Practice Guidance for Delivering Outcomes in Service Coordination
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The National Center on Outcomes Resources (NCOR) is the research division of The Council on Quality and Leadership in Supports for People with Disabilities and provides leadership in outcomes research, analysis and dissemination. NCOR is a clearinghouse and information resource on outcomes data on all aspects pertaining to people with disabilities.

NCOR operates under a cooperative agreement between The Administration on Developmental Disabilities – United States Department of Health and Human Services and The Council on Quality and Leadership in Supports for People with Disabilities.
This manual sets forth the fundamental requirements for organizations providing services and supports to people with disabilities. This manual is designed to guide you in the use of Personal Outcomes as the basis for quality enhancement in human services. The key to understanding outcomes is learning about people. People live their lives and discover their own priority outcomes. The role of formal and informal service and support systems is to assist people to achieve their personal outcomes. First, we provide people with the opportunity to experience the variety of life so they can identify their priority outcomes. Then, we use our resources and creativity to facilitate those outcomes. This manual provides an introduction to the organizational processes and supports that, when individualized for each person, facilitate personal outcomes.

These practice guidelines are not prescriptive requirements for an organization. Rather, they represent a fundamental approach to the design, delivery, and evaluation of services to people with disabilities. We have developed this Practice Guidance as a pathway to successful service and support implementation.
Practice Guidance for Service Coordination

This Practice Guidance defines a framework to affect the process of service coordination. It identifies strategies for the service coordination organization as well as for the individual service coordinator who is partnering with the person with developmental disabilities.

The framework rests on three essential principles:
- Person- and family-centeredness
- Self determination and choice
- Community inclusion

The ways in which these concepts are applied will be addressed in this guidance, as follows:
- Role definition, defining the role of the service coordinator as broker
- Communication, ensuring that self determination principles apply
- Assessment, determining the needs, strengths, preferences of the individual, and the resources available to the individual
- Outcome-based planning, basing plans on the individual’s goals, choices and direction
- Collaboration, partnering with the individual, their supports, providers and funders
- Measurement, identifying effective and appropriate measures of quality
- Accountability, understanding that the coordinator is accountable to the individual, the funder, and to the community team
- Resource efficiency, integrating cost efficiency with quality measures and the effective use of community resources
- Satisfaction, ensuring that the services that are provided are consistent with quality measures and the expectations of the individual
- Ethical considerations, ensuring the maintenance of individual rights throughout the process of coordination
- Advocacy, representing the individual’s perspective in the community, with service providers and funders; preparing the individual for self-advocacy
This Practice Guidance assists organizations to provide service coordination that reflects current ideas. It encourages those who support people with disabilities to promote fruitful partnerships and expanding opportunities in the community.

Overview

During the past 40 years, societal attitudes about people with disabilities have changed positively. People with disabilities have found new self-esteem through expanded avenues for self-expression, accomplishment, and respect. The dynamic between self-advocates, families and professionals has evolved. Legislation reflects the bedrock values that have been espoused by individuals, families and advocates since the 1970s.

Today, the ways in which people are supported are defined by the three primary values of person-centeredness, inclusion and self determination. Service coordination is described and measured by the degree to which people are included in all aspects of community life and are sustained in achieving the outcomes that they themselves express.

Defining terms – service coordination

Service coordination plays a major role in transforming attitudes from that of protecting people to that of assisting people to become self-directed individuals.

Programming, casework, and case management are terms that have been used to describe professionals who support people with disabilities. Each of these terms implies that professionals were planning for, monitoring, or managing cases and/or individuals. The inferences associated with these terms are paternalistic. They do not reflect the ideas of partnership or self determination.

Service coordination, also known as resource coordination, reflects a paradigm shift from management to support. It infers that the role of the professional is to coordinate services and resources. The service coordination concept includes the idea of brokering services. The coordinator is an agent who will:

- Partner with the individual to determine preferences
- Assist the person in assessing needs
- Define, with the individual, expected outcomes
- Develop outcome-based plans in concert with the individual, and identified support persons and members of the community team*
- Locate services and resources that are consistent with individual preferences
- Develop community linkages
- Maintain funding and eligibility
- Monitor, review and revise outcome-based plans
- Ensure that mutually agreed upon outcomes are accomplished

In this new paradigm, the coordinator will broker services that are traditionally available to people with disabilities. In addition, the coordinator will seek out generic resources in the community that have not traditionally been used by and for people with disabilities.

Service coordination is a collaborative process. The coordinator ensures, through this process, that the choices made by the individual are actualized in the broader community.

Defining terms – the core concepts

Person-centeredness refers to the fact that the work that is accomplished — needs assessment, plan development, ongoing interventions — begins with the person, not the available services. Working with the individual, and other support persons, the coordinator will assess needs and determine the goals and preferences of the individual. Then, the coordinator will locate the services, including the funding, that will promote that person’s vision.

Being person-centered often means that the coordinator will have to develop new services by collaborating with people or facilities that are not traditionally used by people with disabilities. Make the assumption that resources are available for the individual. Then it becomes a matter of locating them, obtaining commitment and adapting services to the particular needs of the individual. This is very different from beginning with the program or services, finding a “slot” and “placing” the person.

Another aspect of the person-centered approach is the identification of the strengths, skills and resources that are available to the individual from other people or resources. The coordinator will then use these resources to broaden the individual’s support network.

The goal of inclusion is to include people in all aspects

* Support persons may be family members or others committed to the individual; members of the community team are representatives of community resources that are utilized to support the outcome-based plan.
of community life. Inclusion is the opposite of segregation or separation. Thinking about inclusion becomes easier when the language that we use reflects this value. Talk about individuals as people, rather than as recipients, clients, or consumers. Don’t define or categorize people by their disabilities or their medical diagnoses.

Identify natural supports in the community. They may be family members, co-workers, friends or neighbors. Tapping into the resources offered by these support persons will be the starting point to achieving inclusion.

Helping people to learn self-advocacy skills will ultimately assist them in establishing their own relationships. Advocating with them in community institutions — churches, schools, recreational facilities, workplaces, childcare facilities — are further steps to achieving inclusion.

**Self determination** refers to the process of providing people with disabilities the opportunity, resources, and responsibility for carrying out the decisions they make. The concept goes beyond the idea that people have the opportunity to express their hopes and dreams. In an atmosphere of self determination, those who support individuals on their life journeys will be committed to the realization of a self-directed vision. Self determination can have far reaching results for providers and service coordinators as well. People now define outcomes for themselves and choose the providers and supports necessary to accomplish those outcomes.

**Role definition**

The service coordinator is a broker of services or resources. Resources may be specialized, generic or natural. Specialized services have been established for people with developmental disabilities and have been designed to achieve results on their behalf. They may include vocational programs, school or recreational programs, community living or supportive working programs or targeted funding. Generic resources include services that have been designed and are offered to the community at large, not specifically for people with disabilities. Such programs and services are the most underutilized by people with developmental disabilities. For the service coordinator to develop linkages with such community facilities on behalf of individuals continues to be a daunting — but very valuable — brokering task. For example, locating a local community pool and establishing a relationship with the onsite swimming instructor to teach people to swim may be a better alternative to waiting for a “slot” at the centralized facility built for people with disabilities.

Natural supports are people who have an interest in the individual because they know that individual through naturally occurring relationships. Natural supports may be family members, co-workers, students, friends and neighbors. Natural supports have a commitment to the individual because they know and value that individual. However, many people don’t have a cadre of natural supports. The service coordinator may have to assist the person to use his or her own social skills to develop new relationships on the job, at school or in the neighborhood.

Families are natural supports or resources. Families have a special role that must be respected by the coordinator. In many cases, families are the primary supports and, thus, are essential collaborators with the service coordinator on behalf of the individual. Family members are the constants in individuals’ lives and will often be most effective in assisting the service coordinator in the process of person-centered planning.

It is the role of the coordinator, as the integrative factor, to coalesce community team members to:

- Partner with the person and/ or family
- Establish desired outcomes
- Include all supports identified by the individual in a holistic, outcome-based planning process
- Identify existing and current resources
- Identify untapped resources
- Ascertain and document the person’s long term outcomes and short term objectives
- Advocate with the funder(s) and projected providers
- Ensure that eligibility and access requirements are met
- Ensure that all quality, satisfaction and evaluative measures are appropriate
- Ensure that resource efficiency tactics are in place

The critical element in the planning and brokering process is person- and family-centeredness. This means that the goals of the individual become the point of departure for the process. However, the coordinator may meet the person when he or she is already in the midst of a program and receiving services. The coordinator’s first step, then, is to review the current program with the person and to determine the level of satisfaction. The coordinator may have to revise an existing plan, or develop an entirely new plan based on the person’s needs and choices. It is vital to remember that needs and desires are likely to change over time.
Communication

Communication is essential to establishing any partnership. The first step is to find out how the person communicates. Those who are closest to the individual will be invaluable in helping you to understand how to communicate, particularly with people whose disabilities thwart easy discussion. Service coordinators will need to know how to modify their own behaviors to optimize interactions with people who may rely on structure and consistency to feel comfortable.

Establishing relationships with family members, providers and support persons identified by the individuals is helpful. Seek out others with developmental disabilities who know the person and who may have developed advocacy skills. Such allies, who are trusted by the individual, will ease eliciting information from the person. These relationships will also be valuable later on, as the service coordinator measures the effectiveness of the program and the level of the person’s satisfaction.

We understand that individuals are part of families that have their own histories, skills, strengths and values. People are also integral members of cultural groups that have influences on values, attitudes and choices. Thus, aspects of cultural life such as holiday traditions, religious observances, foods, mores, as well as culturally based perspectives on disabilities will be critical to effective communication with individuals and family members.

At the beginning of the relationship with the individual, the coordinator will also want to determine the level of satisfaction with existing services and the person’s opinion about service coordination. We cannot make assumptions that change is important to an individual. Conversely, because the individual has been involved in a living situation, we can’t assume that the situation continues to meet the individual’s needs.

Maintaining connections with the individual, family, support persons, and service providers is the coordinator’s responsibility. Updating everyone committed to the individual helps to build a focused collaborative team. This is a necessity for progress in meeting the outcomes defined in the plan. However, while the coordinator is accountable for keeping everyone current, it is also necessary for the coordinator to accomplish this with consideration for the person’s needs and preferences.

For example, the coordination organization or the funder may require a schedule of contacts that is at odds with the preferences of the individual. Here, the key is flexibility.

Find ways to accommodate the person, perhaps by relying on family historians or other supports, to obtain the information necessary to maintain the person’s eligibility. The coordinator will also have to be flexible enough to be able to respond in emergencies, or at critical times in a person’s life.

For coordinators to be responsive, they have to be available. Ideally, service coordination organizations will have access to technology to increase the availability of individual coordinators and to ensure consistent interactions with community team members. Thus, the coordination organization will want to put into place a comprehensive system for communication that includes methods for:

- Ordinary in-house communication during business hours
- Contacting coordinators on the road during business hours
- On-call communication after hours
- Emergency triage communication at all times

Keep in mind that because people use many modes of communication, the organization cannot rely solely on voice mail for incoming messages or paging. It is preferable to develop systems that include a mix of technology and old-fashioned personal conversation. Likewise, the organization policies should identify expected response times. Those policies should be available to everyone involved with the individual.

In emergencies, the coordinator is not necessarily the first person to be contacted. The coordinator’s role is to prepare the individual and his or her supports with information and a plan for unexpected events. Everyone involved with the individual should understand how to react in crises. It is the coordinator’s role to ensure that everyone is prepared and will react consistently. After the fact, the coordinator should be apprised and be able to respond appropriately to the person’s changed situation.

Assessment

Assessment is a comprehensive information gathering process that generally identifies:

- Current needs
- Unresolved issues
- Supports, strengths and resources
- Current services and level of satisfaction
- Projected outcomes, goals and choices
Assessment begins the process of outcome-based planning. Components of assessment include concerns related to:

- Residence
- Arrangement
- Site
- Recreation, friendship, and social life
- Family life and relationships
- Cultural concerns
- Health and medical needs
- Rehabilitative and therapy needs
- Work life
- Nutrition
- Transportation
- Finances
- Civic and community life

With respect to each of these components, the service coordinator will want to elicit information relative to the individual’s requirements, such as:

- Ongoing needs
- Newly identified needs
- Support persons and other resources currently involved
- Level of satisfaction with the current plan
- Resources involved in implementing the plan
- Personal strengths and skills
- Goals, hopes, desires, and preferences
- Additional supports necessary to achieve the goals
- Additional resources necessary to achieve the goals

Assessment is not a one-time-only event. It is a process that involves learning about the individual and the aspects of his or her life that have an impact on the choices that person will make. The coordinator cannot expect that one interview session or one visit is adequate to fully understand and assess the complexities of any individual’s situation.

Recognize that, over time, the individual’s personal needs and desired outcomes may change and these changes will have to be reflected in a formalized way.

Also recognize that the individual may already be receiving services. In this situation, the coordinator will assess the effectiveness of the current program, the person’s level of satisfaction with the program or service, understanding that the person may choose to change direction or emphasis.

Onsite assessment is essential. Without personal contact, the coordinator will not fully appreciate the context in which the person is living and the factors that affect his or her capacity to express a vision for the future. Meeting individuals in a one-on-one situation, or with the involvement of natural support persons, is fruitful because this situation provides the opportunity to gain a more complete picture of the person’s situation. But the primary stakeholder remains that individual. Thus, assessments and meetings, either formal or informal, cannot take place without the individual’s personal involvement.

Coordinators should already have a fundamental understanding of the limits of public funding that can be utilized to accomplish essential life goals and outcomes. However, the scope of the assessment interview should not be limited by knowledge about limited resources. The goal of the interview remains the development of that person’s vision for the future. Nor should knowledge of funding complexities or limitations curtail the scope of the plan that will be developed or revised as a result of the assessment process. Limitations on resources should never lead us to invalidate a person’s dreams or goals. We may have to acknowledge that we lack resources or capacity, but we must continue to affirm people’s dreams.

Outcome-based planning

Outcomes dominate the discussion of quality in services and supports for people with disabilities. At the current time, however, there is no standard definition or classification of outcomes. Different categories of outcomes are often used in an interchangeable manner. Three major outcomes categories are currently in use. Figure 1 depicts the three types of outcomes.

Clinical Outcomes. Clinical outcomes focus on cure and symptom reduction. For example, the clinical outcome that results from services and supports (in the form of medication) for a person with depression is a reduction in the symptoms of depression. This is clinically recorded in charts, records and through utilization review.

Functional Outcomes. Functional outcomes focus on increasing functional status in designated areas. For example, physical therapy is provided for an individual to increase range of motion which then enables him or her to execute additional activities of daily living. This increase in activity of daily living skills is measured through standardized scales. The standardized scales make possible comparisons to norms for various groupings of people.
Personal Outcomes. Personal outcomes focus on the items and issues that matter most to people in their lives. For example:

With medication, William’s symptoms of depression are greatly reduced. He joins a group to increase social functioning. However, he is not satisfied with symptom reduction and increased social functioning. He wants to find a job and work. He wants to use the increased functioning in a personally valued setting.

With physical therapy, Mary Ellen increases her range of motion in her arms and legs. The increased range of motion enables her to perform more activities of daily living functions. She looks forward to moving out of the fourteen-person board and care home and living with two close friends.

The new motorized wheel chair gives Mike the function of mobility. He is no longer content to be transported to the sheltered workshop for the day. He wants to get together with some friends, do volunteer work at the hospital during the week, and go fishing on the weekend.

Clinical, functional, and personal outcomes are, in the current usage, all outcomes. Yet, clinical, functional, and personal outcomes are very different. The psychiatrist, treating a person with an anxiety disorder, may attempt to lessen the symptoms through medications. The psychiatrist is clearly working on a clinical outcome. In contrast, the partial hospitalization, rehabilitation, or group therapy session may attempt to increase social functioning. These professionals are working on the functional outcome of greater social skills. The individual, however, may define his or her expectation of an outcome in a different manner. The personal outcome may be defined as either being closer to or farther away from family, it may involve part-time work, or it may be limited to wanting to be alone or with just a few trusted people.

The identification of the person’s priority outcomes is followed by the individualization of organizational process to facilitate the outcomes. These processes are not programs. They are actions that organizations take to facilitate the outcome as defined by the person. Personal outcomes call for truly individualized organizational processes. A specific organizational process that succeeds in facilitating personal outcomes for one person may fail for another person. A process that is appropriate for one person may be an outrageous imposition on another.

Clinical, functional and personal outcomes are measurable. Ideally, the assessment phase of the coordination process will yield information that can be utilized to develop short and long term goals as well as intermediate objectives that will support the ultimate outcome defined by the individual.

The guiding principle upon which any planning process is based is that the outcomes identified in the plan are person-centered and person-directed. Any plan that is developed should be the result of intensive interaction between the coordinator and the individual and among the community team members identified by the individual. The success of outcome-based planning is dependent upon the commitment of support persons acting as resources to the individual and accepting accountability for facilitating or collaborating on intermediate steps.
The coordinator and the coordination agency are accountable for ensuring that all services that will be identified in the outcome-based plan are:

- Culturally competent
- Locally available
- Appropriate to the needs of the individual
- Reflective of the desires of the individual
- Accessible with respect to the person’s special needs
- Supportive of the person’s safety and well being
- Resource efficient

Thus the coordinator has interlocking responsibilities with respect to the development and implementation of the plan, including:

- Ascertaining and documenting the outcomes that are desired by the individual
- Locating the resources, including the funding mechanisms, that will support the outcomes
- Advocating with funding sources or community resources on behalf of the individual
- Establishing the necessary linkages between and among community resources
- Integrating the support persons who have committed to working with the individual on components of the plan
- Ensuring that benchmarking relative to the ongoing work of accomplishing outcomes occurs
- Applying quality measures
- Updating the plan as changes in priorities or associated strategies occur
- Addressing cost and resource efficiency to ensure continuing availability of funding

Collaboration

There are two levels of collaboration. The first level is a broad collaboration between and among systems, including funding systems, programs, service provision and resource or service coordination. In this environment, the service coordination organization is an active participant in helping to transform systems to the benefit of people with disabilities. This is not only a policy-based effort; it is also an educational process that ultimately sensitizes the greater community to the needs and strengths of its citizens with disabilities.

It is the agency’s responsibility, through the coordinator, to coalesce major systems on behalf of the individuals who are served. Major systems include:

- Primary public funders, such as state wide entities with accountability for services to people with disabilities
- Associations of community providers
- Public agencies that provide essential services, such as the departments of social services, education, and the like

The coordinator should consider representatives of these agencies as members of the community team. The individual coordinator is responsible for ensuring active collaboration among the community team members and the individual.

Sometimes it appears that the service coordinator or the organization is at odds with other components of the community team, particularly when funding is at stake. However, coordinators must have a good understanding of the regulations and funding constraints under which the funding agency operates. They should also act under the assumption that each entity has the same goal, that of providing quality services to all people with disabilities. Further, the individual coordinator must be well versed in community services and be willing to think creatively about ways that these services can be tapped as alternatives to publicly funded programs.

Tactics for ensuring ongoing collaboration include:

- Maintaining formal as well as informal opportunities for communication between and among all parties
- Providing ongoing information relative to individuals and services as requested
- Ensuring that information sharing is subject to confidentiality policies and procedures
- Providing and requesting ongoing training of staff vis a vis regulation and expectations
- Sharing information about public programs and the limitations of public programs with individuals, families, and support persons
- Advocating for expansion of public programs or changes to regulations to affect greater access
- Providing information about cost and resource efficiencies
- Cooperating with public agencies as they attempt to provide services in an equitable manner
- Establishing internal tracking and accountability mechanisms
Measurement

The reason for developing relevant measures is threefold, to:

- Ensure quality
- Review program utilization
- Plan for expansion in scope of services and numbers of persons served by the organization

Without measurement, provider organizations and individual coordinators have no way of knowing if processes are effective in accomplishing identified outcomes.

Measurement is a necessity for several reasons, including having data to accomplish the following:

- Project the human and other resources needed to maintain service coordination for individuals served and to expand the scope of service
- Understand the ways in which the organization, and the individual coordinator, can improve services for people
- Determine the level of success in achieving individual outcomes
- Maintain information required by the funder vis-à-vis the organization
- Maintain information required by the funder vis-à-vis the individual to ensure continued eligibility
- Maximize the capacity of the organization to influence the broader service delivery system on behalf of all individuals served

The types of measures that the service coordination organization relies upon will be defined by the data sets the organization collects and maintains. The organization will have to determine which questions it wants to answer in order to collect and analyze data that will be most helpful. Questions might include the most basic ones, such as demographics, as well as the following:

- Who is participating?
- What services are people receiving?
- What supports do people need to participate?
- Why have people chosen this provider organization?
- Have the interventions provided by the organization made a difference? And how have they made a difference?
- How can we better serve people in the future?
- Are services delivered in a timely manner?
- Is information accurate?

When the provider organization is under contract to a public funder, simple record keeping, such as the names of participants and dates of participation, will not be sufficient. The organization will have to provide information that supports the effectiveness of the service coordination program and reflects the capacity of the provider organization to support the overall goals of the funder agency. This means that the individual service coordinator must be meticulous in maintaining documentation that proves efficacy. For example, documentation of contacts should include:

- Date of contact and persons involved in the contact
- The type of contact
- With whom the contact was made
- The purpose of the contact
- How the contact supports the accomplishment of the outcomes outlined in the individual's plan
- Issues that were raised
- Solutions that were developed
- Time frames for any follow-up activity
- Plan for the next contact

Data collection and reporting is only as good as the method of analysis. In turn, analysis is only as valuable as the plan the organization has for responding to the information. Thus, prior to beginning to accrue data, the organization will develop policies and procedures for responding to the information.

Analysis often depends on the quality indicators the organization develops. Developing indicators for quality that address not just issues of regulatory or funding requirements, but also effectiveness of the organization in realizing outcomes is essential. Both sets of indicators will prove to be the basis for benchmarking. To understand the value of benchmarking based on quality indicators, the organization will have to institute a process of consistent and regular internal quality audits. The capacity of the organization to track activity, to retrieve relevant information and to act on it will be enhanced by the use of integrated technology.
Accountability

Who is the person or entity to whom the coordinator and the organization are accountable? There are several answers to this question, just as there are several levels of accountability. The first level of accountability is the individual coordinator to the person, ensuring that outcomes are met, that eligibility for funding is maintained and that services are delivered effectively.

The coordinator is also responsible to members of the community team identified by the individual. It is the coordination role to:

- Integrate the work of community team members
- Seek input from community team members at critical points in the process, such as during assessment, review and implementation of the outcomes
- Ensure that each community team member has the information that is necessary to accomplish the assigned task
- Ensure that representatives of funding, resource or service entities have accomplished the activities agreed to in a timely and effective manner

The coordinator is accountable to the funder of the services or program in which the individual is participating. Documentation that supports accountability will ultimately redound to the benefit of the people who are served. Such documentation may include:

- Proof of cost efficiency
- Proof of individual satisfaction
- Tracking of activities related to the achievement of goals, objectives, outcomes and timelines

Often, this facet of accountability is not direct, but is rather a responsibility of the coordinator to the coordination agency that in turn maintains documentation and reports to the funder. Within the organization, the coordinator is accountable to other co-workers to share information about successful practices and effective community resources. Information sharing, while maintaining confidentiality, is essential when coordinators are organized to function in teams.

The organizational level of accountability is more complicated. The organization is accountable to the individual coordinator, ensuring that the coordinator has:

- Access to information about local community resources
- Training necessary to accomplish resource coordination

- Supervisory or team support
- Ongoing training in the skills that are necessary for coordination, including negotiation, problem solving, resource utilization, and key concepts related to developmental disabilities
- Access to expert resources for specific issues, such as medical, health, and rehabilitative issues
- Adequate means of communication
- Access to systems for tracking progress toward reaching outcomes

The organization is also accountable to the people served, to effectively represent the needs of people to systems, particularly funding systems. This is why maintaining data, as part of the ongoing process of measurement is ultimately beneficial to everyone served by the organization. An understanding of geographic distribution of people, the resources available, and the continuing needs, ultimately assists in planning for programs and services that will benefit everyone.

The most critical aspect of accountability to people, however, is fiscal accountability. Fiscal accountability is closely allied to regulatory accountability, as funding is most often linked to program and regulation. The organization is obligated to develop tracking and reporting mechanisms that document the way in which the organization is actualizing its mission to serve people in their communities. Documentation must support the mandates that are stated and implied in regulation. Similarly, documentation must reflect each step in the assessment, planning, implementation, and review and transition processes that are inherent to service coordination.

The coordination agency will have to be prepared to report on a regular basis the following:

- Basic demographic information about persons participating
- Needs, desires and preferences associated with the outcome-based plan
- Goals, objectives and activities undertaken in support of the outcome-based plan
- Projected timelines and activities
- Costs, both projected and actual, associated with services, programs and activities
- Levels of satisfaction of persons participating
Resource Efficiency

Resource efficiency refers to the way in which organizations, and individual coordinators, use the supports that are available to them on behalf of individuals. Resources include:

- Services, including generic or specialized supports
- People or natural supports
- Funding

The goal of resource efficiency within the organization is to assist the system at large to serve as many people as possible, as effectively as possible. On an organizational level, the coordination agency practices resource efficiency when it uses personnel and infrastructure practically. For example, organizing personnel into teams has benefits not only for the coordinators in the team who experience significant co-worker support, but also for individuals and community team members. In a team situation, each member of the team is invested in the success of the outcome-based plan for each individual. Therefore, each team member will also be able to interact with community team members and follow-up on activities on a day-to-day basis. Cross training of team members with specific expertise is a benefit to this type of organization.

Technology enhances communication, documentation, tracking and reporting. Thus, technology is ultimately a resource efficient tool because it has the effect of integrating the work of coordinators, allows all team members equal access to information, and makes essential reporting less time and labor intensive.

Creativity

The most powerful and effective aid in facilitating outcomes for people is the service coordinator’s creativity. Creativity reframes reality; it changes the rules and creates new possibilities. Instead of being bound by the realities of the service system, service coordinators can gather together different people and resources and ask the questions:

- How many different ways can we think about this issue?
- How would a teacher, an architect, or a software designer solve this problem?
- What opportunities and resources, outside the formal service system, can I use to solve this problem?
- Who else can help me think about this issue?

Creativity is possibly the most effective implement in the resource efficiency toolbox. When outcome-based plans are truly person-centered, it is likely that traditional funding streams and services will not address all of the individual’s needs. The lack of financial resources cannot stand in the way of the person realizing his or her life goals. The coordinator may negotiate with the funding agency, may advocate with the program, but, ultimately, the coordinator will have to develop linkages with community services that are not usually approached.

One way to do this is through a process of person-centered planning that includes a broad circle of people already known by the individual. These people will become not only natural supports, but they will also become links, reaching out to others in the community on behalf of that person.

Networking with programs that serve other individuals, such as disease specific associations, departments of aging, advocacy groups, and the like are other avenues to take. Developing linkages with groups that are focused on the particular goal or outcome is effective. If the person is interested in travel, then look to a local travel club or tour group. It becomes easier to problem solve when we focus on the desired outcome, not the fact that the individual has a disability.

Satisfaction

The organization will want to measure satisfaction among its primary constituency, the people served, as a way of ensuring the effectiveness of the coordination practice. From a pragmatic standpoint, measuring satisfaction may be necessary for continued funding and/or may be required by regulation.

Before beginning to measure satisfaction, the organization will want to:

- Define quality
- Identify the target groups
- Develop a baseline
- Determine the method for measurement
- Identify the components that will best reflect the practice of coordination
- Develop a plan for responding both individually and programmatically

Generally target groups will include:

- Individuals who are served and/or family or natural supports
- Other service providers
- Funders
If the organization has not measured individuals’ satisfaction with the service coordination agency on a regular basis, or if the data is not current or complete, then it will be necessary to develop a baseline for comparison.

The baseline can be established through a survey process that focuses on the satisfaction of a representative sample of individuals or one that surveys each individual with respect to the organization. The same is true of ongoing satisfaction measures. Depending on the culture of the organization, sampling may be sufficient, and the sampling may be done annually. Other organizations may find that they want to sample a fraction of the people participating on a quarterly basis, so that everyone will be surveyed each year.

There is a difference between surveying people about satisfaction with the organization or the individual coordinator, and their level of satisfaction with the outcome-based plan and/or the processes and activities associated with the plan. Pulse taking, at critical points in the process, is a good idea in that it furthers the progress of achieving outcomes and maintaining focus.

Surveying people on their attitudes about individual coordinators or about the way that coordination is practiced can be hampered by the individual’s feelings about the coordinator. Organizations will have to develop processes that enhance objectivity and confidentiality to counteract this effect. Ensuring that people can respond anonymously, or confidentially, is an important way to be certain that the information is not biased.

It is essential that the survey method or methods take advantage of the person’s preferred method of communicating. Working in partnership with friends, or with other people with developmental disabilities who know the person well is a good strategy for ensuring the individual’s comfort level and eliciting helpful responses.

Individuals, and family members as well, will have to be assured that honest answers will not have a negative impact on the individual’s level of service. Some families are fearful that complaining about a program or service will result in the loss of that program. There is the worry that if individuals complain about a specific service provider, that there will be unpleasant repercussions. However, the coordinator is responsible for knowing not only the level of satisfaction with coordination, but also the level of satisfaction with the services that are in place.

When the organization is developing satisfaction surveys, each survey will address components of quality that are relevant to each group. Natural supports and family members may value timeliness and accuracy in making referrals to community resources, for example. Other service providers might value the comprehensiveness of the information they receive from the organization and the funder might concentrate on process and timeframes.

How to determine what quality means to people is sometimes problematic. One way to accomplish this, particularly if the organization does not already have an established system, is to host focus groups, or to identify small test groups, to talk about the kinds of things they look for and expect from a coordination organization. From these observations, the organization can develop a pilot survey and test it with small groups. The results of this process will lead to a standard survey or interview tool.

Develop processes for responding to survey results before the survey or interview is conducted. The coordination organization should already have strategies in place for answering specific questions or complaints from individuals as well as from providers and funders. Look at the results as an opportunity for validation or for change that will ultimately benefit the organization and the constituents.

Ethical Considerations

Providers and organizations that work with people with disabilities must be aware of the ethical considerations that apply to people with respect to fundamental rights. Often, fundamental rights will be defined in regulation. The coordination organization will develop policies and procedures that reflect practice parameters that uphold people’s rights. The service coordinator must be conversant in fundamental rights, and practice in a manner that is respectful of them.

There are aspects of fundamental rights, such as those related to surrogacy, guardianship, and competency, for which the coordination organization should seek legal guidance for the coordinator and legal representation for the individual.

Three aspects of fundamental rights that are central to any discussion of ethics in the developmental disabilities/service coordination environment are:

- Confidentiality
- Informed consent
- Choice

Clearly, the sharing of information relative to the outcomes, goals and objectives of the plan is a necessary process. All other information must be kept confidential. Protecting confidentiality is a many faceted task. The
organization will want to examine the way in which information is shared, stored, and recorded. Problematic situations include:

- Individuals’ files or demographic information kept personally by coordinators
- Use of cell phones to discuss information about people
- Faxes with information about people that may be viewed by others
- Documents with information about people left in copiers or printers
- Emails and other documents with information about people transmitted over the Internet

The coordination organization should already have in place a process for release of information and other releases or agreements to participate in service coordination. However, the manner in which people’s releases and agreements are obtained is important. The process of obtaining releases is related to informed consent. Informed consent does not just refer to medical procedures. The outcome-based planning process itself requires an informed consent process assuring that the individual has directed and understands the outcomes, as well as the intermediate goals and objectives. Communication methods are critical to obtaining informed consent, and may include reliance on natural supports and friends, as well as the creative use of alternative modes of communication.

Informed consent for medical procedures may require the coordinator to involve people who are close to the person. It may also be necessary to consult with medical experts for the coordinator to understand the issues well enough to assist the individual with decision making. The coordinator will have to be prepared to facilitate communication between medical personnel and the individual. This is to ensure not only that the physician or other health provider has a sensitivity to the person’s situation, but also that all of the person’s questions are understood and answered fully. The goal is for the person to be an active participant in his or her health care regimen and to have choices respected.

Choice relates to all life decisions. The coordinator’s function is to assist the individual to understand the multiplicity of possibilities that are available to achieve desired outcomes. One of the most important choices for a person may be the choice of providers of services. The service provider — including the coordination organization — may have a vested interest in the selections the individual makes. Long term providers have a financial stake, and often an emotional stake, in continuing to be associated with the individual. But in a person-directed process, it may be that the individual cannot achieve the desired outcomes by continuing with the current provider. Thus, the coordinator will have the role of assisting that person to choose from alternative viable options and to facilitate necessary transitions.

Advocacy

The coordination organization has a role in advocating not only for the individual but also for the population. This role is necessary because one of the primary functions of the organization is to make the system work for all people with disabilities. Advocacy is defined by several processes. It is an educational process, in that the organization educates the community at large, as well as provider communities, about the needs of the population it serves. It is a process that initiates change, in that it helps to bring about transformations in systems to benefit individuals in general. It is also a collaborative process, in that it makes linkages between and among other organizations with similar vision for the purpose of transforming the system.

On an individual level, advocacy is defined by the same processes. Negotiation, mediation, and responsiveness are skills that coordinators will need to develop to become effective advocates. The coordinator’s role is to educate community resources about the individual and to build a network of community supports to achieve that person’s desired outcomes. Representing the person’s skills and strengths, as well as the person’s needs is part of the educational process. When dealing with programs and funding agencies on behalf of individuals, the coordinator will have to understand the roles and responsibilities of contact people within the agencies. The coordinator will also have to know well the processes and regulations under which programs function.

Conversely, coordinators will have to be able to explain the limits of programs to individuals and to be prepared to locate alternatives in the community. Developing linkages in the community on behalf of individuals, and forming interlocking circles of support is the final aspect of individual advocacy. In many ways, this process is the essence of service coordination.