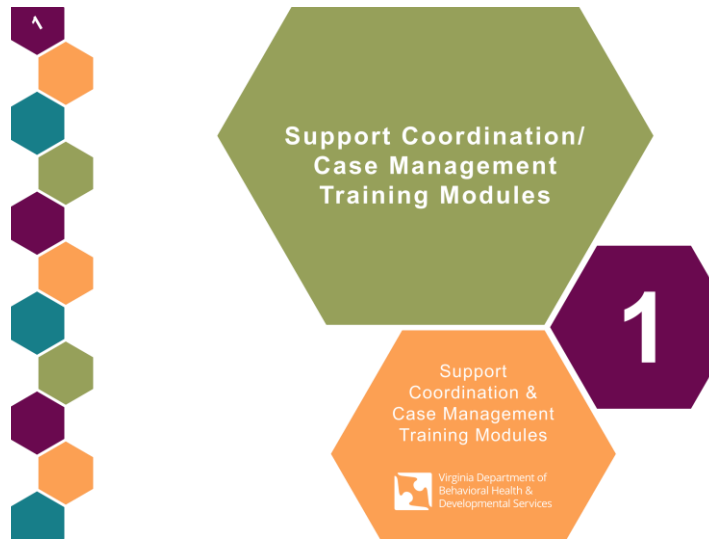



Slide 1





Welcome to Module 1 of the Department of Behavioral Health and Developmental Services (DBHDS) Support Coordination/Case Management Training Modules. This curriculum is designed for Support Coordinators and Case Managers in the Mental Health, Substance Abuse and Developmental Disability disciplines.

Slide 2



Introduction to the Curriculum

Module 1	What is Support Coordination/Case Management?
Module 2	Professional Responsibilities
Module 3	Accountability
Module 4	Engagement
Module 5	Disabilities Defined
Module 6	Health Integration
Module 7	Assessment
Module 8	Plan Development
Module 9	Plan Implementation
Module 10	Crisis Support
Module 11	Employment



Module 1 — Support Coordination/Case Management Training | 2


Support Coordination/Case Management is a very exciting and challenging profession. The Support Coordination/Case Management curriculum is intended to help Support Coordinators/Case Managers learn more about effective Support Coordination/Case Management, assist in building upon existing knowledge, and encourage the Support Coordinator/Case Manager to continue to develop professionally to enhance the services delivered. For some, this will serve as a starting point in learning about Support Coordination/Case Management, while for others it will be a refresher.

There are 11 Modules in this curriculum. Each Module includes a narrated PowerPoint and a PowerPoint text document which may be downloaded and printed. Each module will also include materials pertinent to the topic discussed that may also be printed from the materials section.

The Modules must be taken in order and completed within 30 days of the start date. There is a quiz at the end of each module. A passing score of 80% must be achieved in order to pass. A certificate of completion will be available upon completion of all 11 modules.

In addition to the eleven Modules listed, there are 3 training modules covering Housing, designed for Support Coordinators/Case Managers who work with people with developmental disabilities. These three modules are housed on the Commonwealth of Virginia Learning Center (COVLC).

Slide 3



Terminology — Terms Used in the Modules

Support Coordination


Case Management

Individual Support Plan (ISP)

- Outcomes
- Support Activities
- Support Instructions

Individual Service Plan (ISP)


- Goals
- Objectives
- Strategies



Module 1 — Support Coordination/Case Management Training | 3


The terms Support Coordinator/Case Manager and Support Coordination/Case Management will be used throughout these modules. The term Individual Support Plan or Individual Service Plan will be referred to as the ISP throughout this curriculum.

Slide 4



Introduction to Module 1

Module 1A What is Support Coordination/Case Management?
Module 1B Using the Support Coordination/Case Management Process



Module 1 — Support Coordination/Case Management Training | 4

Module 1 provides the definition of Support Coordination/Case Management along with the general responsibilities provided within this service. It is made up of 2 sections.

- Module 1a. What is Support Coordination/Case Management?, covers the definition of Support Coordination/Case Management, the process involved and the services provided.
- Module 1b. Using the Support Coordination/Case Management Process, uses examples of 2 people, Paul and Maria, to walk through the process involved in providing effective Support Coordination/Case Management services.

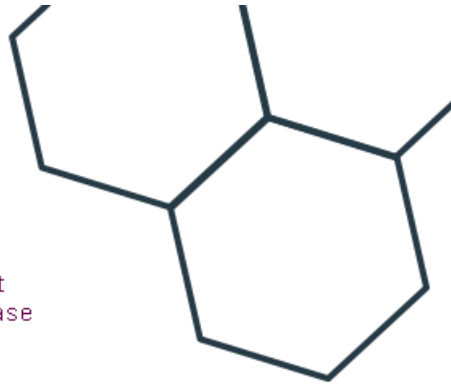
Slide 5



Module 1A
What Is Support
Coordination/Case
Management?

Objectives:


- Understand the definition of Support Coordination/Case Management
- Identify the steps in the Support Coordination/Case Management process



The objectives for Module 1a are to:


- understand the definition of Support Coordination/Case Management; and
- identify the steps in the Support Coordination/Case Management process.

Slide 6



The Importance of Support Coordination/Case Management & SC/CMs

- Support Coordinators/Case Managers are experts and vital participants on a person's team who empower people to understand and access quality, safe and efficient services.
Case Management Society of America, 2016
- Being a Support Coordinator/Case Manager is a huge responsibility and provides an amazing opportunity to make a difference in people's lives.



Module 1 — Support Coordination/Case Management Training | 6

Support Coordination/Case Management is the core service that many Virginians with behavioral health and developmental disabilities depend upon to help navigate and make the best use of a publicly funded system of services.

Support Coordinators/Case Managers are experts and vital participants on a person's team who empower people to understand and access quality, safe and efficient services (Case Management Society of America, 2016)

In some ways, Support Coordinators/Case Managers are the most important staff members in our entire system! They make sure people get access to the services they need and choose, that those services actually meet their needs and result in good outcomes. And if they don't, Support Coordinators/Case Managers take the lead in problem solving and advocating in order to hold the system accountable.

Being a Support Coordinator/Case Manager is a huge responsibility, and provides an amazing opportunity to make a difference in people's lives.

Slide 7



The Importance of Support Coordination/Case Management

If not for Case Management services, my brother would still be living an unproductive life... [it has] allowed him to live on his own, come and go as he pleases, function with a sense of productivity, and have a responsible life.

— Jennifer

Great things can happen if you let people help you. The Case Manager worked with me to develop a treatment plan and helped me through the recovery process... I know the recovery process is an on-going one and that I need to focus on my wellness every day but feel I know how to do that now.

— Lisa

Having a Support Coordinator has made such a difference in my son's life. There is someone there to advocate for Michael when my husband and I can't. Someone who helps us understand DD services and all of the choices we have for Michael's support. I always appreciate the updates we get and feel more at ease knowing that we're not alone.

— Andrea



Module 1 — Support Coordination/Case Management Training | 7

These are some quotes that illustrate the importance of Support Coordination/Case Management.

“If not for Case Management services, my brother would still be living an unproductive life... [it has] allowed my brother to live on his own, come and go as he pleases, function with a sense of productivity, and have a responsible life.” (Jennifer)

“Having a Support Coordinator has made such a difference in my son’s life. There is someone there to advocate for Michael when my husband and I can’t. Someone who helps us understand DD services and all of the choices we have for Michael’s support. I always appreciate the updates we get and feel more at ease knowing that we’re not alone.” (Andrea)

“Great things can happen if you let people help you. The Case Manager worked with me to develop a treatment plan and helped me through the recovery process ... I know the recovery process is an on-going one and that I need to focus on my wellness every day but feel I know how to do that now.” (Lisa)

Slide 8



Support Coordination/Case Management Defined

Collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a person's needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes.

Case Management Society of America,
Standards of Practice for Case Management 2016
www.cmsa.org



Module 1 – Support Coordination/Case Management Training | 8

The Case Management Society of America (CMSA), has been instrumental in developing and standardizing the practice of Support Coordination/Case Management for all practice settings. CMSA is a non-profit association founded in 1990 has been dedicated to the support and development of Support Coordination/Case Management. Their definition of Support Coordination/Case Management has changed several times over the years to keep up with the evolving profession. In 2016, they defined Support Coordination/Case Management as a collaborative process of assessment, planning, facilitation, coordination of services, evaluation and advocacy for options and services to meet an individual's and family's needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes.

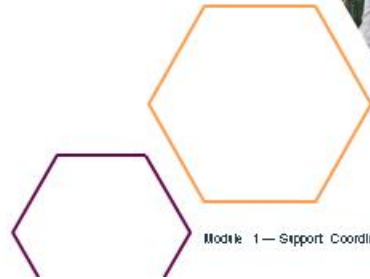
The link provided is for the CMSA website. The link is also listed in the material section of this module.

Slide 9



Required Knowledge, Skills & Abilities (KSAs)

Virginia's licensing regulations require Support Coordinators/Case Managers to possess a core set of knowledge, skills and abilities or KSAs in order to do their job well.



Virginia's licensing regulations require Support Coordinators/Case Managers to possess a core set of knowledge, skills and abilities (KSAs) in order to do their job well.

Slide 10



SC/CM Service Requirements

- Service Requirements for Providers of Case Management Services
- Qualifications of Case Management Employees or Contractors
- Permanent Regulations

Once finalized, a link for permanent regulations will be posted in the material section of this module.




Module 1 — Support Coordination/Case Management Training | 10

The administrative codes for Support Coordination/Case Management Service also outline service requirements for the state of Virginia. It is important to remember that each organization may also have additional requirements that the Support Coordinator/Case Manager will need to know.


The proposed permanent regulations are currently out for public comment. Once they are finalized, a link will be provided in the material section of this module.

Slide 11



Support Coordination/Case Management Requirements

- Department of Behavioral Health & Developmental Services (DBDHS)
www.dbhds.virginia.gov/quality-management/Office-of-Licensing
- Department of Medical Assistance Services (DMAS)
www.virginia.aid.dmas.virginia.gov/wps/portal/ProviderMenu
- Office of Human Rights
www.dbhds.virginia.gov/quality-management/human-rights



Module 1 — Support Coordination/Case Management Training | 11

Given the critical work that Support Coordinators/Case Managers do, they are subject to a number of state and federal laws, rules, and regulations. The following agencies fund and regulate services for people with behavioral health or developmental disabilities, including Support Coordination/Case Management:

- the Department of Behavioral Health and Developmental Services (DBDHS);
- the Department of Medical Assistance Services (DMAS); and
- the Office of Human Rights.

In reviewing their requirements, you will notice that the rules and regulations vary depending on the services provided and the population being served.

Links are provided to these resources. These links may also be found in the material section of this module.

Slide 12



The Support Coordination/Case Management Process is made up of seven stages. Preparation, Engagement, Assessment, Person Centered Individual Support Plan (PC ISP), or Individual Services Plan (ISP) Development, ISP Implementation, Monitoring and Evaluation, and Transitions, Transfers, Discharges or Ending Services. The following slides will briefly explain the purpose of each stage of Support Coordination/Case Management. The Support Coordination/Case Management process will be covered in more depth in subsequent modules.

Slide 13



Preparation

- Seek out background information of those seeking services
- Become familiar with referral sources
- Learn about the community(ies) in which those served live or participate



Module 1— Support Coordination/Case Management Training | 13

Being prepared to provide Support Coordination/Case Management includes knowing background information about those seeking services, being familiar with referral sources that will assist someone in meeting their goals and outcomes and learning about the community in which a person lives and participates.

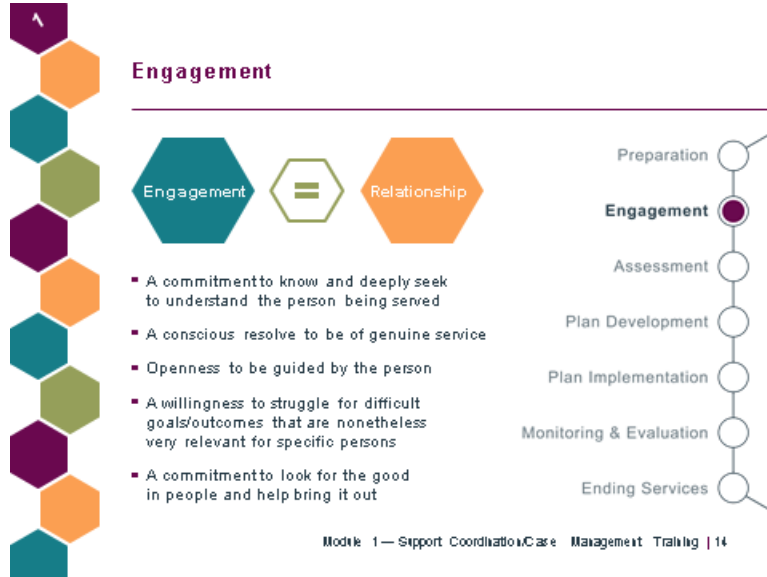
The term community refers both to a geographic location (e.g. where people live) and a group of people who share common characteristics or values. Getting to know the communities of those served may be accomplished by:

- attending community events;
- asking people about their experiences in the community and what is important to know; and
- learning about the community through books, the Internet, or documentaries.

Getting to know the referral sources is critical to being able to link people to services that will help them reach their goals or outcomes. Here are some tips on ways to learn more about the referral sources in the area.

- Ask people who have first-hand knowledge about their experiences.
- Talk to colleagues, especially those who have been providing Support Coordination/Case Management for a while.
- Search the internet at sites such as 2-1-1 Virginia. Look at provider web sites and sign up for relevant LISTSERVs.

Slide 14

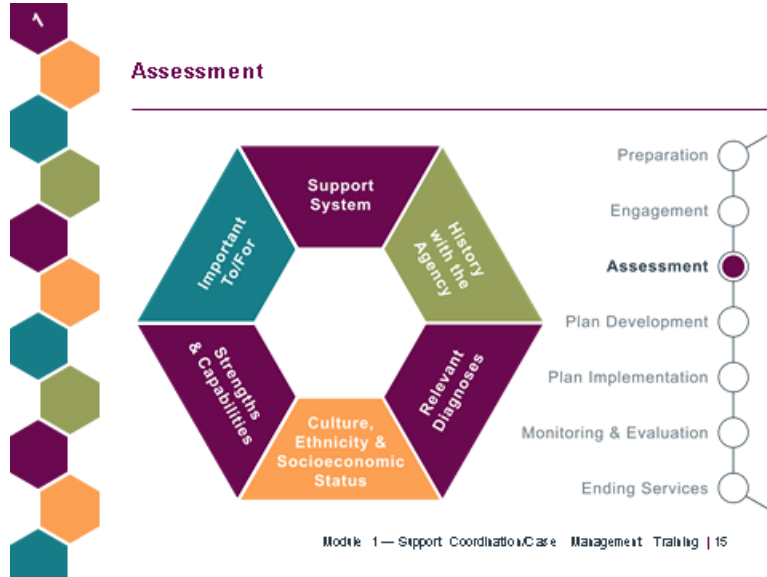


Relationships are key to providing effective services. Engagement refers to the development and maintenance of a helping relationship with the person being served.

Entering a relationship with someone seeking services should be approached with humility and care. The following are essential characteristics for engaging someone in a helping relationship: (These were presented by Michael Kendrick, in his keynote presentation entitled “When People Matter More Than Systems.” He presented this at a conference entitled “The Promise of Opportunity” in Albany, New York, 2000)

- a commitment to know and deeply seek to understand the person being served;
- a conscious resolve to be of genuine service;
- openness to be guided by the person;
- a willingness to struggle for difficult goals or outcomes that are nonetheless very relevant for specific persons; and
- a commitment to look for the good in people and help bring it out.

Slide 15



As will be discussed in Module 7, assessment involves the gathering of information that guides the work. It is characterized by the following:

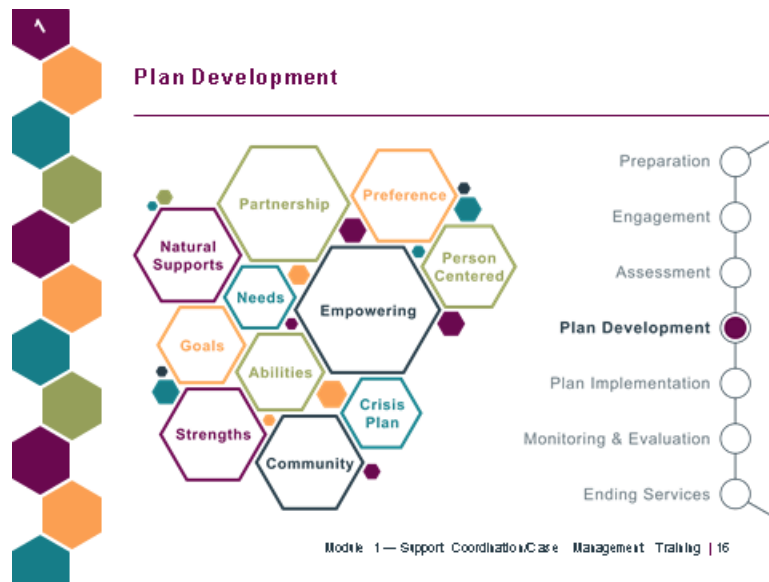
- assessment is an ongoing process;
- it focuses on the person seeking services, as well as their support system and environment;
- it is a collaborative process between the Support Coordinator/Case Manager and the person using the service; and
- it is oriented towards the strengths and capabilities of the person and their environment.

It is important during the assessment phase of Support Coordination/Case Management to:

- seek an understanding of what is important to and for the person. In other words, what things make the person happy, content, fulfilled, comforted, satisfied, healthy and safe;
- seek an understanding of the person's culture, ethnicity, and socioeconomic status and how each affects them;
- understand the criteria for relevant diagnoses to help guide what types of services might be most effective; and
- know the person's history with the agency. This might help to evaluate what services have been effective (or not) and why.

Assessments may be conducted using formal tools and informal strategies. The Support Coordinator's/Case Manager's organization will inform which tools to use.

Slide 16



Developing an individual support/services plan (ISP), requires the Support Coordinator/Case Manager to have skill in facilitation as it often involves bringing together a group of people to continue gathering information and organizing what has been learned about the person seeking services. Obtaining properly authorized releases in order to make collateral contacts with a person's significant others to promote implementation of the ISP is essential.

The ISP:

- is based on the assessment of a person's needs, strengths, abilities, personal preferences, goals, and natural supports;
- describes a person's goals and measurable objectives that will lead to achieving the goals, and strategies to help meet needs along the way;
- is developed through a partnership with the person who owns the plan, their network of supports, and the service provider(s);
- is person-centered and empowers a person as an equal partner; and
- should enhance community integration through increased opportunities for community access and involvement.

A plan may also include a crisis plan that indicates a person's preferences regarding treatment in an emergency situation, if necessary.

More about Plan Development will be covered in Module 8.

Slide 17

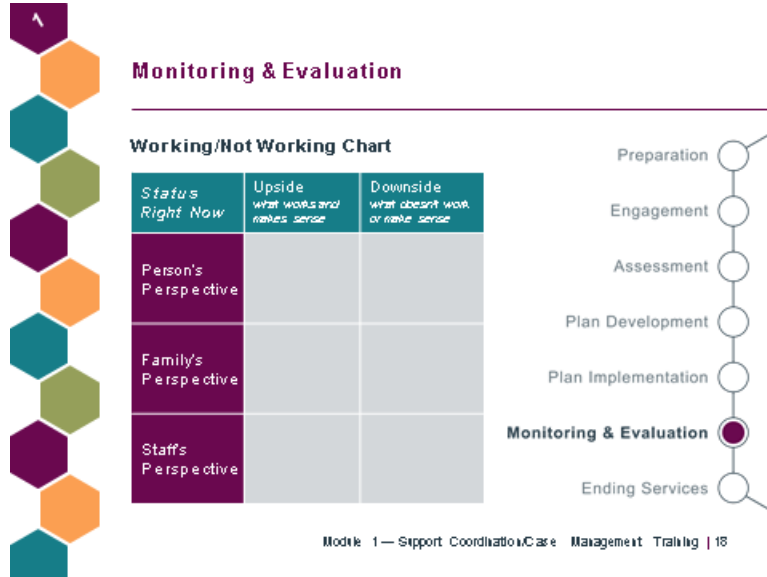


Plan implementation requires the Support Coordinator/Case Manager to perform several services that support the achievement of a person's goals and outcomes outlined in their plan.

They include:

- assuring the coordination of services among providers, human service agencies and systems, such as local health and social services departments, along with natural community based supports;
- linking to community supports and resources that are likely to promote the personal goals as developed in the ISP;
- assisting to locate and obtain needed services, resources, and appropriate public benefits;
- providing follow up instruction, education, guidance, and developing a supportive relationship that promotes the ISP; and
- addressing and problem solving about the barriers to using services and other resources in the community.

Slide 18



The Support Coordinator/Case Manager is always evaluating supports and services to see if they are helping people meet their goals and increase their connection to their communities. Monitoring may be done through regular contact with the person using services, key members of their support system, service providers, and periodic home and site visits to assess the quality of care and satisfaction.

It is also important for the Support Coordinator/Case Manager to understand and monitor health status, including medical conditions, medications and side effects, and assist in accessing primary care and other medical services, as needed.

Documenting reviews and updates to the assessment and ISP are part of monitoring and evaluation.

Using the person centered tool developed by the International Learning Community for Person Centered Practices, Working/Not Working is helpful in the evaluation process. This tool and the instructions on how to use it may be found in the material section of this module.

Slide 19



Ending Services

Successful transitions include:

- Plans to address how to handle set-backs
- Ensure the necessary supports are in place
- Necessary communications & documentation
- An understanding that people react differently to losses



Preparation

Engagement

Assessment

Plan Development

Plan Implementation

Monitoring & Evaluation

Ending Services

Module 1 — Support Coordination/Case Management Training | 19

The last stage of Support Coordination/Case Management involves supporting someone through the transition when they no longer need Support Coordination/Case Management services or will be transferred to another Support Coordinator/Case Manager. It often includes a planned process of using fewer services and more natural supports in the community.

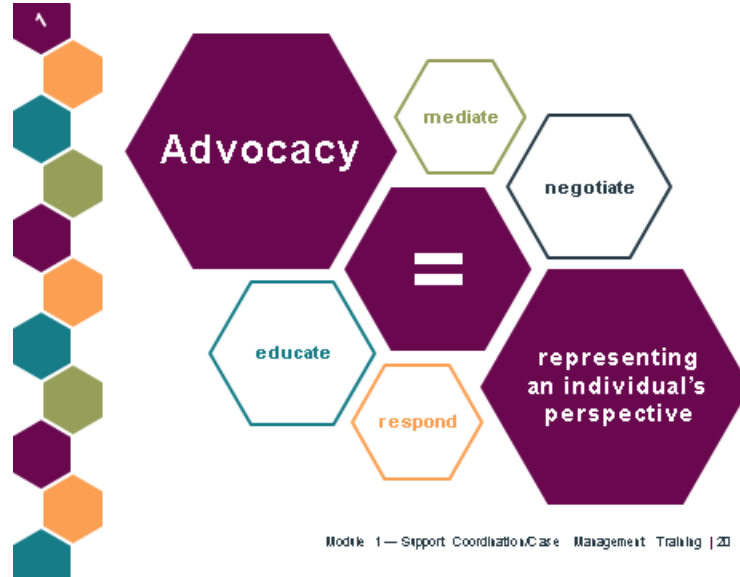
Transition and ending Services can occur for many reasons.

- The Support Coordinator/Case Manager is leaving the position.
- The Support Coordinator/Case Manager isn't leaving the position, but services are going to be provided by another Support Coordinator/Case Manager or service provider.
- The person no longer needs or wants Support Coordination/Case Management services.
- The person no longer meets the criteria to use Support Coordination/Case Management services.
- The person moves to another area of the state.

Successful transitions and discharges are those that:

- include plans to address how to handle set-backs;
- ensure the necessary community supports are in place;
- include the necessary communications and documentation, if services will be provided by another Support Coordinator/Case Manager or service provider; and
- understand that people react differently to the loss of relationships, especially helping relationships, and they may need help to process those reactions.

Slide 20



Advocacy is a responsibility of the Support Coordinator/Case Manager that may occur throughout the entire Support Coordination/Case Management process. It is the Support Coordinator/Case Manager’s job to make sure that those served are connected to all the services they need. If the appropriate services are not available, the next step is to advocate for them.

Advocacy involves representing an individual’s perspective in the community, with service providers and funders. Negotiation, mediation, and responsiveness are skills that Coordinators/Managers will need to develop to become effective advocates. The Coordinator/Manager’s role is to educate community resources about those served and to build a network of community supports to achieve a person’s desired outcomes.

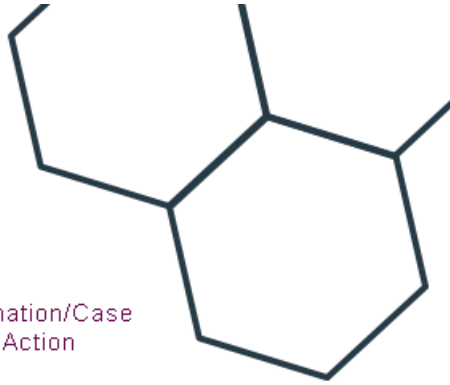
When dealing with programs and funding agencies on behalf of those served, the Support Coordinator/Case Manager will have to understand the roles and responsibilities of contact people within the agencies. The Coordinator/Manager will also have to know the processes and regulations under which programs function.

When possible, it is preferable that the person supported act on their own behalf. This helps to enhance self-efficacy, or belief in one’s own competence, and increases a sense of empowerment. Therefore, the responsibilities of advocacy also include teaching what it means to be a self-advocate and how to practice self-determination.



Module 1B
Support Coordination/Case
Management in Action

Slide 21



In Module 1a, the stages of the Support Coordination/Case Management process were presented. In section 1b, Sam and his Case Manager, Jill, and Mary and her Support Coordinator, Rebekah, go through the process together. First, there will be an introduction to Sam and Mary and then how they came to use Support Coordination/Case Management services. Then their journey working together will be presented.

Slide 22



Introduction



Module 1 — Support Coordination/Case Management Training | 22

It is important to remember that like all relationships, the helping relationship is a dynamic, complex and multi-dimensional one. The examples presented are not meant to be all encompassing of what occurred between Sam and Jill, and Mary and Rebekah, but merely an illustration of how to apply each step of the Support Coordination/Case Management process.

Slide 23



Objectives

- Recall the main stages of service delivery
- Translate the Support Coordination/Case Management process into action



Module 1 — Support Coordination/Case Management Training | 23

The objectives for Module 1b are to:

- recall the main stages of service delivery; and
- translate the Support Coordination/Case Management process into action.

Slide 24



Meet Sam



Module 1— Support Coordination/Case Management Training | 24

Sam is a 25 year old who is good with his hands and learns things easily. He is the youngest of three boys. Sam's father died when he was a teen and he has lived with his mother most of the time. Sam has several aunts and uncles from his father's side with whom he has a good relationship. Sam has a particular interest in history especially the Vietnam War. Sam loves the art of tattooing and has several tattoos. He has wondered what it would take to become a tattoo artist. Sam is also quite resourceful.

Sam was referred to Case Management services upon his first involuntary psychiatric hospital admission, following his threatening behavior towards a neighbor. After quitting school, Sam has become increasingly reclusive and moody, alternatingly sleeping for long periods of time and wandering the neighborhood at all hours. He sometimes stays with relatives and in a homeless encampment in the woods at other times. His mother has periodically demanded that he get a job or move out of her home, but she later accepts him back for a while. When she refused him back this last time, he was arrested for trying to enter his neighbor's house with a gun. The police reported that he seemed agitated, combative, and confused, repeatedly saying that he was just trying to "secure the perimeter" and seeming to respond to internal stimuli." Trained CIT officers determined that his behavior might be attributed to a mental health crisis, and contacted the local community services board (CSB) for a prescreening. Sam was determined to be an immediate "danger to self or others." He refused a voluntary admission and was hospitalized under a temporary detention order (TDO) for three days.

Where is Sam now?

A discharge Case Manager from the hospital helped develop a discharge plan to ensure continuous, coordinated treatment and a smooth return to the community. She discharged Sam with instructions to go to the Same Day Access center at his local CSB. He was admitted for mental health services, including medication management and Case Management. Sam is back at his mother's house for the time being, but she would like him to move out. The agreement made was that the CSB would help him find alternate housing. She has also expressed concern that Sam will stop taking his medication again and has asked that the CSB work with him on this issue as well.

What does Sam want?

Sam would like to move out too, but he has never maintained a home of his own and it is unclear how much he really has in the way of daily living skills. He has never had a steady job, other than occasional day jobs as a 'helper' in construction and landscaping. Sam says he would like to get a job. He does not currently have any income, nor does he receive any disability benefits.

Slide 25



Meet Mary



Module 1 – Support Coordination/Case Management Training | 25

Mary is a sweet, opinionated, playful, 33 year old woman with an infectious laugh currently residing in a house on two acres of land. The property line backs up against a national forest allowing for the presence of a variety of wildlife to naturally appear in Mary's backyard. This brings her great joy as she has a love of animals. Mary can frequently be found outside soaking up the sun and watching the animals that come to her backyard.

Mary's home is a DD Waiver funded group home. She shares her home with three other women. Mary has lived in this home for just over a year. Prior to moving here, Mary lived with her parents. She is their only child. When Mary was 18, Mary's parents obtained guardianship. Mary's father passed away when Mary was 23. Mary was reported to cry frequently at the loss of her father. When Mary's mother felt like she could no longer support Mary on her own, she decided to explore group homes. Mary currently lives an hour away from her mother which is not ideal for either, but after touring several options, this home was the best fit for Mary. Mary will sometimes cry without known cause to those supporting her. Her support staff believes it is because she misses her parents.

Mary requires direct support with all of her activities of daily living, ADL's, and depends on a hover lift to assist with transfers. Mary receives most of her hydration, nutrition and all of her medications via g-tube. She is at risk for decubitus ulcers and has an active seizure disorder. While Mary spends some time out of her house, (she goes to the salon monthly to have her hair and nails done and goes shopping), her physical and medical support needs for personal care have created a barrier to community integration for any extended amounts of time. Mary's mother shared that Mary use to attend church regularly and enjoyed when the choir sang.

Those who know Mary best are able to understand when Mary is satisfied and dissatisfied but she does not have an effective means of communicating. It was recommended that Mary receive a referral to a speech and language pathologist to have a communication evaluation completed to determine if there would be an augmentative communication device appropriate to support Mary to communicate more effectively with those supporting her and people she meets in the community. Mary's Support Coordinator/Case Manager will make a referral.

Slide 26



Examples of People

Sam's and Mary's stories highlight just some of the complex issues facing the people who seek services from Virginia's Community Services Boards (CSB).



Module 1 — Support Coordination Case Management Training | 26

Sam's and Mary's stories highlight just some of the complex issues facing those who seek services from Virginia's Community Services Boards (CSBs). We will refer to Sam and Mary throughout this module.

Slide 27



As covered in Module 1a, these are the stages in the Support Coordination/Case Management process. Preparation, Engagement, Assessment, Plan Development, to include crisis planning, Plan Implementation, Monitoring and Evaluation, and Ending Support Coordination/Case Management Services.

The remainder of this Module will discuss the work Sam, Mary and their respective Support Coordinators/Case Managers do throughout this process.

Slide 28

Preparation — Working with Sam

Strengths:

- Supportive Family
- Survival Skills
- Work Experience
- Interest in Getting a Job

Needs:

- Assessment of Daily Living Skills
- Maintain Temporary Living Situation with his Mother

Preparation
Engagement
Assessment
Plan Development
Plan Implementation
Monitoring & Evaluation
Ending Services

Module 1 — Support Coordination/Case Management Training | 28

Jill has been a Support Coordinator/Case Manager for over a year. She is well aware of community resources related to entitlements, housing, transportation, and employment. She read through Sam’s file, with particular attention to the hospital discharge and intake assessment. She thought about items to address with him.

She saw that Sam had strengths: a supportive mother and extended family, survival skills, previous work experience, and interest in getting a job.

She also detected some immediate needs: assessing daily living skills, as well as continuing and maintaining the temporary living situation with his mother.

Slide 29



Rebekah was recently assigned to Mary as her Support Coordinator. Mary was not very happy with the change as she really liked her previous Support Coordinator and was quite unhappy when she decided to leave the agency.

Rebekah knew this information and made sure to spend time reading Mary’s entire plan, and her communication chart. While reading this information she found out that Mary really likes animals, has a great sense of humor, and there has been a lot of change in her life. Rebekah also called Mary’s mother and asked about Mary’s life at home, what her interests were, what school was like for her and some other questions just get to know her better. Rebekah also spoke to the house manager about Mary to get to know her better.

Rebekah discovered that Mary’s strengths include: having a great personality, a supportive mother, and that she is not afraid of expressing her opinion. She loves animals and other people love being around her.

Rebekah also discovered there were some immediate needs that should be addressed: Mary is able to communicate but it can be difficult to understand her as she does not always use words. She is in need of a speech and language pathologist referral to see if a communication device would be of benefit to her. Also, she has been known to cry for no reason. Staff feels that it may be because she misses her parents. A referral for a therapy animal preferably a dog is something the team feels may help her with her feelings.

Slide 30

Engagement — Working with Sam

- Establish a Trusting Relationship with Sam
- Show Respect to Sam's Mother

Preparation

Engagement

Assessment

Plan Development

Plan Implementation

Monitoring & Evaluation

Ending Services

Module 1 — Support Coordination Case Management Training | 30

Jill knew that establishing a trusting relationship with Sam and his supporters would be key in helping him reach his goals. She decided to do the following to help establish an effective helping relationship with Sam:

Jill made an appointment to meet with Sam and his mother at their home so that she could interact with them in their natural environment and observe health and safety conditions there, which would help her in the assessment.

Even though Sam is the one seeking services, she knows that his mother’s support will be essential. Jill made sure that she showed her respect and deference.

Jill established common ground by letting Sam know that she was aware of his desire to get a job and live independently and told them both that she will work hard with Sam to achieve those goals.

Slide 31

Engagement — Working with Mary

- Spend Time with Mary
- Talk About Mary's Interests

Preparation

Engagement

Assessment

Plan Development

Plan Implementation

Monitoring & Evaluation

Ending Services

Module 1 — Support Coordination Case Management Training | 31

Rebekah knew that Mary might be resistant to working with a new Support Coordinator. So, to help the transition go smoothly, she visited Mary to just sit and talk with her about the animals in her yard, while observing her home and how staff interacted with Mary. She asked if Mary would take her on a tour of her home and told her how much she appreciated the time Mary was spending with her. She also let Mary know that she had talked to her mother recently who said she would be visiting soon. Rebekah asked Mary if it would be okay if she came by to meet her mom, but assured her she would not stay long so she would not interrupt their visit. Mary agreed.

Slide 32



Jill first asked Sam “what happened that led to your being admitted to the hospital?” and listened intently to his story. Sam’s mother interjected a number of times with her own perspective of events and past issues. Jill listened to her, but always returned to Sam with follow up questions.

Between the two of them, she learned that Sam’s mother often viewed him as “unmotivated and irresponsible” and that she still took care of him; cooking and cleaning and doing his laundry like she always had. She reported changes in him as a teenager, with sleep problems, difficulty telling reality from fantasy, and withdrawing from others. She said she wanted him to ‘finally grow up and take care of himself.’

Jill learned that: Sam was frustrated with being “treated like a child” and frequently would verbally lash out with frightening threats laced with military jargon. Periodically, the tension between them would reach a breaking point and either she would kick him out or he would storm out. When he was on his own, however, Sam would feel increasingly inadequate, vulnerable, and afraid.

Slide 33

Assessment — Working with Mary

- Gathering information to guide work
- Collaborative process between Mary and Rebekah
- Oriented towards Mary's strengths and capabilities

Preparation

Engagement

Assessment

Plan Development

Plan Implementation

Monitoring & Evaluation

Ending Services

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Rebekah took the time when meeting with Mary to assess her living situation and how the staff interacted with her. Rebekah discovered that Mary would really like to see her mom more often, but the driving time for Mary's mom is getting harder. Rebekah also discovered that Mary would love to be out in the community more to participate in events, but her personal care needs create a barrier to be out for any extended period of time. Rebekah also found out that Mary had not been going to church on a regular basis because there is not enough staff every Sunday to take all living in the home to the different services they want to attend.

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Plan Development —
Working with Sam

“I want to move into my own place in 6 months.”

“I want to get a job in 3 months.”

Preparation

Engagement

Assessment

Plan Development

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Ending Services

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Jill let Sam and his mother know that together they would help Sam identify what his choices might be and develop a plan for the next few weeks, that she would accompany him to the CSB offices for additional assessments and information gathering, and after that they would come back together to complete a more comprehensive plan. Together they agreed to put the following into his initial plan,

Sam’s outcomes of their work together to be:

- I want to move into my own place in six months; and
- I want to get a job in three months.

Sam has several steps he will take to achieve his outcomes. His mother agreed to help him with several of them. They are:

- Sam will practice cleaning skills twice a week for the next six months;
- Sam will practice cooking skills twice a week for the next six months;
- Sam will practice laundry skills once a week for the next six months
- Sam and his mother will talk with Sam’s cousin, Bill about hiring Sam again in the family landscaping company;
- Sam or his mother will call Jill if tensions seem to be “boiling over”;
- Jill will refer Sam to the Department of Aging and Rehabilitative Services, or DARS for employment training and job development with a target date of 1 month.

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Rebekah let Mary know that she would work with her team to help her do the things she wanted to do. Mary’s mother who is the guardian is very supportive of helping Mary live her fullest life possible. Rebekah contacted Mary’s favorite staff and Mary’s mother to develop her Personal Profile which is part of the ISP. In the process of doing this they also created an easy one page profile so that people would know how to support Mary in the manner she prefers. The Profile will help the team when they are developing the plan to figure out what Mary really wants to achieve in her life and the steps to get there.

During the plan meeting, the following outcomes/goals were what Mary wanted in addition to all the necessary health and safety outcomes:

- “I want to shop at my favorite stores”;
- “I want people to understand me better”;
- “I want to go to church regularly”; and
- “I want to work with animals”.

Activities that would help Mary achieve these outcomes/goals may include:

- Mary takes a therapy dog class;
- Mary purchases the items in the community such as lotions, body spray, clothes, etc.;
- Mary is linked to a Speech-Language Pathologist (SLP) for evaluation on which device is best for her to use for communication needs;
- Mary learns to use the communication device(s) if recommended; and
- Mary visits several churches in the area that her roommates attend and/or other churches of her choice that are near to home, seek possible natural supports at current church for transportation, add to her community engagement schedule to attend church or explore addition of companion services.

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**Plan Implementation —
Working with Sam**



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Referrals to:

- Governor's Access Plan (GAP)
www.dmas.virginia.gov/gap
- Department for Aging & Rehabilitative Services (DARS)
www.vadars.org

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To implement the plan, Jill refers Sam for an assessment for the Governor's Access Plan (GAP), which is a program that integrates primary and behavioral health services and coordinates care for Virginia's uninsured adults with serious mental illness (SMI).

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To implement Mary’s plan, Rebekah links Mary to a Speech-Language Pathologist for a consultation, and along with the Residential provider, who accompanies Mary for training on use of the communication device.

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Monitoring & Evaluation — Working with Sam



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- Maintain contact with DARS
- Add applying for Supplemental Security Income (SSI)
www.ssa.gov/pubs/EN-05-11000.pdf
- Working with benefits specialist for Plan to Achieve Self-Support (PASS)
www.ssa.gov/disabilityresearch/wi/pass.htm

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Jill maintained contact with DARS to ensure he was following up on their recommendations for obtaining employment.

Jill later met with Sam and his mother to review the plan. They agreed that his goals/outcomes would remain the same, and they went over each of his objectives/activities to eliminate ones he had already achieved and revised others to reflect his progress. They then added new objectives/activities that would help him make progress in reaching his goals/outcomes. This included filing an application for Supplemental Security Income, or SSI, and working with the benefits specialist to develop a Plan for Achieving Self-Support, (PASS), that, if approved by the Social Security Administration, would help him save more of his earnings once he gets a job. He was approved for GAP funding which will help him pay for medical care, mental health treatment and medications.

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Rebekah will monitor Mary’s services to ensure that all providers supporting her are following the outcomes laid out in the plan and updating the plan as needed.

Rebekah will also advocate for Mary as needed to ensure Mary is progressing toward the life she wants.

Rebekah will gather all the Person Centered reviews and evaluate progress on Mary’s outcomes on a quarterly basis. She will meet with Mary to discuss any trends she is seeing and if no progress is made, find out how to better support Mary and adjust the plan accordingly.

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Jill knows she still has a lot of work ahead of her with Sam, and the feedback she is getting from his other service providers has confirmed that he values their relationship and their work together remains productive. At the same time, Jill is holding the hope that Sam will develop more natural supports – those supportive relationships and resources most people depend upon from family and friends, employment and income, and other community involvement. She looks forward to Sam achieving his goals/outcomes of living independently and getting a good job, and makes sure that every visit they have together includes some time spent talking about what that will be like for him.

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Rebekah knows that Mary is always going to need supports, but will at least annually let her and her mother know the services that are available under the waiver and help them to explore any services that they might be interested in at that time.

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Being Sam's & Mary's Support Coordinator

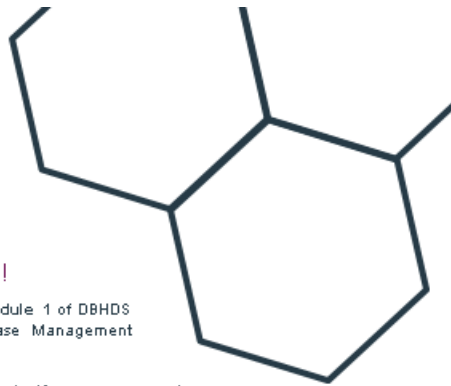


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Jill's and Rebekah's work with Sam and Mary illustrates the complexity of what is involved in providing Support Coordination/Case Management services. Effective Support Coordination/Case Management requires the Support Coordinator/Case Manager to work in a wide variety of roles in the community and to respond quickly and flexibly when new situations arise. It also requires tailoring the approach to each person using Support Coordination/Case Management services. No two people are exactly the same, and neither are their hopes and dreams. What is common among all people who use services is that they deserve and desire a Support Coordinator/Case Manager to honestly care and engage with them.



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Congratulations!

You have completed Module 1 of DBHDS Support Coordination/Case Management online training.

Click here to complete the assessment.

Congratulations!

You have completed Module 1 of the DBHDS Support Coordination/Case Management online training. Please note that all of the web links provided in this Module are contained in the accompanying training materials. Please complete the assessment for Module 1 before proceeding to Module 2.

Thank you for your participation!