CONFLICT-FREE CASE MANAGER/INDEPENDENT FACILITATOR ROLES & RESPONSIBILITIES

STAGE 1 – Introduction

- Record Review – Relevant documents, conversation with the current DD social caseworker
    - Individual Service Plan
    - Relevant documentation in electronic case management system
    - Communication style/support needs
    - Supports Intensity Scale – Family Friendly Version
    - Risk assessment/indicators
- Contact the person
    - CFCM/IF introduces themselves, their role and the process
    - Initial discussion of "What will you need?" to be supported and successful in this process
    - Coordinate next steps (scheduling time/s to meet in-person, etc.)
    - Initial ask of who else they would like to have included in this process
- If applicable, contact the person's family and/or friend/s
    - CFCM/IF introduces themselves, the CFCM/IF role and process
    - Initial discussion "What will you need?" to be supported and successful in this process
    - Coordinate next steps (scheduling time/s to meet, etc.)
    - Initial ask of who else they think would be beneficial to have included in this process
- Contact the person's community provider/s
    - Introducing themselves and the CFCM/IF role
    - Introducing the process
    - Initial information gathering "What should I know…"
    - Coordinating next steps
- Follow-up with relevant contacts with the Qualitative Review of Life Domains

STAGE 2 – Pre-Planning Information Gathering

- Engage the person in the Qualitative Review of Life Domains
- Continue to get to know the person – what is their communication style; what are their likes, interests, strengths, passions, talents; who and where is important to them; how do they like to be supported
- Resource mapping – who is in that person's life and where/how do they spend their time
- Information gathering to understand how the person can best engage in the planning process (how they like to be supported, communication style, plan format, dates, times, locations, who do you want to be there including any new resources)
- Discuss with the person their interests and how their experiences and opportunities and the people in their life match their interests
- Explain the resources and opportunities available through the new rate structure and individual budgets, including access to employment and community services

- Outline the major topics to be discussed at the planning meeting
- Identify the topics the person does NOT want to be discussed at the planning meeting
- Review varying planning process formats for the person to select
- Preparing with the person for how they want to be involved in the planning meeting
- Create opportunity to discuss difficult topics
- Understand initial "important to" and "important for"
- Develop initial recommendations regarding the planning process to be followed including any follow up conversations and/or observations
    - Additional conversations with the person
    - Conversations with family/friends
    - Conversations with people who know the person well (e.g. DSPs, Community Provider)

STAGE 3 – Planning Process

- Communicate with the team (person and, if applicable, family, community provider/s)
- Finalize logistics for future meeting/s
- Gathering any resources needed to facilitate based on the planning format (e.g. markers, technology, etc.)
- For each life domain, the person, supported by the team, discusses if the person has had enough experiences to decide what they want to do or do they need more experiences before they decide
- The CFCM/IF will identify and document the goals and specific action steps
- For each goal area or life domain, the team lists specific action steps
- For each action step, the CFCM/IF will ensure the team lists (a) where it will happen, (b) when it will happen, (c) how the person will get there, (d) what accommodations and/or technology the person might need, (e) what it costs, and (f) who is responsible for ensuring the experience actually happens
- For each action step, the team discusses (a) what things the person can do by themselves; (b) what the person's family and/or friends can do; (c) what other community people can help them do; (d) what other community resources might help them; (e) what they will need from paid staff
- For each action step, the team will review other community resources that might help the person, including who will contact them; if insufficient community resources are identified, community mapping may be recommended through community supports or support brokerage
- Explain the resources and opportunities available through the new rate structure and individual budgets, including access to employment and community services
- The person and CFCM/IF select a measurement format for each life direction or goal to measure their own progress and growth
- If there is risk or safety concerns involved in the life domain or goal, describe them and describe the strategies or supports that will be used to support the person to be safe
- Schedule a date and time for the routine check-ins

STAGE 4 – Referrals and Writing the Plan

- The CFCM/IF will send out referrals to any agencies identified during the planning process
- The CFCM/IF will follow up on all referrals made on behalf of the person
- The CFCM/IF will write the plan (**ghost writer**) and ensure it is in the person's voice and is what was agreed upon at the planning meeting(s)
- The CFCM/IF will ensure supporting documents are present and aligned with the plan (e.g. Behavioral Support Plan, Nursing Care Plan, Purchase Order, Employment Add On, etc.)
- The CFCM/IF will submit the plan as required
- The CFCM/IF will assist in request for supplemental funding, if needed

STAGE 5 – Check-Ins Monthly/As Determined by the Person with 6 Month In-Person Check in

- Contact the person and their team
- Document any changes to the Qualitative Review of Life Domains
- Review if anything has changed regarding what is important about the person, to the person, for the person, or how to support the person
- Review each goal or life domain in the plan and the measurement strategies agreed upon, to understand (a) have the action steps happened, and (b) has progress been made
- Address:
    - Any of the goals or life domains need to be revised
    - Any new or different action steps
    - Changes in where it occurs
    - Changes in when it occurs
    - Changes in who provides support
    - Changes in transportation
    - Changes in accommodations and/or technology needed
- Determine if there are new goals or activities the person wants to pursue
- Record revisions or new goals
- The CFCM/IF will make any amendments to the plan and PO/planned services
- Discuss if any concerns about safety occurred; if so, describe them and describe the strategies or supports that will be used to keep the person safe
- Use the monitoring form to document outcomes and follow-up actions as a result of the check-in with the person and their team