

## **IMPLEMENTATION OF THE SERVICE PLAN, MONITORING AND EVALUATION, TRANSITION, AND CLOSURE**

The participant/family shall receive efficient and effective delivery of services as specified in the service plan. It is the ultimate goal of the Service Coordinator to assist the participant/family to become as independent as possible and develop the skills needed to obtain services with minimal assistance.

### **Implementation of the Service Plan**

Once a service plan is developed (through the annual Service Coordination Assessment), the Service Coordinator shall implement the service plan by assisting the participant/family in linkages and access to community resources and agency services that will assist the participant in fulfilling their unmet needs and goals. During the implementation stages, the Service coordinator fulfills such roles as educator, advocator, facilitator, collaborator, coordinator, etc.

### **Monitoring and Evaluation**

The service coordinator shall periodically monitor and evaluate the service plan. Participants' progress toward reaching outcomes and appropriateness of services shall be reviewed **every six months** (by phone or in person) **and any time there is a significant change**. A full assessment and review of continued eligibility will be conducted annually.

### **Transition**

Participants will have a transition plan in place for all appropriate times of transition, such as age, service discontinuation, change in a Service Coordinator or agency, or major life event.

Discussions about transition begin as soon as the participant is enrolled in the Adult Brain Injury (ABI) Program and continue periodically throughout enrollment. Discussions should include expected outcomes and behaviors appropriate to Health Care, Educational/Vocational, and Independent Living. Collaborate with other agencies to identify appropriate transition team members including the participant and the caregiver/family. When possible, schedule a transition meeting with the family and other appropriate key players within six (6) months of the anticipated transition.

The Transition Plan form may be completed to identify action steps, timelines, and person(s) responsible including incorporating participant/family concerns and priorities. Document that a Transition Plan has been placed in the participant file in the SHS Information System. When a Transition Plan Form is not utilized, documentation is necessary in the transition activities in the SHS Information System.

## **Closure**

The length of time participants are enrolled in services is unique to the individual's needs and progress towards goals. At the point that a participant has reached all their goals and sustained them over some time, the Service Coordinator and participant/family may discuss a change in program enrollment (Service Coordination vs. Paid Services) or possible closure from either enrollment. Through effective Service Coordination, it is the goal for all participants to ultimately be able to achieve and maintain their independence and no longer require our services.