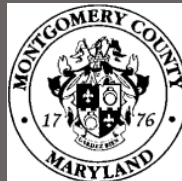


Coordination of Community Services

A MEMBER OF YOUR TEAM

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Tonight's Takeaways

- What do you need from your Coordinator, (CCS)?
- What does your Coordinator need from you?

What you need from your Coordinator

- Availability and Responsiveness
- Knowledge of participant's needs and desires
- Knowledge of Policy and Procedures
- Knowledge of Service options
- Knowledge of specific Provider Agency's (focus, capacity, admission procedures)

Availability and Responsiveness

- Typical Coordinator caseload is 40 participants, with frequent requirement to cover additional cases for colleagues On-Leave or vacancies. Some CCS agencies spread clients on the Waiting List across caseloads while others create exclusive Waiting List caseloads
- Average size of each participants team includes family members, one or more provider agency's involving two and sometimes up to five people per provider,
- Of the 2080 work hours in a year, a coordinator generally works 1880 hours.

Services to people receiving DDA funding

- Monitoring visits in various service settings at least four times per year for people receiving services.
- Pre-Person Center Planning Meeting
- Person Center Planning Meeting
- Provide resource information and referrals

Monitoring Visits - You need your Coordinator to;

Get everyone who the participant wants present to agree to a date, time and place

Travel to the participant's preferred location for the visit

Review Outcomes progress...Service Provider should share progress of Goals based on the Service Implementation Plan

Explore interests, likes, needs, risks by reviewing the 9 Focus Areas. The team could also complete another person-centered tool such as the Integrated Star

Review and update the Health Risk Screening Tool (HRST)

Document all communication and action taken on behalf of the participant.

Pre PCP Meeting - You need your Coordinator to;

Assist participant with determining who will be invited to participate

Introduce or Review Outcomes progress

Assist participant with the development of Outcome(s) by reviewing the Focus Areas of the PCP

Review and update the Health Risk Screening Tool (HRST)

Share Outcome(s) and request required documentation from Provider agency(s)

Document all communication and action taken on behalf of the participant.

PCP Meeting - You need your Coordinator to;

Assist participant with determining who will be invited to participate

Schedule the Meeting

Review and confirm the services being requested and ensure the participant's assessed needs are substantiated

Compile and transcribe all information into the LTSS PCP provided by the participant and team

Obtain signatures and submit the PCP to DDA for review and approval

Document all communication and action taken on behalf of the participant.

The meat of the PCP: Outcomes & Services

- The Person Centered Plan in the Maryland, Long-term Services and Supports (LTSS) database system provides an outline of the participant's demographics, needs, strengths and services. The coordinator must populate the PCP based on the contributions of the entire team.
- The DDA has established the PCP based on the Council on Quality and Leadership principles, called Personal Outcome Measures and Charting the Lifecourse domains.
- Learn about what is Important to the Participant and what is Important For the participant.

My Human
Security- Non-
negotiable human
and civil rights

My Community –
Access to be in, a
part of, and included
in the community

My Relationships –
social support,
familiarity,
intimacy, and
belonging

My Choices –
Decisions about
one's life and
community

My Goals – dreams
and aspirations for
the future

**Personal Outcome Measures: Five
Factors are the Outcome Category in the
LTSS PCP**

My Human Security

- 1 People are safe
- 2 are free from abuse & neglect
- 3 have the best possible health
- 4 experience continuity & security
- 5 exercise rights
- 6 are treated fairly
- 7 are respected

My Goals

- 20 People choose personal goals
- 21 People realize personal goals

My Community

- 8 People use their environments
- 9 live in integrated environments
- 10 interact with other members of the community
- 11 participate in the life of the community

My Relationships

- 12 People are connected to natural support networks
- 13 have friends
- 14 have intimate relationships
- 15 decide when to share personal information
- 16 perform different social roles

My Choices

- 17 People choose where and with whom they live
- 18 People choose where they work
- 19 People choose services

Personal Outcome Measures: one of indicators becomes the Outcome



Charting the LifeCourse Domains

Focus Area Exploration (FAE's)



Knowledge of participant's needs & interests towards A Good Life

- Various tools a Coordinator can & should use:
 - Supports and Services Planning Tool
 - The Integrated Star
 - MCPS Student Profile



Integrated Star



Phone calls, FaceTime, Zoom meetings,



Find fun activities and recipes, shop online for craft supplies, and use grocery pickup for cookie ingredients. Participate in community "virtual or no contact" activities.



Schedule outdoor activities such as snowball fights, sled riding, and caroling. Decorate masks, offer cookie delivery, look at light shows together. Participate in same activities while at own homes such as watching the same movie while everyone is on Zoom.



Direct Support Professionals can research recipes and activities, assist in planning and implementing activities. Consult nurse about concerns.





Resources

Technology

Connect Using

- ZOOM Call/Web Conferencing
- Google Hangouts
- Messenger
- Portal
- Facebook
- Gaming

Virtual Holiday Celebrations

Virtual Holiday Games

Virtual Holiday Crafts

Community Based

Charting the LifeCourse (CtLC) Learning Tools
<https://www.lifecoursetools.com/learning-materials/>

Radio Station Listings...

MD On-Line Worship Services

Community Activities

Local Parks & Recs

Outdoor Concerts

Christmas Tree Farm

Local Holiday Light Exhibits

Local Parks & Recs

Holiday Caroling

Outdoor Gatherings – Safe Outdoor Heaters

Holiday Free Audible Books On-Line

- MD Public Libraries (check out online learning through local libraries)
- Online Library
- Google Bookstore
- Operation ASL Story time

Eligibility Specific

- MD Developmental Disabilities Administration (DDA)
- DDA Regional Offices
- DDA Coordinators of Community Services (CCS)
- DDA Central Region Providers
- DDA Eastern Shore Providers
- DDA Southern Region Providers
- DDA Western Region Providers

Knowledge of regulations & policies

- Federal Home and Community Based Services
 - Community Pathways, Community Supports, Family Supports Waiver
- Maryland State Plan Amendment for Targeted Case Management
- Maryland Health – General Article 7-1002, subtitle 10
- COMAR 10.09.36.03-1
- COMAR 10.09.48
- COMAR 10.22
- Maryland DDA PolicyStat

What your Coordinator needs from you?

- Availability and Responsiveness
- Share participant's needs and desires
- Knowledge of Service options (waiver service definitions & scope)
- Get to know Provider Agency's (focus, capacity, admission procedures)
- Take an active role in learning about DDA Policy and Procedures
- Mindfulness of Timelines

What you need from your Coordinator

- Availability and Responsiveness
- Knowledge of participant's needs and desires
- Knowledge of Policy and Procedures
- Knowledge of Service options
- Knowledge of specific Provider Agency's (focus, capacity, admission procedures)

Resources and References

- Handouts
 - Personal Outcomes Measures
 - HRST Checklist
 - Services & Supports Planning Tool
 - Service Implementation Plan

Maryland Developmental Disabilities Administration

- <https://health.maryland.gov/dda/Pages/home.aspx>
- https://health.maryland.gov/dda/Pages/Maryland_Community_of_Practice_for_Supporting_Families_Webinar_Series.aspx

- Charting the LifeCourse
 - <https://www.lifecoursetools.com/>
- The Council on Quality and Leadership: CQL
 - <https://www.c-q-l.org/>
- Potomac Community Resources
 - <https://www.pcr-inc.org/>

Contacts

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Questions/Comments