Service Orientation Guide

"MAKING A DIFFERENCE EVERY DAY"

Welcome to Pathways to Community!

We understand that the process of transitioning your loved one into a new environment can often times be overwhelming and full of unknowns. Our intent is to eliminate the ambiguity and stress that may be associated with that change. To ease the transition, we have created a guide that outlines what you can expect when working with Pathways to Community (PTC).
It is our hope that the following guide will set a precedent of transparency and communication, values which PTC prides itself on. We strongly believe that collaboration and communication are essential for any great partnership. Please read the Service Orientation Guide thoroughly, as it will provide you with valuable insights into service expectations and further your understanding of the partnership you are forming with PTC. We welcome any questions or feedback, please do not hesitate to contact the PTC Intake Coordinator (IC) at any time.

Welcome to the Team!

From all of us at Pathways to Community!

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Prior to Intake

The PTC Intake Coordinator (IC) is the main contact and representative throughout the intake process. It is IC's responsibility to coordinate and facilitate a smooth transition for the Individual into the new home. PTC is a Department of Human Services (DHS) licensed service provider. There are a number of licensing regulations and compliance expectations which we are required to abide by. To help ensure we meet all of the Individual's needs as well as comply with DHS licensing, there are several things we will require during the intake process.

Below is a list of items the IC might request from the team:

- Individual Abuse Prevention Plan (IAPP)
  *A Risk Management Plan (RMP) may be provided if an IAPP has not yet been developed.
- Coordinated Service and Support Plan (CSSP)
  *An Individual Support Plan (ISP) may be provided if a CSSP has not yet been developed
- Photo copy of guardianship papers
- List of all current medications/treatments. Signed Physician Orders and Protocols for all current medications/treatments
- Completed PTC Individual Data Sheet*
- Physician Signed and completed health referrals
- Signed Authorizations necessary to appoint the Professional Payee*

Other Requirements:
A physical exam within 30 days prior to the admission date or within three days after. The IC will provide the team with the PTC health forms that must be completed at the physical. PTC health forms include a Physical Exam Referral form and a Standing Order Comfort Medication List, both must be thoroughly completed and signed by the doctor performing the physical examination.

Integration Activities

t In addition to the intake paper work, the IC will also coordinate several activities and opportunities for the individual and future housemates to hang out prior to the official move day. Scheduled activities/outings may range from dinner at the house to an activity in the community. These steps are essential to reduce anxiety, build relationships, and promote excitement and investment into the new home. These may include:

- **Dinner Activity/Tour**- opportunity for the individual to meet and interact with future housemates and view his/her future home.

- **Offsite Activity**- the individual will gather in the community to interact with future housemates and staff in a positive and fun environment continuing the opportunity for relationships to build.

Although we understand that timelines may not always permit for all of the integration activities, we try when at all possible to incorporate as many as possible.

FAQ: Do we need to purchase renter's insurance?

PTC does not provide coverage for individual belongings. It is up to the guardian whether or not to purchase renter's insurance for the individual.

FAQ: Who is responsible for furnishing their bedroom?

The individual is welcome to bring any of their own personal items or furniture they already have or want to purchase into their new home, however we recognize that not everyone has these items to bring. In turn, PTC will provide any basic furnishings they would require as identified by the team.

FAQ: If PTC purchases the furniture, what happens if the individual leaves?

Any property purchased by PTC will remain in the home should the individual leave.

Intake & Admission

- Completion of consents, authorizations, and preliminary service plans.
- Finalize any details regarding the services that PTC will be providing.
- Discussion around the service environment, informal objectives, management of funds, frequency of team meetings/reporting, individual plans/protocols, and other miscellaneous meeting notes regarding the individual and services they are to receive.
- Discuss and review the current Abuse Prevention Plan.
- Schedule a 45 day meeting date. This meeting must take place within 45 days of the intake and is typically scheduled as close to the 45th day as possible.

After the Intake Meeting:

For the first few weeks thatthe individual is living in the home, PTC staff will gather baseline data and complete assessments which will provide for the creation of new programming tools. Preliminary plans and programming documents are brought to the 45 day meeting for review. Items you will receive at the 45 Day meeting:

- Coordinated Service and Support plan Addendum (CSSP Addendum)*
- Individual Support and Abuse Prevention Plan (ISAPP)*
- Self-Management and Assessment Plan (SMAP)*

The 45 Day Meeting

- Review of plans identified above (CSSP Addendum, ISAPP, and SMAP)
- Completion of consents and authorizations
- Discuss any pertinent information in regard to how the individual has been adjusting to the new environment. Identify how this information needs to be reflected in service provisions, plans, and programming to ensure the health and safety of the individual.
- Finalize and approve any formal plans and outcomes as applicable for the individual.
- Schedule the next team meeting. The next team meeting will be determined by the meeting frequency identified by the team. It is required that the team meet at least annually from the date of the 45 day meeting, however they may choose to meet quarterly or semi-annually.
- The month in which the 45 day meeting is held is considered the annual reporting month going forward. Each year the team must meet at minimum, annually within 365 days of the last annual meeting to complete the annual consents and authorizations.

Goal Setting & Formal Objectives

- The team will discuss how the individual is doing in their new home and use this information along with historical insights to identify what formal objectives they would like to see the individual participating in.
- It is common for the individual to have three to four different objectives related to independent living skills and/or personal development that they are participating in at one time.

- For example, they may need to improve skills related to hygiene, laundry, chores, budgeting, cooking, planning/ organization, social skills, etc. The team and the individual would discuss and determine which ones they want as formal objectives.
- Once the core program areas are identified the team will establish the specific criteria for mastery for each program. Such as, “John Doe will clean his room one time per week, with three or less verbal prompts, 90% for 12 consecutive months”.
- Once the criteria and frequency of implementation for each program is identified and agreed upon by the team, the PTC Designated Coordinator (DC) will write the program and it’s methodology for implementation within 10 days of the meeting.
- The program itself will be implemented as identified by the team; typically it is the 1st day of the upcoming month to provide for a clean start.
- PTC staff will then implement the program as written and document the success of each trial as they occur. This in formation is then used to create percentages for success which are included in a progress report and sent to the team at the frequency identified by the team.

Team Meetings throughout the Annual Year

- The team will meet throughout the year at the frequency identified in the CSSP Addendum.
- At scheduled team meetings, the team will receive verbal performance updates as well as written progress reviews at the frequency identified in the CSSP Addendum.

Progress Reports

- Progress reports summarize objective and narrative feedback about the progress of the individual.
- A summary of success for each formal outcome and recommendations to continue, modify, or discontinue based upon program mastery.
- The team can modify or change programs at any time throughout the annual year. However, they are typically evaluated on a quarterly basis.
- As the team meets throughout the year, they share the opportunity to meet formally and discuss progress as well as determine if they want to make any changes to programs and/or plans.
- The team does not have to wait until a team meeting to make changes, however a formal environment in which the whole team is together often provides the best opportunity to collaborate around these changes.

Day to Day

Now that we have outlined a brief overview of the transition process, let's take a look at what you can expect from PTC on a day to day basis.

Site Supervisor

- The Site Supervisor is the team's touchstone for communication, and is responsible for the program's oversight.
- They typically work direct care shifts throughout the week.
- It is the Site Supervisor's responsibility to be constantly open to assessment and ready to update the team with new ideas and feedback to ensure complete transparency and forward progress.

- The Site Supervisor works hard to ensure continuity and implement all actions, plans, and determinations made by the team in order to create an environment which will offer the best opportunity for success.
- If something is not working or if we anticipate roadblocks to success, the Site Supervisor will provide consistent communication to encourage and create opportunities for collaboration on effective ways to improve the situation.
- The Site Supervisor has one central focus and commitment; this is to serve and partner with the individuals, families/ team, and staff of their house.
- The Site Supervisor does not typically oversee multiple programs or houses; instead they concentrate on their one program. As a result, the Site Supervisor has the opportunity to create strong and lasting relationships with all the residents and be fully vested in their success on many levels.

Planning and Organization

- Staff will create opportunities when at all possible for each individual to be a part of the decision making and planning for their day to day routines.
- After formal goals have been identified, the Site Supervisor will collaborate with the individual and identify when each trial will be implemented throughout the week. This provides for investment in routines as well as consistency which contributes to the overall structure.
- In addition to the formal goals and skills training that are integrated into a fixed schedule, one time per week the Site Supervisor will encourage each individual to sit down and plan out their events and activities for next seven days.
- In conjunction with their fixed schedule, we then help them to process through and identify when other plans/activities they want to participate in will take place.

- As a result, we have a visual aid and reference guide that lists out what has been planned for each day throughout the week.
- This level of inclusion reduces power struggles and promotes a personal investment. It provides for the opportunity to guide and give feedback on their decisions and feel a real sense of responsibility, control, and pride in the decision. The individual receives praise for completing goals and activities as planned, and they are supported when they are struggling. This routine strengthens and reinforces itself every day. Additionally, having a detailed and written plan that they have participated in minimizes anxiety and unknowns that can create stress.

FAQ: How do I let staff know when we plan on taking the individual out of the home for an activity, vacation, etc.?
We make every effort to plan at least seven days in advance for week day and weekend routines and activities. In turn, it is greatly appreciated if you can communicate as far in advance as possible when you are planning on taking the individual out of the home. For planning purposes, we ask that you provide anticipated times for pick up and drop off. Also, a list of items you want the individual to pack in order to accommodate the activity.

Medical Appointments & Oversight

- Per DHS licensing, if assigned, PTC is ultimately responsible for the routine care that an individual receives from a medical or health professional. In turn, we are responsible for the scheduling, transportation, and completion of all medical appointments.

- It is also our responsibility to obtain thorough documentation of each appointment/exam on the appropriate PTC health referral form.
- PTC staff persons are required to obtain physician orders and any follow-up documentation. They are required to review medical referrals before leaving the medical appointment, if there is anything that is difficult to under stand or read; staff will get clarification from the prescribing medical professional at that time.
- We understand that although it is our responsibility to ensure these health needs are met, many family and/or team members may want to be present for appointments and continue their involvement in the individual's health care management. We hope to partner with family and/or team members to meet everyone's desire for involvement. In the instance that there is a family or team member who would like to continue scheduling and attending appoint ments, we ask that this is communicated and coordinated with the Site Supervisor.
- This will ensure we have the opportunity to attend and obtain all follow up orders, recommendations, and docu mentations that are required per licensing.

FAQ: What if the family or and team member wants to continue scheduling and transporting the individual to medical appointments?

If the family/team member wants to continue scheduling and transporting for medical appointments, we require coordination to ensure we are able to attend. PTC must be included in every communication and coordination in regard to health care needs and scheduling of medical appointments when assigned this responsibility.

FAQ: What time of day are medical appointments typically scheduled for?

We typically schedule appointments for the early to midafternoon when at all possible.

FAQ: What if both parties are unable to attend to due scheduling conflicts or other issues?

If there is a scheduling conflict where both parties are not able to attend, the attending party will be responsible for follow up communication and for obtaining appropriate documentation. In the rare occurrence that a PTC staff person is not in attendance, health referrals will be distributed to the attendee for completion by the physician.

Medication Administration

- All PTC staff are trained in Medication Administration and in each individual's medication side effects.
- When assigned this responsibility, staff are responsible for the administration and monitoring of prescribed medications and over the counter medications.
- All medications must have written physician orders.
- Per licensing we are required to keep all medications in a locked medication cabinet in the home.
- Only staff have access to the medication cabinet and will administer medications per the physician orders.
- Staff document daily on a Medication Administration Record (M.A.R.) to show that medications were administered as prescribed.
- Should there be a medication error or side effect noted, staff will notify the appropriate persons as applicable and follow their recommendations.
- If an individual refuses medication, staff will verbally offer medications three times before documenting it as a refusal.

- Should an individual refuse for three consecutive doses, the physician and team will be notified (unless otherwise identified in the CSSP Addendum).
- Staff will verbally (informally) encourage individuals to become familiar and independent with their medications and administration times. Should the team feel it is appropriate, a formal goal can be established that encourages the individual to request and identify medication at the appropriate times.
- If they are successful, staff will administer and document the trial as successful.
- If they forget to request medications, staff will administer and document the trial as failed.
- This data will be calculated and reported at the frequency identified by the team.

FAQ: What if I want staff to administer a PRN comfort medication that is not listed on the Standing Order Comfort Medication List (S.O.C.M.)?

We require a physician's order for all medication; we will request an order for the identified comfort medication from the primary physician. PTC staff will not be able to administer the PRN comfort medication until the physician's order was received.

We encourage family/team members to identify any additional comfort medications before the initial S.O.C.M. is signed so the identified comfort medications can be included.

Pharmacy

- PTC works with one pharmacy, Omnicare.
- Upon admission current physician orders and treatments are transferred to Omnicare.
- Medications and treatments are delivered to the home on a bi-weekly cycle.

- PTC maintains close communication with Omnicare to ensure any changes or physician orders are up dated as needed.
- Omnicare sends out a report every two weeks to the home which list out current medication and doses. The Site Supervisor reviews and approves the list for accuracy then submits the report back to Omnicare. Omnicare then delivers medications to the home as identified.

Transportation & Activities

- Staff persons use their own vehicles to transport individuals throughout the week to activities, events, and appointments.
- As previously noted we make every effort to plan out schedules in advance so everyone knows where they are going throughout the week. Also, since staff and the individuals are planning this schedule together they are on the same page in regard to how these events will be executed.
- In conjunction with the posted schedule, staff provides verbal prompting and processing to ensure there is not a misunderstanding or misled expectations in regard to the week's plans.
- Staff will try to accommodate last minute requests; however we continue to verbally encourage and prompt each individual to voice their plans in advance so they are not disappointed if we cannot accommodate a re quest due to an existing schedule conflict.
- Activity costs and memberships typically come out of the individuals personal needs which are allocated by the guardian.
- Per the individual's budget, the guardian approves funding each week or month for activities.

- If requested, staff will help to manage this money in the home while planning for events/activities that the individual wants to participate in.
- The Site Supervisor will also access any resources avail able to identify activities, clubs, sports, dances, and other events which are available for free or at a limited cost.

Meal Preparation

- Staff are ultimately responsible for meal preparation and planning.
- Individuals can participate in meal planning and meal preparation with supervision as approved by the team.
- Staff verbally encourage individuals to participate in the creation of a menu for the coming week.
- Staff facilitate collaboration amongst the housemates to create healthy meal options that everyone can agree on.
- Staff posts a weekly menu so everyone knows the meal plan throughout the week.
- Food options for bag lunches will also be purchased and considered when grocery shopping.
- PTC does not typically purchase junk food such as chips, cookies, and soda. Instead grocery funds are primarily spent on items that can be used to prepare a variety of family style meals and healthy snack options.
- Individuals may use their allowance or personal needs money as approved by the team to purchase snacks or treats such as soda or other related items.
- The Site Supervisor will routinely make trips to the grocery store to keep the house stocked with essentials as well as ingredients for the week's menu.
- PTC has a shared cookbook in which we access recipes for meal options. We also encourage families/team members to pass along favorite recipes to add to our menu options.

FAQ: I want my son/daughter to have a specific food or beverage item available to them every day; will this be covered by the house grocery budget?

Keeping in mind that we are operating on a shared budget, any special accommodations that are not required by a dietary need may not be considered a necessity and a reasonable purchase. Some items and/or brands may be too costly to be a fixed item in the budget.

In this circumstance, we would require that special request not be shared by all housemates, and instead be purchased via the individual's personal needs. We are open to discussion and happily address these on a case by case basis.

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Individual Data Sheet

- In this form we request that you provide us with any and all Individual specific information, including as much detail as possible in regard to the individual's daily routines.
- This information is extremely helpful and necessary to ensure that PTC has the most current Individual specific information as well as pertinent contact information for family, team members, and medical professionals who are currently serving the individual.

Professional Payee

- To help manage and keep all funding sources active, PTC works with a Professional Payee, Owens & Company.

- It is their sole responsibility to complete renewals, report forms, and communicate with the appropriate entities to ensure assistance monies such as MSA (Minnesota Supplementary Aid), and FA (Food Assistance) stay active.
- Once appointed, they manage and allocate the individuals benefits and income as authorized by the guardian. Including the allocation of funds for rent, utilities, grocery and personal needs as approved by the guardian.
- The guardian still has full authority over the funds and the payee is responsible for the maintenance and disbursement of funds as directed by the guardian.
- PTC covers the cost associated with these services as we recognize the value in having a professional who is focused on maintaining the individuals funding sources and the additional tasks that accompany this responsibility.

Coordinated Support and Service Plan Addendum (CSSP Addendum)

- Within 45 days of service initiation, based on the person's CSSP, the team will meet to assess and determine the following:
    - The scope of the services to be provided to support the person's daily needs and activities;
    - The person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;
    - The person's preferences for how services and supports are provided;
    - Whether the current service setting is the most integrated setting available and appropriate for the person; and
    - How services must be coordinated across other providers licensed under this chapter serving the same person to en sure continuity of care for the person.

*These determinations are what make up the document(s) that are the CSSP addendum.

Self-Management Assessment Plan (SMAP)

The SMAP is an assessment of the following areas:

- The person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;
- The person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and
- The person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others. The assessments will produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.

Individual Abuse and Prevention Plan (IAPP)

- The IAPP is a plan that very simply identifies areas where the individual may be susceptible to abuse.
- Prior to January 1, 2014 when 245D took effect, this information was included in a document called the Risk Management Plan (RMP).
- We understand that not everyone will have an IAPP as this document is very new and may not yet be developed. As a result, we will ask to see the RMP if the individual has one.

- It is common for the team to approve an RMP/IAPP that has already been created for the individual and use this plan for the first 45 days.
- As we are still getting to know the individual, this provides us as the new service provider an outline of what we need to be doing to ensure the individuals health and safety.
- If the individual does not have an RMP/IAPP already in existence prior to intake, PTC will work with the team to identify any current and historical vulnerabilities /risks to create a plan.
- Once an initial IAPP/RMP has been approved at intake, PTC will then make its own assessments throughout the first few weeks as we get to know the individual better and develop a more robust and thorough plan.
- This more robust plan that is created from the IAPP is called the Individual Support and Abuse Prevention Plan (ISAPP)

Individual Support and Abuse Prevention Plan (ISAPP)

- The ISAPP is developed based on the RMP/IAPP that is signed in at intake as well as the SMAP that is completed at intake. Information from both of these plans are combined to make the ISAPP which is reviewed and signed in at the 45 day
- The ISAPP is a much more comprehensive version of the IAPP. Essentially it includes all the information that was identified in the IAPP, however in greater detail. In turn, it will identify a thorough understanding of areas where the individual may be susceptible to abuse, as well as a specific plan to minimize the risk of abuse.
- The ISAPP also identifies the supports the individual needs based on the Self-Management Assessment that was completed at intake.

Acronym Reference Guide

- IC-Intake Coordinator
- team-Interdisciplinary Team
- IAPP-Individual Abuse and Prevention Plan
- ISAPP-Individual Support and Abuse Prevention Plan
- SMAP-Self Management and Assessment Plan
- CSSP-Coordinated Service and Support Plan
- S.O.C.M.-Standing Order Comfort Medication List
- ISP-Individual Support plan (Pre-245D document)
- RMP-Risk Management Plan (Pre-245D document)
- GRH- Group Residential Housing
- MSA-Minnesota Supplementary Aid
- FA-Food Assistance
- DT&H-Day training and Habilitation
- ADL-Activities of Daily Living
- IADL-Instrumental Activities of Daily Living
- CRS-Community Residential Setting
- IHO-Independent Housing Option

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