## Title XIX MR/DD HCB Waiver Service Coordination
## Home and Day Visit Guidelines

### *Role of MR/DD Service Coordinator*

Federal Waiver program administrators require a monthly home visit for each participant of the Title XIX MR/DD HCB Waiver program. The frequency of visits stems from the need to ensure the service coordinator has ample opportunity to provide timely service and fulfill obligations. Obligations include assistance to the participant and caregivers to obtain the skills needed in terms of building and maintaining adequate and individualized support systems. The purpose of the support system is to ensure the person's needs are met with the least necessary amount of service in order to have a maximum quality of life and safety while living in the community. The Waiver program values each person's right to live in the "least restrictive environment" with as much freedom and choice as that person can safely manage. Without the Waiver program, many, if not all of the enrolled participants are at risk of being hospitalized, institutionalized or even incarcerated in some cases. We believe that all persons regardless of disability can achieve a viable level of quality of life when they have supports from the community.

### *Purpose of Visits*

The purpose of the visit is to provide information, role modeling and assistance in order to establish ongoing plans of intervention for building strong support networks. Through home visits, needs can be identified and agreements obtained for assistance with improvements. The Service Coordinator is viewed as the "gatekeeper" for accessing services and has responsibility to ensure more intrusive interventions are not necessary. The service coordinator is charged with the duty of ensuring the health, safety and welfare of each assigned participant. The duty of the service coordinator is not superseded by the presence of a legal guardian.

## Record Review

Review record to determine any needed clinical, service, or documentation updates which may be needed. Ensure familiarity with participant diagnostic criteria, annual and current medical and habilitation status, personal preferences and family demographics. Review the previous month's home/day visit documentation to ensure all requests have been resolved with measurable outcomes. Make plans for intervention in any incomplete areas of needed intervention.

## Visit Preparation

Prepare any needed materials such as SC IPP copy, consent forms, copies of the Waiver manual, blank APS/critical incident reporting forms, community resource brochures, policy information or data collection tools as requested by the participant, home provider, or clinical Therapeutic Consultant.

## Setting Parameters of Visits

Call the participant and/or home or day service provider. Always introduce yourself by name and title. Define your role, and the purpose of the visit. Provide description of the parameters of the visit including arrival and departure time and specific tasks for completion. Ask for any questions. Instruct participant and/or home or day service provider to consider needs and provide information regarding any area you may be able to assist with or resolve prior to the visit. Provide information regarding any specific tasks for completion during the visit. Obtain initial and periodic statements of understanding of the terms of the visits from each participant and/or provider.

## Scheduling Visits

Inquire about the most convenient time for your arrival. Minimize risks of interference with participant lifestyle choices, habilitation program, and community or medical appointments. Offer a choice of a set scheduled day and time for the visit each month, utilize a monthly scheduling routine of scheduling the next visit at time of visit. Accommodate preference within reason and capacity.

## Beginning the Visit

Always arrive on time. Engage in appropriate rapport building. Provide a business card or other form of identification upon arrival.

## Initial Personal Well Being Assessment

Request a tour of the home or day environment including the participants sleeping accommodations. Make a brief verbal assessment of the overall status of the appearance and environment for the participant and caregivers. Discuss any concerns about safety hazards or cleanliness with the participant and care providers. Document the status in terms of overall well being and address any unmet needs accordingly. Assessment is repeated at each visit.

## Protective Services Referrals

Assessment of the health and safety of the participant in the environment is routine. Ensure the personal dignity of each individual is maintained whenever any concerns arise. Routine service coordination events require documentation of reference about the overall appearance of the participant. If the participant appears disheveled, shows signs of illness, bruising or other concerns, which have not been addressed by the support provider, then protective intervention may be needed. Compare provider and participant self reports to objective facts and subjective interpretations. Clarify concerns where needed. Review any written reports pertaining to the matter. Discuss possible solutions. Offer potential options which may include exploration of potential possibilities if unknown. Determine the likelihood of resolution without more formal means as it relates to the ramifications of failure of the provider or participant to gain resolution. Prioritize the level of necessary intervention - if any. Make arrangements for intervention if selected by the participant or provider or otherwise required by law. Provide information regarding the plan of intervention. Non-routine interventions must be approved by supervisors. ***__Service Coordinators are mandatory reporters of any suspicion of Abuse or Neglect as required by WV State Public Law.__**

## Review of Last Months Services

Provide information to the participant and provider regarding your actions and the case status over the last month. Report about any updates, completed requests, noted progress, solved concerns or other completed follow up.

## **Order of Business for Visits**

*Accessible Information: Ensure active treatment.*

1) Ask the participant and/or care provider to have available:
    a) current copy of the IPP
    b) schedule/appointment calendar and
    c) on-going data collection instruments

*Status Review: Obtain verbal reports of the current overall status of well-being of the participant.*

2) Inquire about and document reports of the participants:
    a) sleeping patterns,
    b) appetite,
    c) behavior,
    d) community supports,
    e) recreational activities,
    f) any barriers to positive outcomes
    g) currency of crisis back up plan and
    h) any other needs as identified

*Systems Maintenance: Check legitimacy of services.*

3) Ensure the currency and applicability of the following authorizations, and certifications:
    a) Currency of IPP in terms of service units, provider ratios, progress objectives, and outcomes

4) Monitor the working condition of the following items:
    a) Fire/Smoke alarm batteries, sprinkler systems if applicable
    b) Wheelchair ramps, appendage splints, speech devices, adaptive feeding utensils
    c) Communication Logs between residential and day service sites and/or medical personnel including reporting of any incidents

*Documentation of the Visit: Required for continued funding*

5) Professional legal documentation is required for the following:
   a) physical well being and other medical appointments

   b) psychological/psychiatric appointments
   c) social and legal appointments
   d) therapy and habilitation appointments
   e) critical incidents
   f) frequent maladaptive behavior
   g) verbal or written results of all appointments and
   h) dates for additional follow-up appointments

*IPP Review: Ensures focus of purpose of program*

6) Review of the IPP and ongoing data collection instruments for any changes in strengths, or needs. Make general notations about areas of :
   a) maintenance,
   b) needed improvement,
   c) actualized improvement or
   d) regression

*Planning Needed Follow-Up Actions: Often results in more referrals*…

7) Provide suggestions or plans for minor revision of any areas in which methods are not sufficient to result in progress or in areas in which progress is recognizable. Link with the responsible parties for interim service requests, and quality issues. Convene the team as needed for approval of major changes.

*Quality Assurance: Checks and Balances*

8) Assess the cleanliness, and functionality of any medical, or adaptive equipment. Target methods and prepare plans for intervention if replacement or repair is needed.

*Trouble Shooting: Early identification of quality concerns*

9) Inquire about the level of active treatment, and practicality of program functions. Give feedback regarding the accuracy, frequency or currency of daily data collection efforts.

Redirect providers who may show zero variation in the amounts and/or quality of daily service. Present to core support team and update the financial allocation requests when indicated.

*Organizing Future Services: Planning Structured Interventions*

10) Plan the next service planning meeting. Confirm scheduled dates. Encourage the participant to invite any natural supports. Offer to provide an invitation. Determine likelihood of stability of services for the next quarter.

*Step for Case Management of Customer Satisfaction*

11) Encourage the participant and providers to maintain an ongoing list of questions, concerns, desired changes, potential improvements for discussion with the core support team. Assist the participant and provider to prioritize any concerns or issues.

*Quality Assurance Check for Customer Satisfaction*

12) Seek requests for information gathering for presentation to the participant and care provider and subsequently the core support team.

*Exiting the Home Visit: Final checks for service requests*

13) Ensure an emergency or special staffing is not needed. If any issues arise requiring immediate intervention, then proceed accordingly. Convene the core support team via telephone or in person for any changes to established IPP which need team approval. Schedule next visit.

## Building Responsive Support Teams

Building responsive support teams is the biggest challenge a Service Coordinator has. The support team expects the service coordinator to be the cure all for progress. This expectation is the accountability to the participant in terms of quality of supports. The service coordinator establishes a rapport with various individuals who are significant to the participant. Once the committed players are

identified, then the service coordinator forms the commitment of the team into dedication. The participant's job is to utilize the available resources for maximum value. The job of the service coordinator is to teach the team members how to work harmoniously and collaboratively to increase the participants' sense of independence.

Service coordination begins and ends with linkage of the participant and care providers to responsive resources. The referral process is an action of making oneself a continuously accessible medium for communication between all members of the support team. The service coordinator preserves dignity by assuming the responsibility of asking for any needed help on behalf of the participant and with the participants' agreement. Once consents are obtained, then the service coordinator routinely coaches the Therapeutic Consultant, day program provider and/or other members of the support team. Documentation includes problem solving to maximize the quality of outcomes. In the event responsible parties are not producing quality outcomes, then the service coordinator provides advocacy to expedite resolution of unmet needs.

## Barriers to Success

The service coordinator facilitates exploration of efforts to identify barriers. The dispensation of barriers often begins with service coordination. As the person responsible for integrating all assessment information into one cohesive whole, the service coordinator is in an ideal position to identify and prioritize efforts to destroy obstacles blocking the path of success for the participant. Barriers may be natural or man made. Accommodations and adaptations lessening the impact of any barrier may also be natural but are always *"service coordinator made."* Any barrier preventing successful mastery, core support team engagement is resolved by basic service coordination functions of advocacy. Any unresolved barriers are to be presented to the core support team for creative reduction or total elimination.

## Service Coordination Role Modeling

In the beginning stages, more general descriptions of the service coordination role is indicated, but as participants and providers gain independence, it is increasingly more appropriate to verbalize only specific tasks for completion. Provide information including description of barriers, and methods for overcoming obstacles in the event specific plans for service coordination intervention are incomplete. Periodically,

as natural opportunities arise, identify tasks the participant and/or provider can complete rather than the service coordinator. Encourage completion of such goals only when ample abilities have been demonstrated for lower priority level tasks. For example, if the service coordinator discovers the participant has demonstrated the ability to phone a friend and keep a date, then it may be an opportunity for the participant to learn to phone the service coordinator to set the date for the home visit. The service coordinator is in an ideal situation to act as the back up responsible party to ensure the event occurs and the participant is supported to learn rather than suffer negative consequences as a result of delay.

## Service Coordination Delegation

Use discretion, structured plans of intervention and IPP approval when delegating any service coordination responsibilities to the direct care provider and/or participant. Ensure focused plans of assessment, monitoring and intervention are in effect to prevent gaps in service or unmet needs. Maximize the participant's ability to perform any needed self-intervention. Transfer of the service coordination functions to the participant and core support providers reduces the necessity of continued service coordination. At this stage of mastery of vital skills of self preservation the role of the professional is reduced to simple monitoring for stability of the functional level. All stages of service coordination intake, assessment, planning, and intervention, monitoring and follow-up are reflected in the documentation. The service coordinator engages the participant, legal representative, individuals with a vested interest, and service providers in futures planning for an effective use and discharge of the participant from formal services.