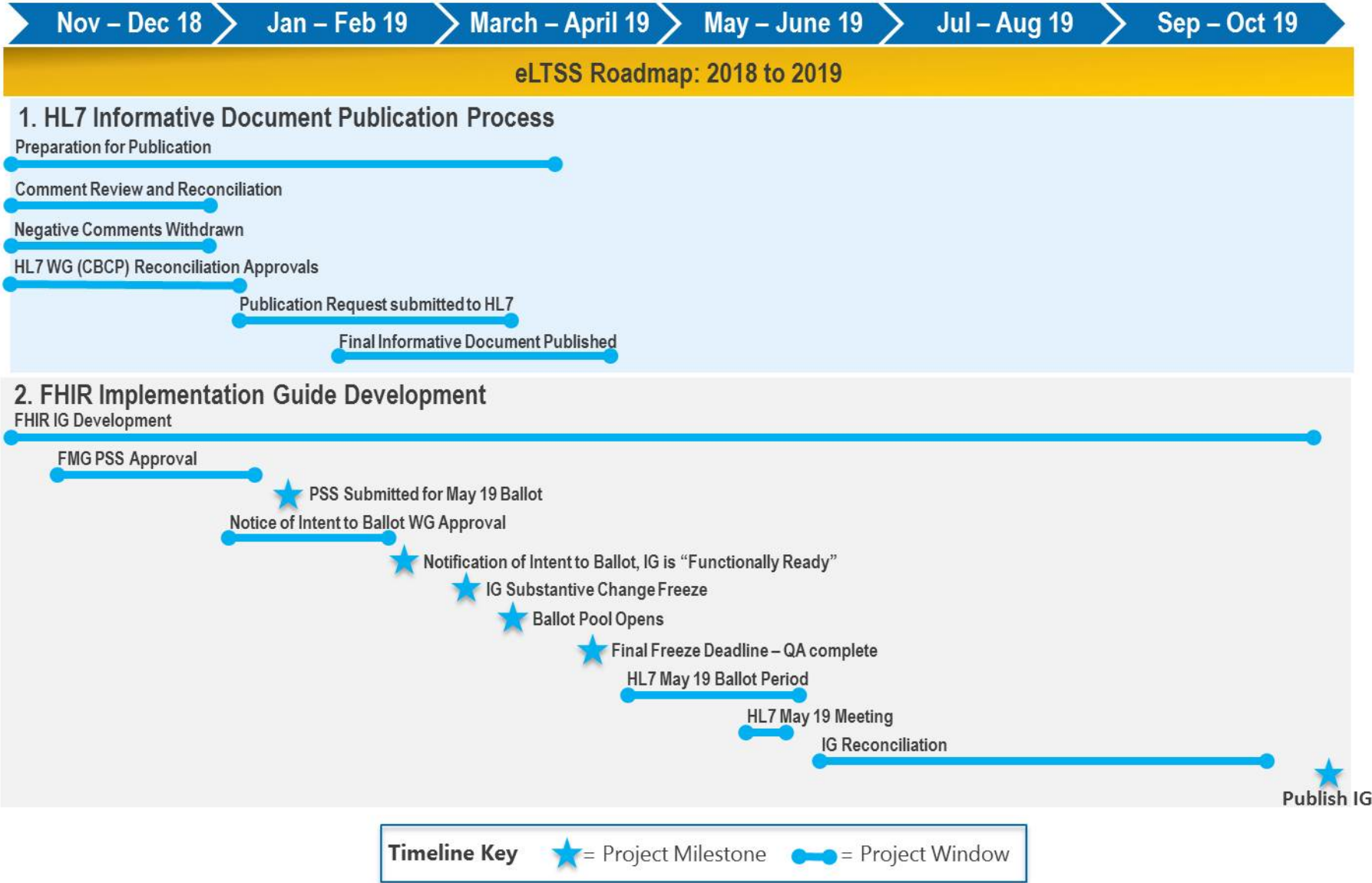
- **January – September 2019**

- » **January – May:** eLTSS FHIR Implementation Guide: The eLTSS FHIR Implementation Guide is currently under development and is expected to be included in the May 2019 HL7 ballot.
 - This IG provides robust formal guidance on how to leverage FHIR to exchange eLTSS Dataset data. It will also be able to support continued piloting efforts by implementers.
- » **June – September:** eLTSS FHIR IG ballot comments dispositioned
 - The disposition process includes reviewing and responding comments as well as update and republishing the final IG based on comment resolution.

eLTSS Current Phase of Work

- The scope of this work will build on previously conducted work that supported development of eLTSS plan standards and further collaboration between ONC, CMS, and TEFT grantees with standards development organizations (SDOs)
- Informative Document reconciliation and publication
 - » Complete comment disposition
 - the team must bring the proposed dispositions to the HL7 sponsoring workgroup (Community-Based Care and Privacy (CBCP)) to get approval for the proposed dispositions.
 - » Workgroup votes on proposed dispositions
 - » All approved changes based on dispositions must be incorporated into the final document
 - » Final document published
- eLTSS FHIR Implementation Guide
 - » The Georgia team (Georgia Department of Community Health (DCH) and Georgia Tech Research Institute (GTRI)) and ONC Support team (SRS, Carradora) teams will use the published eLTSS Informative Document as a basis to create an HL7 FHIR Implementation Guide (IG). The FHIR IG is scheduled for the May 2019 HL7 Ballot Cycle.

eLTSS Roadmap 2018 to 2019



Working with a Standards Development Organization – HL7

eLTSS Engagement with HL7

- Working with an SDO such as HL7 provides a way to integrate our efforts to enable interoperability for Home and community based services (HCBS) and supports into the broader healthcare interoperability landscape bridging the gap to the larger clinical ecosystem. Being able to leverage an industry recognized standard gives implementers the framework necessary to create interoperability between and across different healthcare entities.
 - » <http://www.hl7.org/>
- Within HL7, our work is being conducted under the guidance of the following workgroups:
 - » Community Based Care and Privacy (CBCP)
 - » Patient Care (PC)
 - » Structured Documents (SD)
 - » FHIR Management Group (FMG)
 - » Financial Management (FM)
 - » Orders and Observations (O&O)
- Participated in the **2018 HL7 September Working Group Meeting**

eLTSS Informative Document

eLTSS Informative Document Contents

- Informative Document: Provide the HL7 Community with context and narrative around how two national recognized standards, FHIR and C-CDA, can be used to represent and exchange the eLTSS Dataset
 - Introduction, Objectives and Background
 - LTSS Ecosystem Overview and Information Sharing Use Cases
 - FHIR and C-CDA for LTSS Service Plan Information Exchange
 - Approach for Selecting Standards
 - Overview of Selected Standards and Mapping Results
 - Exchanging LTSS Service Plans Using FHIR
 - Exchanging LTSS Service Plans Using C-CDA
 - Considerations for Future Work
 - Appendices:
 - eLTSS Dataset
 - FHIR and C-CDA Mappings
 - FHIR and C-CDA sample instances
 - C-CDA rendered sample
 - Quality of Mapping Legend

HL7 Ballot Voting Results

- The eLTSS Informative Document was balloted through the HL7 September 2018 Ballot Cycle

Voter Role	#
Affiliate	5
Consultant	21
Government/Non-Profit	36
Payor	9
Pharmaceutical	0
Provider	22
Vendor	24
Total	117

Vote Type	#
Affirmative	43
Abstain	56
Negative	4
Did Not Vote	14
Total Voters	117

- » The eLTSS Informative Document achieved quorum and the ballot passed
- » A total of 75 comments were received from Voters

eLTSS FHIR Implementation Guide

eLTSS FHIR IG Development

- Based on the scenarios articulated in the eLTSS use cases, the FHIR framework is a great fit for enabling eLTSS exchanges due to its focus on streamlined API-based interoperability, flexible and modular approach and comprehensive focus aimed at supporting clinical, administrative and social services workflow needs.
- The eLTSS FHIR Implementation Guide (IG) will provide implementers with online guidance (API specifications, capability statements, and resource profiles) on how to use FHIR to exchange eLTSS data.
- The FHIR IG development process is strict and relies heavily on prescriptive deadlines with each step being dependent on previous steps and outside resources (artifact approvals, tooling modifications/versioning, etc.).
- The goal of this next phase of the eLTSS project is to mature and formalize the details published in the eLTSS Informative Document into the eLTSS FHIR IG which will be balloted as a Standard for Trial Use (STU). An STU balloted IG at provides implementers with comprehensive guidance on how to use FHIR to enable electronic exchange of the eLTSS Dataset data items.

HL7 FHIR Balloting Timeline and Artifacts (1/2)

What Needs Done	How Do We Get It Done?	Why Do It?	When is it Due?
Introduce Upcoming Ballot to HL7	<ul style="list-style-type: none"> Contact FHIR FMG of our upcoming plans and get insight from them on action needed Attend Jan 2019 HL7 WGM to present our upcoming plans to FHIR, CBCP, and Other Interested WGs (O&O, FM, PC) 	HL7 recommends that prior to officially compiling a ballot that a project considering developing a ballot circulate and introduce the idea of the work to the appropriate HL7 work groups. This allows the work groups to provide guidance and feedback before the formal ballot process begins.	1/18/19
Project Scope Statement (PSS)	<ul style="list-style-type: none"> Modify the existing PSS for the eLTSS Informative Document for the FHIR IG Need approval from: CBCP WG, FHIR Management Group (FMG), US Realm Steering Committee, Steering Division, Architectural Review Board, and Technical Steering Committee. 	This form is the formal introduction of our work to HL7 WGs. This form outlines the sponsoring WGs, project team, project scope and need, and any external drivers and dependencies.	1/27/19
FHIR IG Proposal	<ul style="list-style-type: none"> Complete and submit to FHIR Management Group (FMG) 	Acceptance of proposal will result in the creation of the eLTSS project within the HL7 framework.	TBD
Notification of Intent to Ballot (NIB)	<ul style="list-style-type: none"> Work with CBCP WG to complete and submit form to HL7 	This officially notifies HL7 of our projects intent to move forward with a ballot for the May 2019 cycle.	2/17/19
Functionally Complete IG	<ul style="list-style-type: none"> Work with CBCP FHIR Liaison (John Moerhke) Download and install appropriate HL7 FHIR IG Tooling Develop Profiles Develop FHIR Sample Files Populate required IG sections with Content 	To validate and prioritize ballots and to develop the framework to support the ballots, HL7 is requiring a Functionally Complete IG as part of the NIB package.	2/17/19
Final Content	<ul style="list-style-type: none"> Submit Complete FHIR IG to HL7 for QA 	HL7 requires a new QA period for all FHIR ballots to ensure ballots are well developed prior to the ballot period.	3/3/19
Final Freeze	<ul style="list-style-type: none"> Complete and submit FINAL FHIR IG Content (all text, profiles, sample files, etc.) to HL7. 	Required by HL7 – ensures the ballot content and structure is ready for ballot opening.	3/24/19

HL7 FHIR Balloting Timeline and Artifacts (2/2)

What Needs Done	How Do We Get It Done?	Why Do It?	When is it Due?
Ballot Consensus Pool	<ul style="list-style-type: none"> Sign up for the eLTSS FHIR IG ballot pool on the HL7 Ballot Desktop 	To vote on an HL7 ballot a voter must sign up to be part of the ballot pool. This is similar to voter registration.	3/1 – 3/28/19
Ballot Period	<ul style="list-style-type: none"> Submit and monitor vote / comments 	This is when the formal voting takes place. Anyone signed up for the ballot pool is able to vote.	3/29 – 4/29/19
May 2019 WGM	<ul style="list-style-type: none"> Held in Montreal (Quebec) Canada Begin comment reconciliation of ballot comments (virtually) 	HL7 requires that ballot results are shared at the working group meeting associated with the ballot. Ballot reconciliation will often begin at the working group meeting.	5/4 – 5/10/19
Ballot Comment Reconciliation	<ul style="list-style-type: none"> Work with ballot voters and CBCP WG to dispose all ballot comments 	Required by HL7 as part of the ballot process.	5/4/2019
Modify IG	<ul style="list-style-type: none"> Make modifications to eLTSS FHIR IG based on comments 	Enhance the specification based on comment feedback.	TBD (based on # of comments)
Publish IG	<ul style="list-style-type: none"> Publish eLTSS FHIR IG using HL7 tooling 	Standard is available for implementation and use.	TBD (dependent on comments)

eLTSS Community Engagement

eLTSS Community Engagement

- Join the HL7 CBCP WG weekly calls to engage in ballot reconciliation review
 - » Tuesdays 12:00 – 1:00pm ET
 - » <http://join.freeconferencecall.com/cbhs>
 - » Conference Audio: (515) 604-9861 / Access Code: 429554
- Attend the January 2019 HL7 Working Group Meeting (WGM) January 12-18, 2019 in San Antonio, TX
 - » WGM Information / Registration:
https://www.hl7.org/events/working_group_meeting/2019/01/
- Visit the eLTSS HL7 GForge Site for ballot-related artifacts:
 - » <https://gforge.hl7.org/gf/project/cbcc/docman/eLTSS%20-%20%20ONC%20Electronic%20Long-Term%20Services%20and%20Supports/>
- Visit the eLTSS Confluence Page for meeting information and relevant artifacts:
 - » <https://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home>

eLTSS Initiative: Project Team Leads

- **ONC Leadership**
 - » Stacy Perchem (Anastasia.perchem@hhs.gov)
 - » Elizabeth Palena-Hall (elizabeth.palenahall@hhs.gov)
- **CMS Leadership**
 - » Kerry Lida (Kerry.Lida@cms.hhs.gov)
- **State of Georgia, Department of Community Health Leadership**
 - » Bonnie Young (bonnie.young@dch.ga.gov)
- **Program Manager**
 - » Johnathan Coleman (jc@securityrs.com)
- **Project Management**
 - » Amber Patel (ayp@securityrs.com)
- **Subject Matter Expert**
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ONC Annual Meeting 2018

November 30, 2018

Shawn Terrell, Administration for Community Living



**Person Centered Thinking, Planning, and Practice is
the foundation of Home and Community Based
Services for people with disabilities across the
lifespan**

Person-Centered

- **Person-centered thinking** recognizes that people are experts in their own lives, everyone can express their preferences and live a full life in their own community that they and the people who care about them have good reasons to value.
- **Person-centered planning** identifies and addresses the preferences and interests that make up a desired life and the supports (paid and unpaid) needed to achieve it. It is directed by the person and supported by others selected by the person, who are independent of any service/support to be delivered in the plan.
- **Person-centered practice** is the alignment of service resources and systems that give people access to the full benefits of community living and delivers services in a way that facilitates achieving the person's desired outcomes.

Person-Centered Requirements/Guidance in HHS Programs

- ACA Section 2402(a) Guidance (HHS-Wide)
- HCBS Final Rule (CMS)
- Long Term Care Rule (CMS)
- Managed Care Rule (CMS)
- Health Homes (CMS)
- Accountable Care Communities FOA (CMS)
- Discharge Planning Rule (CMS)
- Person & Family Engagement Program (CMS)
- No Wrong Door (ACL)
- Mental Health Block Grants (SAMHSA)
- Certified Community Mental Health Clinics (SAMHSA)
- eLTSS Standards (ONC)

Current State of Practice

- Several states have committed, ongoing emphasis on person-centered planning in part or all of their Medicaid HCBS programs.
- Most states have very small commitments
- Large state demand for TA (no central entity)
- No agreed upon practice standards or systems design requirements
- Little end user awareness of what to expect
- Little research on best practices, KSAs, systems design.

Status Quo Prevails

- People are often left with someone else's plan:
 - » Doing things they don't want to do
 - » With people they don't want to be with
 - » In places they don't want to be

ACL Vision for Person-Centered Systems Person-Centered Systems

- People know what to expect
- People who facilitate planning processes are competent
- Systems are configured to deliver services and supports in a manner consistent with person-centered values
- People with lived experience drive change at all levels of the system.
- Quality measures are implemented for process fidelity, experience, and outcomes based on each person's preferences and goals.
- Principles of continuous learning are applied throughout the system.

The Core Concept:

Important **to** and Important **for**
and
the **Balance** between them

Important TO

What is important to a person includes those things in life which help us to be satisfied, content, comforted, fulfilled, and happy.

It includes:

- People to be with /relationships
- Things to do & places to go
- Rituals or routines
- Rhythm or pace of life
- Status & control
- Things to have

Important TO

- Includes what matters the most to the person
 - their own definition of quality of life.
- What is important to a person includes only what people “say”:
 - with their words
 - with their behavior

When words and behavior are in conflict,
pay attention to the behavior and ask “why?”

Important FOR

- Issues of health:
 - Prevention of illness
 - Treatment of illness / medical conditions
 - Promotion of wellness (e.g.: diet, exercise)
- Issues of safety:
 - Environment
 - Well being ---- physical and emotional
 - Free from Fear
- What others see as necessary to help the person:
 - Be valued
 - Be a contributing member of their community

Important To and For are Connected

- Important to and important for influence each other
- No one does anything that is “important for” them (willingly) unless a piece of it is “important” to them

Balance is dynamic (changing) and always involves tradeoffs:

- Among the things that are “important to”;
- Between important to and for

Finding the Balance

- We all make tradeoffs between the many different things that are *important to us*.
 - Some people may love living in a particular place.
 - And are willing to make the tradeoff when living there means a longer commute to the work they love.
- We also make tradeoffs between what is *important to us* and what is *important for us*. These tradeoffs can be temporary OR long term solutions.
 - For some fun time with friends is important to them. Having a clean house may be part of being valued by those same friends. House cleaning occasionally comes before having fun with friends.
 - For another person, expressing personal opinions and saying what is on his mind is important to him, but not cussing in front of his neighbors may be important for him.

And Choice has Boundaries for Everyone

Imposed by society

- Laws
- Expectations/values

My values

- What is and is not OK for me and those I trust

Ripple effect - One choice creates boundaries on other choices

- My relationships
- The work I do
- Where I live

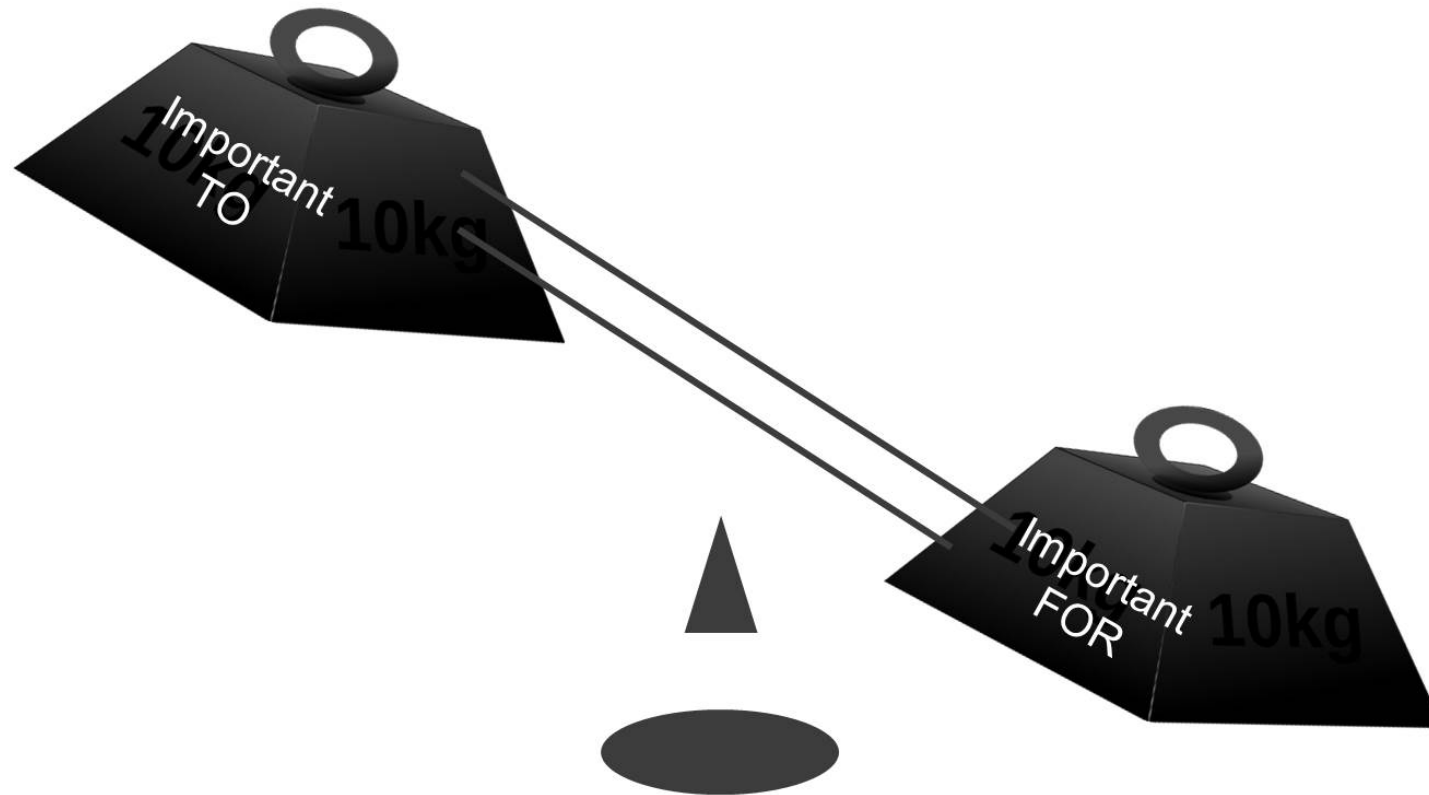
Resource Driven

- Financial – how much time or money I have available

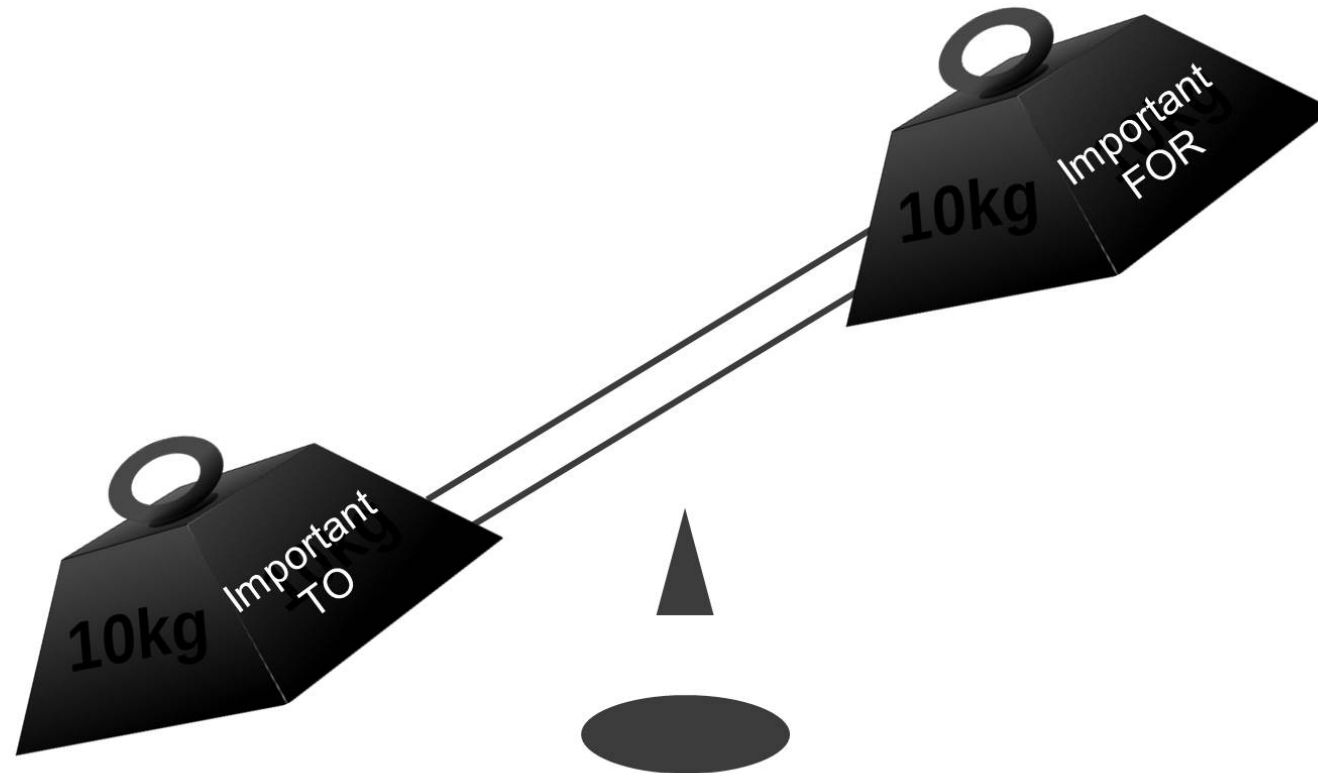
Risk involved

The difference is when the boundaries are set for the convenience of the system and therefore limit choices that meet the person's desires: – operating hours, staff available, policies or procedures.

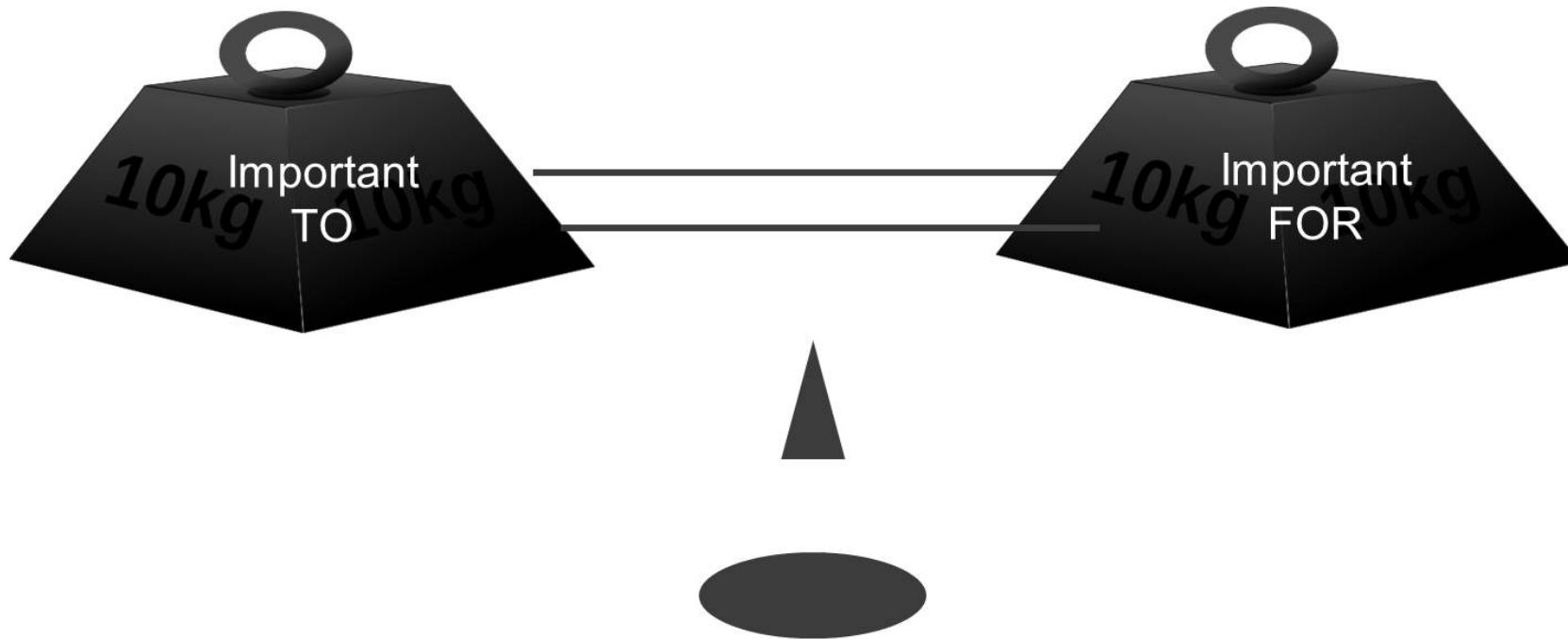
Health and Safety Dictate Lifestyle



All Choice No Responsibility



Balance



Ruth's One Page Description (At Home)

What People Like and Admire about Ruth

- Such a “grandmother”
- A true lady
- Has the gift of gab—can hold a conversation with anyone!
- Always dressed so nicely—everything always matches, right down to socks and earrings
- Very liberal thinker for her age



What is Important to Ruth

- Living with her granddaughter and grandson-in-law
- Being warm and feeling safe with caregivers
- Having a “little pour” before bed (rum and tea)
- Being a part of whatever is going on at home—being in the middle of it!
- Sweets during the day!

Supports Ruth Needs to be Content, Healthy and Safe

- Needs people to ask frequently if she is warm enough and help her put on sweater/sweatshirt if she is not (she'll be cold when you're not)
- Must have assistance with her medications—knows them by color but you need to dole them out and keep track of times
- Needs assistance with bathing and dressing—will tell you what clothes she wants to wear for the day/event
- When bathing, no water on face—she will wash with cloth
- Must talk with daughter 2-3 times a week on the phone—will need you to dial for her
- Must see her doctor right away if she has cough, fever or is “off balance”—indications of systematic infection that will grow quickly!

People who Support her Best

- Like to chit chat
- Are timely and stay busy
- Polite and mannerly
- Have a witty and dry sense of humor
- Can be reassuring and help Ruth feel safe

Questions

