



Development of the Service Coordination Assessment (SCA)

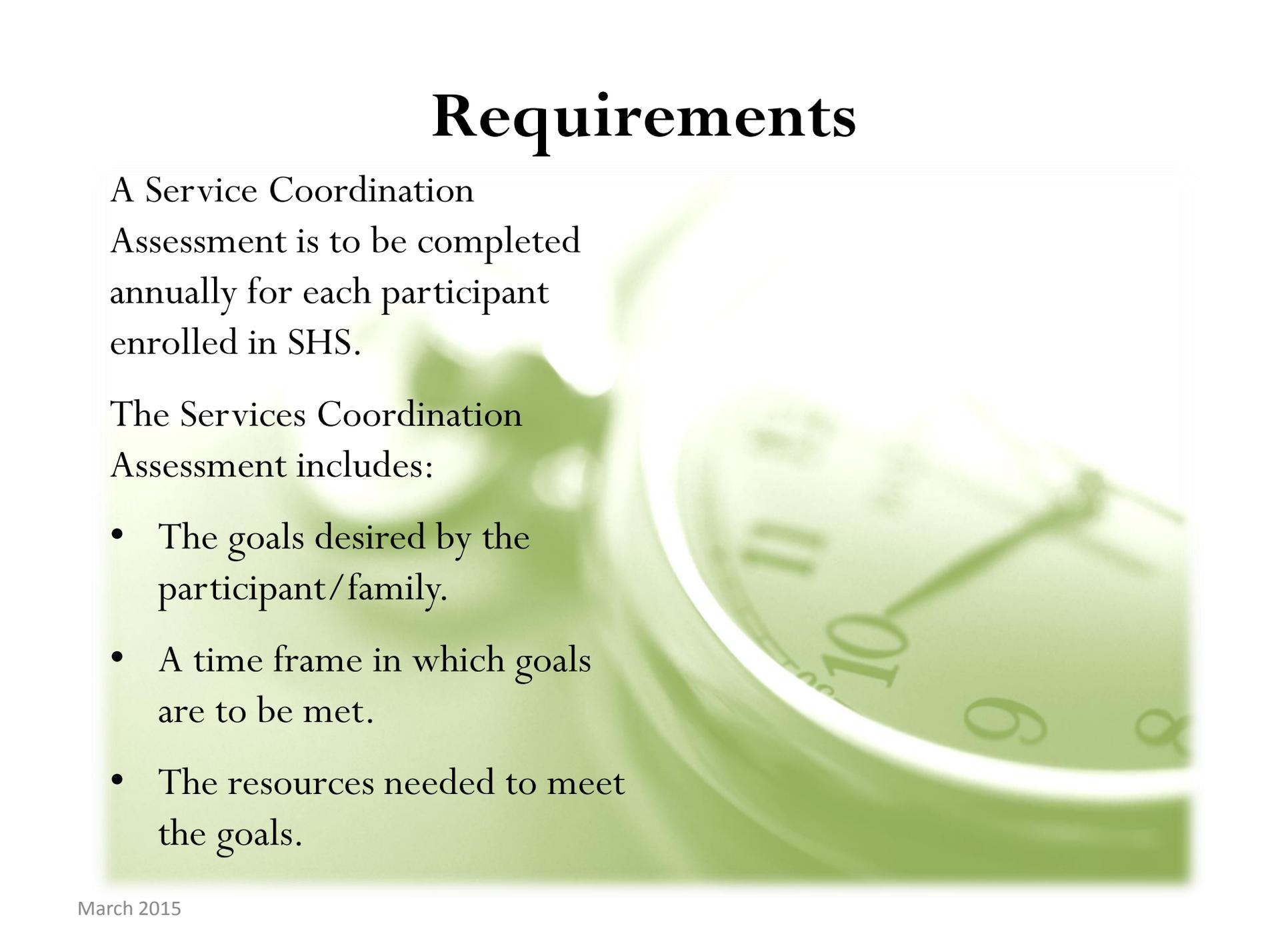
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Assessment is:

- A continuous activity throughout the service coordination process.
- A systematic process to acquire an accurate and thorough picture of the participant's strengths and areas of need.
- The foundation for linking the participant with services needed to meet their identified goals.



Requirements



A Service Coordination Assessment is to be completed annually for each participant enrolled in SHS.

The Services Coordination Assessment includes:

- The goals desired by the participant/family.
- A time frame in which goals are to be met.
- The resources needed to meet the goals.

SCA Component

- The Comprehensive Care Plan is a component of the Service Coordination Assessment (SCA).
- Developed from the information obtained during the assessment process.
- This plan is a “*blueprint*” for how services shall be provided to meet the needs of the participant/family.



Level of Service Coordination



Program specific guidelines and the level of service coordination being provided determine the detail and comprehensiveness of the plan.

Program guidelines may also mandate specific requirements for plan development including:

- Completion Time Line.
- Comprehensive Care Plan Meetings, Notice, and Arrangements.
- Team Members to Include.

Identifies

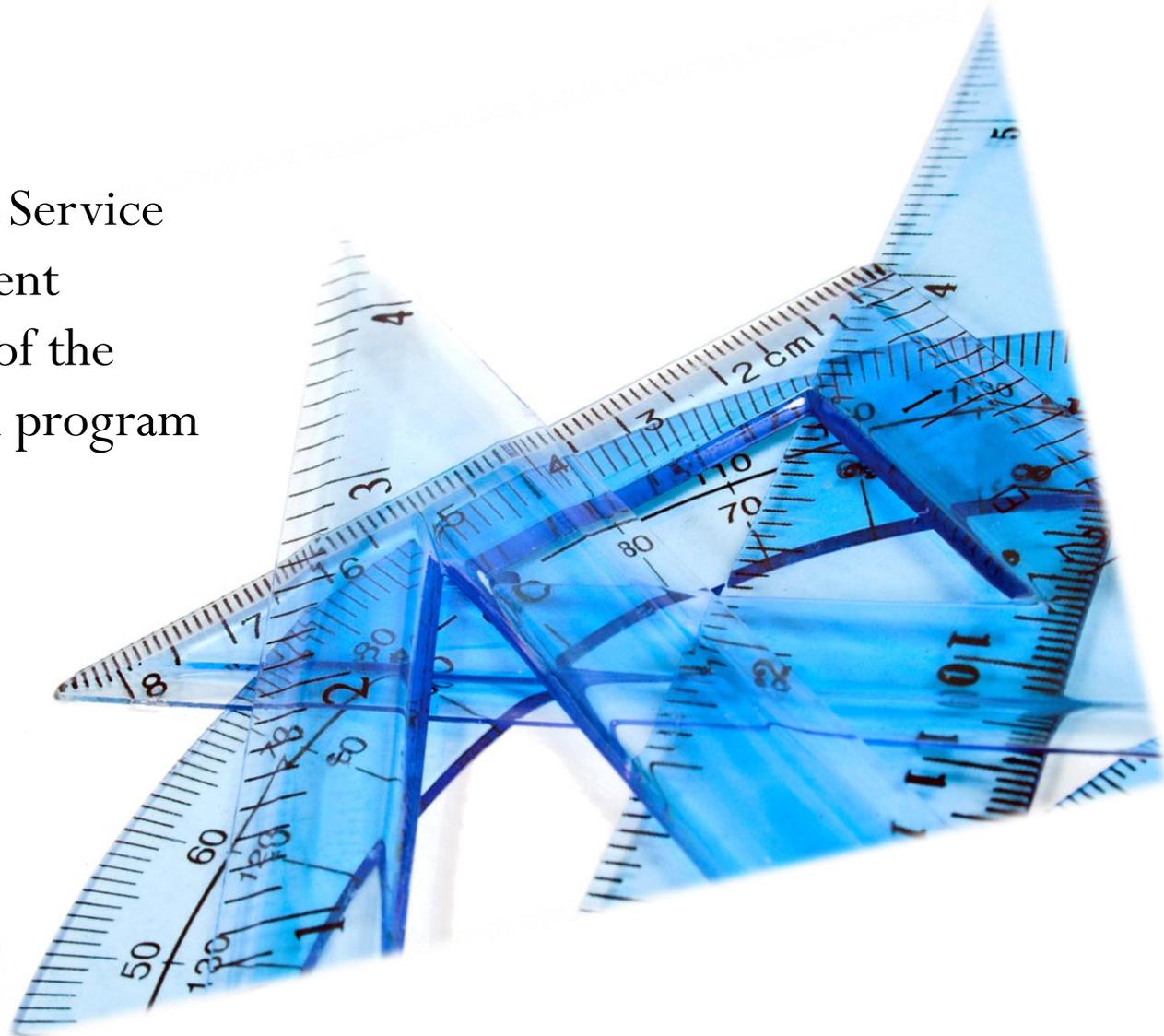


The Service Coordination Assessment is developed in cooperation with the participant/family. It identifies:

- un-met needs, priorities, and resources of the participant/family.
- outcomes or changes the participant/family wants to occur.
- services needed to address the identified goals.
- method, duration, and location of services.
- service providers.
- funding resources to cover the cost of the services.
- effective date for the initiation of services.

Complexity

The complexity of the Service Coordination Assessment depends on the needs of the participant/family and program requirements.



Method

The service coordinator collects information in a variety of ways to assist the participant/family in identifying needs and locating resources. Some of the ways in which information can be collected are:

- In-Depth Interviews
- Direct Observation
- Written Documents



In-Depth Interviews



In-depth interviews include both individual interviews (e.g., one-on-one) as well as "group" interviews (multiple family members, Individualized Education Plan team, health care team or transition meetings).

The purpose of the interview is to probe for information and record it in order to assist in the planning of services.

In the interview process use your active listening skills by paying close attention and then paraphrasing what you think was said.

In-Depth Interviews

Listen for both content and for the underlying emotions.

Sometimes the real message is the emotion and not the content.

When this occurs respond to the emotional message.

Using active listening skills will help avoid misunderstandings and will make the speaker more comfortable, thereby getting more information.

If the participant/family answers are not clear it is generally a good idea to ask further questions for clarification.

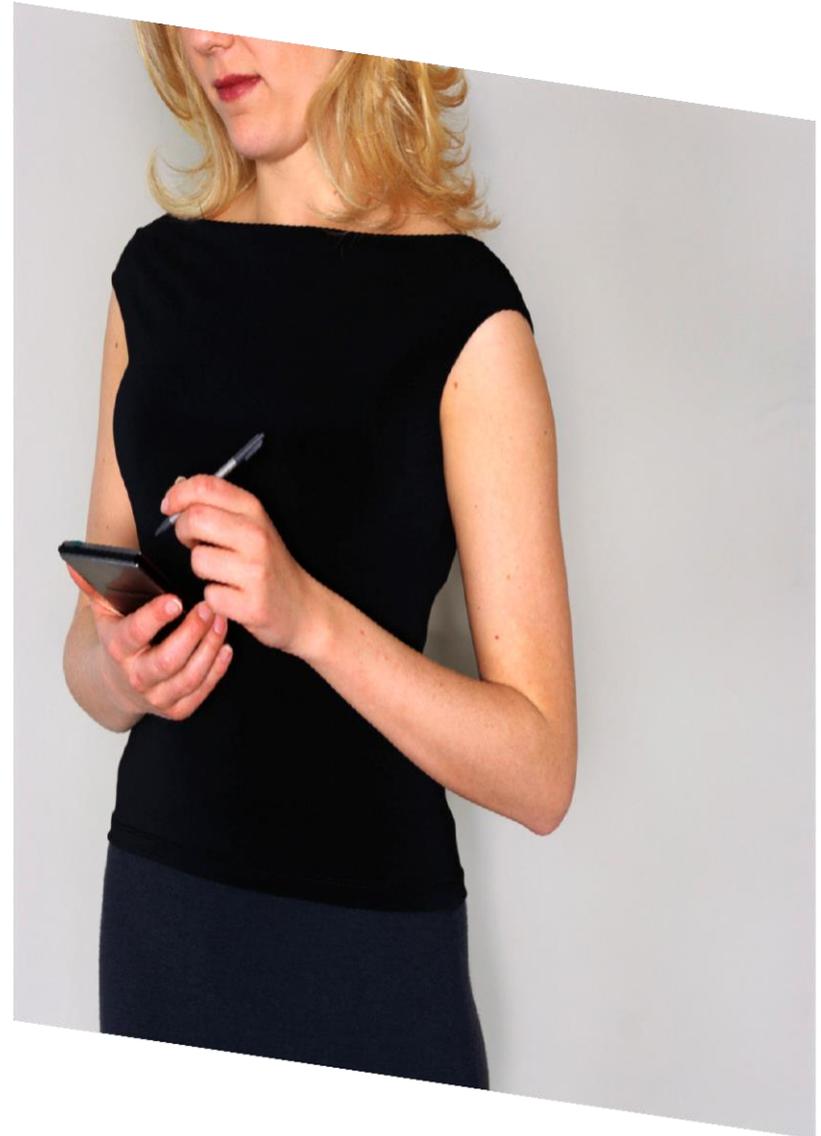


Direct Observation

Direct observation differs from interviewing in that the observer does not actively ask questions but is looking for non-verbal messages.

It may include observing interactions of the participant/family and their body language, observations about the care and safety of the home and observations of the participant's health.

This information can be recorded by taking notes.



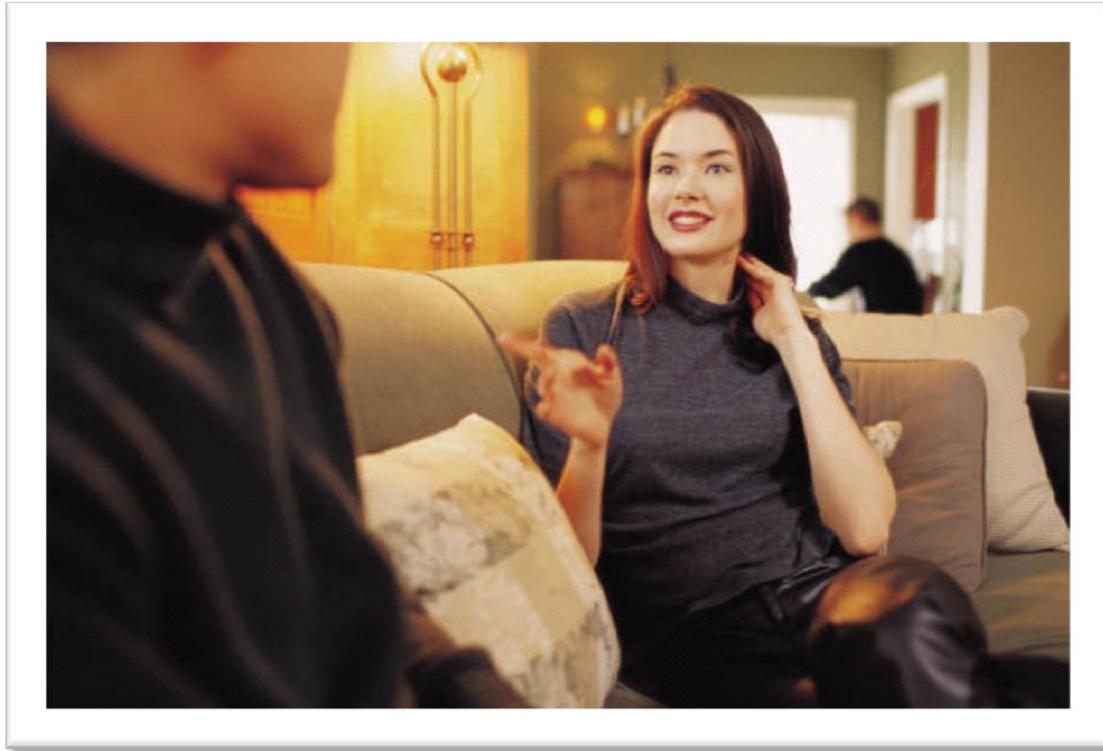
Written Documentation



This refers to existing documents such as medical records, therapy reports, school records, etc.

Written documents can provide an in-depth look at the participant's past and current medical needs.

Rapport



- Establish rapport to promote active participation in the development of the Service Coordination Assessment.
- Encourage the participant/family to discuss their un-met needs and priorities.

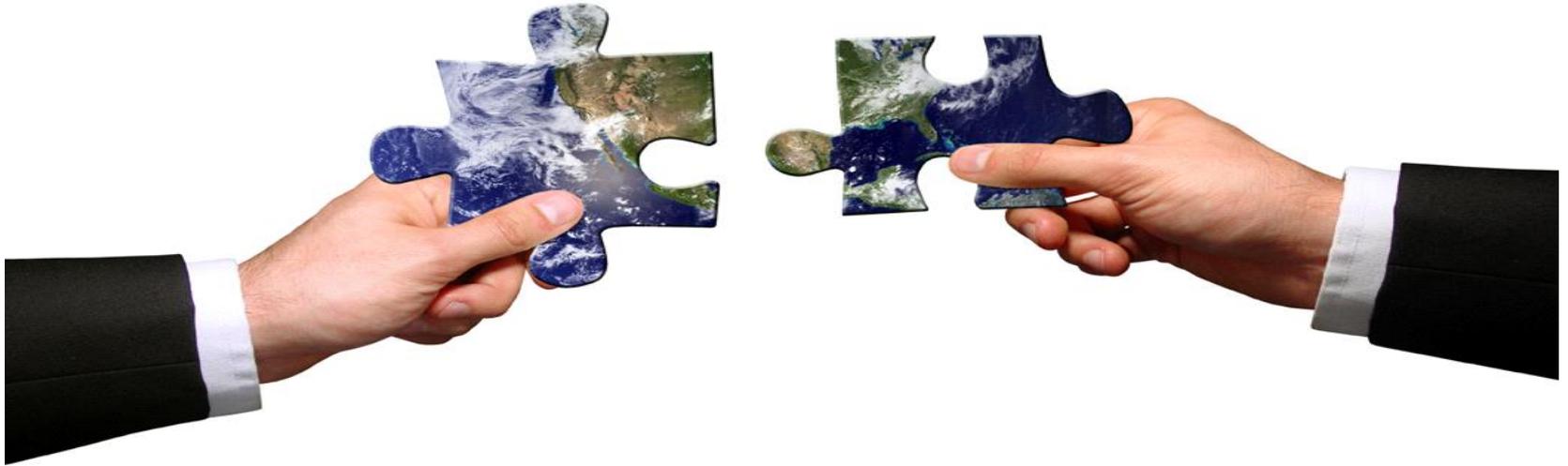
Identify Participant Resources

Assist the participant/family in identifying their resources. Resources include:

- personal strengths and weaknesses,
- community/family support,
- coping skills,
- access to transportation, and
- financial resources (private insurance, MO HealthNet, Medicare or SSI eligibility).



Other Agency Involvement



- Identify other agencies/providers who are involved in providing services.
- Encourage collaboration and contact with other providers.
- Remember to obtain an Authorization for Disclosure of Consumer Medical/Health Information to allow for exchange of information.

Identify & Prioritize Goals

Help identify and prioritize goals. A goal is defined as a statement of the changes a participant/family wants to see occur for their family member or themselves.

Examples:

- I want my daughter to walk upstairs.
- I want to get a job.
- I want my son to feed himself.
- I want people to understand what my son says.



Services

Help the participant/family to identify the services needed to meet the identified goals.



Create opportunities for the participant/family to make decisions regarding the needed services:

- Decide who is to provide the service,
- How often the service is needed
- Where the service is to be provided

Identify the funding source for payment of the service and the date the service is to begin. This is accomplished by completing the Service Plan section of MOHSAIC.

Obtain Identified Services

Provide them with information about obtaining the identified services.

This includes making sure they have:

- the contact names,
- addresses/telephone numbers, or
- referral information for the agency.



Understand Rights & Responsibilities



End with an understanding of:

- the rights and responsibilities of the participant/family and
- the service coordinator role and
- a plan for future contact.

Service Coordination Assessment

Section 1 – Participant Miscellaneous

Section 3 – Insurance
Medical/Dental/Vision

Section 5 – Medical Home

Section 7 – Mobility

Section 9 – Dietary Concerns

Section 11 – Social/Environmental

Section 13 – Educational/Vocational

Section 15 – Cultural Belief System

Section 17 – Safety

Section 19 – Youth Transitions

Section 21 – Participant/Family Statement

Section 2 – Health Care Team

Section 4 – Military

Section 6 – Health Medical

Section 8 – Activities of Daily
Living/Transportation

Section 10 – Emotional

Section 12 – Cognitive Concerns

Section 14 – Family Functioning

Section 16 – Current
Treatments/Therapies/Services and Needed
Referrals

Section 18 – Level of Independent Living and
Community Participation

Section 20 – Quality Assurance

Service Coordination Assessment

Describe the abilities (what the participant is able to do) and the limitations (what the participant cannot do/has difficulty doing)

- such as functioning level or age appropriate development

The Service Coordination Assessment (SCA) tool is used to assist in providing the appropriate level of care and/or services for participants/families.

This is done by gathering information regarding the participant's health care team, the participant's abilities and limitations and the availability of resources in their community.

This tool assists in planning for services by identifying un-met needs, setting goals and developing a plan to meet those goals.

Section 7 – Mobility

- methods used to move
- functioning level or age appropriate development
- assistive devices or durable medical equipment used/needed for mobility
- receives or needs therapy or rehabilitation
- type/amount/frequency of human assistance needed



Section 8 – Activities of Daily Living/Transportation

- functioning level or age appropriate development in areas of feeding, dressing, toileting, personal hygiene, food preparation and household tasks
- assistive equipment used or needed
- type/ amount/frequency of assistance needed and who provides the assistance
- does the participant transport themselves/have access to transportation



Section 9 – Dietary Concerns

- intake method - oral/tube feeding or combination of both
- special diet required/need liquids thickened, must use straw
- eating habits, food preferences and appetite
- how many meals and snacks daily/serving size
- feeding problems-choking, gagging, oral aversion
- needs meals to be prepared by others/needs to be fed by someone/needs supervision



Section 10 – Emotional



- functioning level or age appropriate development
- concerns about behavior/attitude/maturity level

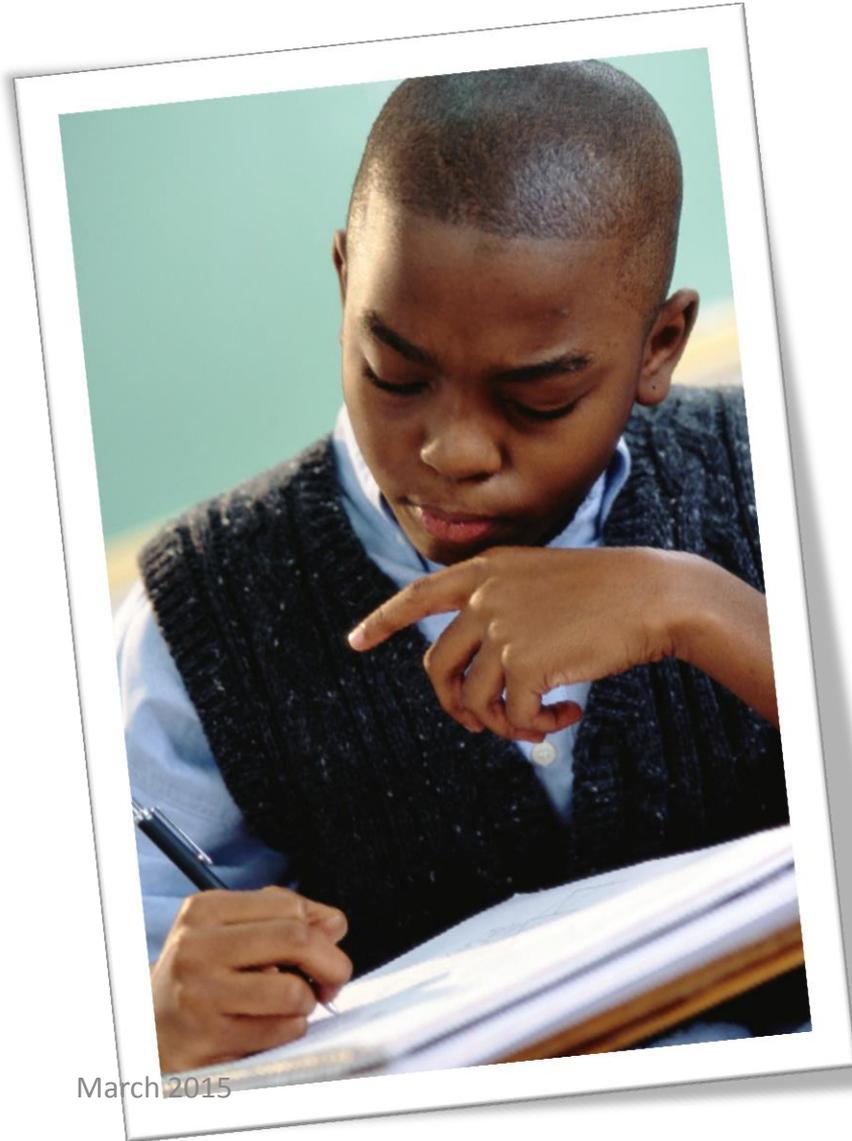


Section 11 – Social/Environmental

- relationships with family, siblings, peers
- what social activities does (name of participant) enjoy
- description of home environment



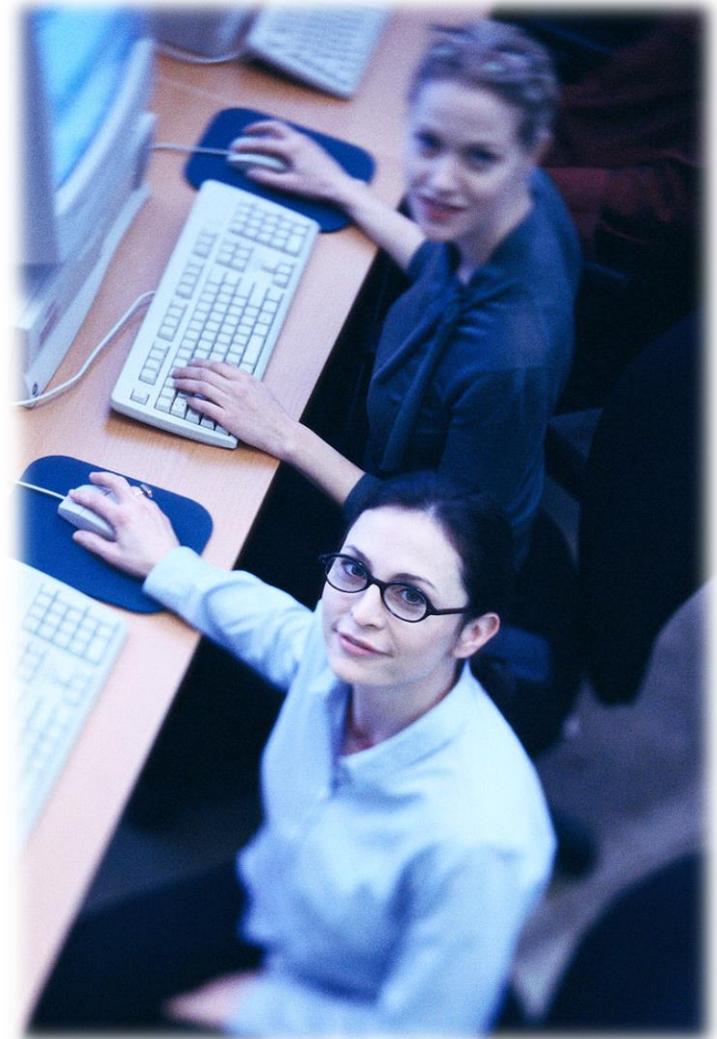
Section 12 – Cognitive Concerns



- results of formal testing from therapist, school or other
- functioning level or age appropriate development in areas of awareness, perception, reasoning, judgment, and comprehension
- memory abilities

Section 13 – Educational/Vocational

- where it is received
 - daycare or developmental preschool,
 - grade in school/special education classes or a sheltered workshop
- job training or rehabilitation program
- appropriateness of setting of educational/vocational services to functioning level



Section 14 – Family Functioning

- understanding or awareness of participant's condition and needs
- who is primary caregiver
- family support system (family, friends, professionals etc.)
- risk factors such as homelessness, financially or mentally challenged, alcohol/drug abuse by participant/family member
- community relationships
- financial resources (employment, other income)
- coping patterns/ways support is sought in stressful situations
- needs of family members in social, emotional, educational, financial and employment areas
- how much assistance is required to meet the needs of the participant

Section 15 – Cultural Belief System

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- A close-up photograph of a man with dark hair and a white shirt, looking down with his hands clasped in a prayerful gesture. The background is a soft, out-of-focus red and white gradient.
- language barrier with no interpreter available
 - religious beliefs which influence the participant/family in different areas, including health care
 - health care beliefs, use of alternative treatments
 - cultural beliefs which affect how the family accesses health care and/or relates or interacts with the service coordinator

Section 16 – Current Treatments/Therapies/Services and Needed Referrals

- is the participant receiving any of the treatments/therapies/services on the list
- if so, are they meeting the needs of the participant
- if not, are there treatments/therapies/services that are needed



Section 17 - Safety



- working smoke detectors and fire extinguisher
- fire escape plan
- storm shelter plan
- is a backup caregiver needed
- personal needs of the participant during a disaster
- Community awareness of participant needs (i.e. generator for participant on ventilator).

Section 21 – Participant/Family Statement

- Anything else the family wants the service coordinator to know (open ended)



Un-Met Needs, Goals, and Plans

- Un-Met Needs:
 - What is the obstacle/problem?
- Goal:
 - A statement of the changes the participant/family wants to happen.
- Plan:
 - What needs to be done to reach the goal, including the type of service?
 - Who will provide the service?
 - How will the service be funded?
 - When will the service begin?

- Questions?
- Comments?

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