The Power of Collaboration

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One to the Tenth Power
Topic Outline

1. The geriatric imperative
2. Aging with lifelong disabilities
3. Public policy and the role of coalitions as *de facto* policy
4. Assisted autonomy as a modus operandi
5. Keys to effective inter-system coalitions
The Geriatric Imperative

- Post-reproductive nonconformity
- Within group variance
- Individuation
Aging with Lifelong Disabilities

• Aging being enveloped by disability, because of difficulty with "aging"

• Similarities between systems: marginal/undervalued; underfunded; reliance on caregivers, etc.

• Differences between systems: person-centered vs. program-driven; large numbers of unidentified clients
Public Policy on Aging with Lifelong Disabilities

- Lagging public policy and the role of coalitions as *de facto* policy
- Newness of aging with lifelong disabilities; historical non-intersection and different priorities of the systems
- Differences between currently older and younger persons with lifelong disabilities
Assisted Autonomy

- History of “autonomy” and laissez faire indifference
- Folly of "independence"
- Assisted autonomy as a modus operandi
- Getting assistance that the person needs and can direct
Inter-System Coalitions: An Answer

- Coalitions between advocacy groups and agencies, and between agencies across systems (aging, ID/DD, late-onset, health, social services, faith communities, parks & recreation, etc) can improve services, produce savings, and reinforce families and people with disabilities.
- Coalitions are time-limited
- Coalitions can be laboratories for public policy development
Inter-System Cooperation: Barriers

- Little or no history of interaction
- Differences in perceived benefits
- Tree versus forest mentality
- Restrictive mental geography
- Shortage of crossed-trained personnel
- Absence of clear-cut goals
- Lack of a non-threatening (neutral) broker
Partners III Project: The Integrated Model of Service

- Assembled best practices from several previous projects
- Created and field-tested with AoA support
  - a model for cooperation between the aging and developmental disabilities systems
- Evaluated results in urban, suburban, and rural settings: Evidence-Based
Partners I, II, III in Maryland and Virginia: 1986-1997

Identified the key elements of effective intersystem cooperation as (1) formal mechanisms for collaboration at local and state levels, (2) diverse outreach strategies by local coalition acting as a virtual organization, and (3) capacity-building opportunities for staff, caregivers, and consumers.

Identified central roles for neutral brokers.
Integrated Model of Service

1. **Collaboration**
   ✓ Statewide Mechanisms
     ▪ Memoranda of Understanding/Agreement
     ▪ Professional/Consumer Advocacy Council (PCAC)
   ✓ Area Planning and Services Committee (APSC)

✓ = essential element
Integrated Model of Service

2. Outreach

✓ Resource fair
  ▪ Home visitor survey
  ▪ Focus groups
  ▪ Telephone surveys
Integrated Model of Service

3. **Capacity Building**
   - Cross-Training of Staffs
   - Training in Self-Care and Advocacy for Consumers and Informal Caregivers
     - Integration of Older Adults with Lifelong Disabilities into Community Services
     - Internships across Systems
Keys to Intersystem Coalition Building:
(1) Starting

<table>
<thead>
<tr>
<th>Spark</th>
<th>a champion or zealot</th>
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<tbody>
<tr>
<td>Specific problem</td>
<td>issue(s) to be addressed</td>
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<td>Incentive</td>
<td>perceived benefits</td>
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<td>Neutral broker</td>
<td>non-threatening matchmaker</td>
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<td>Keys to Intersystem Coalition Building: (2) Succeeding</td>
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<td><strong>Objectives</strong></td>
<td>achievable through specific tasks and activities</td>
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<td><strong>Approvals</strong></td>
<td>top-down and bottom up</td>
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<td><strong>Ownership</strong></td>
<td>members must see the coalition as “theirs” and attend</td>
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<td><strong>Fit</strong></td>
<td>compatibility with other like-minded individuals and groups</td>
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Keys to Intersystem Coalition Building:
(3) Proceeding

**Resources** modest but adequate funding or pool of in-kind

**Real Members** must be more than just people appointed to fit a category

**Executive Involvement** agency heads commit to the coalition, preferably in writing

**Channeling** members convey content back to their agencies (minutes, etc)
Area Planning and Services Committee (APSC) in Metro Richmond

• Established in 2003, evolving from two-year single county MR task force
• Good mix of organizational members, with written commitments; meets monthly all year
• Doctoral student intern, summer 2004, helped with initial surveys of members/registrants
• Identified priorities democratically at outset: cross-training, public awareness, emerging issues
• Down and dementia; loss and bereavement; spirituality and aging; aging in place, etc
Goals of Interdisciplinary Teams

1) Understand respective roles and responsibilities on the team
2) Establish common goals for the team
3) Agree on rules for conducting team meetings
4) Communicate well with other members of the team
5) Identify and resolve conflict
6) Share decision-making and execute defined tasks when consensus is reached
7) Provide support for one another, including the development of leadership roles
8) Be flexible in response to changing circumstances
9) Participate in periodic team performance reviews to ensure that the team is functioning well and goals are being met

(Parntership for Health in Aging [PHA], 2011)
Collaborative Initiatives

- Friendship Café for adults with lifelong disabilities
- Healthy Cooking DVD
- Health Baseline Screening Protocol
- Statewide conferences every June
- Training workshops every November
  - Down and dementia; arthritis and co-morbidities; healthy heart; recreation and exercise
APSC June Conferences 2005-2014

- Spirituality, Loss, and Aging
- The Road to Wellness: Best Practices
- Aging in Place, Aging Well
- Choices: The Future Is Now
- Community Supports: Caregivers and Consumers
- Creative Roads to Inclusion
- Livable Communities
- Later Aging
- Wellness Trends and Resources
- Cutting Edge Breakthroughs
PHA Competencies

• Domain #1: Health Promotion and Safety
• Domain #2: Evaluation and Assessment
• Domain #3: Care Planning and Coordination across the Care Spectrum (Including End-of-Life Care)
• Domain #4: Interdisciplinary and Team Care
• Domain #5: Caregiver Support
• Domain #6: Healthcare Systems and Benefits
Lessons Learned

- Community partnerships; democratic advisory board; marketing vs. selling; “shared enterprise”
- Agree on a dream
- Identify a neutral broker
- Draw in interdisciplinary involvement by recognizing enlightened self-interest
- Accept slow growth