**Service Coordination**

Adapted from: <http://www.ncset.org/topics/coordination/faqs.asp?topic=35>

**What is the distinction between service coordination and case management practices?**

Service coordination, as noted above, entails working with youth with disabilities and their families to identify needs and strengths in all areas of their lives. Service coordinators review all assessment information from across disciplines (educational, health, psychological, vocational, etc.) and consider its impact upon the goals of the youth and their families. They also use this information to assess accommodation/support needs. In addition, service coordinators have access to formal and informal resources for youth and their families, including housing, social services, social security, recreation, postsecondary education, and other areas. In addition, they can help the youth and family acquire an analysis of the financial impact of employment on benefits received.

Case management differs primarily in its focus and access to services and resources. A case manager manages an individual plan through a specific discipline. For example, a special education teacher manages the IEP, a social worker manages the Individual Service Plan (ISP), a rehabilitation counselor manages the Individual Plan for Employment (IPE), and the health care provider manages the health/mental health plan. These professionals do not generally work together or understand how each of their assessment and service plans influence each other.

**How does service coordination support transition planning?**

A major barrier to post-school employment and related outcomes for youth with disabilities and their families is the lack of access to needed adult services and supports. Young people with disabilities, their families, and their teachers, who typically take a lead in the planning process, often fail to receive critical and timely information and assistance from agency personnel (Johnson, Sharpe, & Sinclair, 1997). In addition, many educational and agency personnel do not have experience and knowledge across systems and therefore cannot provide families and youth with options, identify gaps in services, or analyze the impact of services on benefits. A service coordinator can act as a single contact for families and professionals, taking a lead in organizing information, contacting transition team members, analyzing the assessment information, considering future plans, asking families and youth what they want and need, prioritizing programs and services, and assessing the impact of wages and services on benefits.

A service coordinator can help families gain services or appeal eligibility decisions and typically has an understanding of eligibility requirements for each system as well as reporting needs, the availability of options, and the appeals process. A service coordinator also understands the impact of the disability on independent living, employment, postsecondary education, relationships, and advocacy and communication skills.

**What are some best practices for service coordination?**

The following best-practice components are promoted by the Arc:

* Clear and enforced standards at the state level outlining key elements that indicate quality coordination;
* Implementation of individual service coordination at a level closest to the individual;
* Individual service coordination program operation by government or private entities that do not directly provide service, in order to reduce conflict of interest in decision-making;
* Service coordinators with an adequate knowledge base and values orientation to carry out their duties;
* Qualified service coordinators who receive adequate pre-service and in-service training and continuing education;
* Adequate supervision and support for service coordinators on the job;
* Manageable numbers of individuals served;
* An external process at the state level to monitor and evaluate the quality of individual service coordinators (with a capacity to provide technical assistance);
* Adequate funding for individual service coordinators;
* A system without serious gaps in services; and
* A system that has included informal supports and services through a resource mapping process.

From the Arc, “Individual Service Coordination for Individuals with Mental Retardation,” at: <http://www.thearc.org/faqs/servicecoord.doc>

**What are the different models for service coordination?**

Many service coordination models have been developed to provide options for interagency teams based on the needs of their area and the individuals and families they serve. Listed below are four models:

|  |  |  |  |
| --- | --- | --- | --- |
| **Dedicated Independent** | **Primary Interventionist** | **Interagency Team** | **Mixed** |
| The community has a group of people whose sole function is to coordinate services. They are typically independent from the direct service system. Service coordinators are categorized as personnel, and can be either employed by or affiliated with a program or independent of any program. Often personnel are co-funded by the various agencies and/or made up of service coordinators from the various agencies. The model utilizes the expertise of parents, paraprofessionals, and volunteers. | Providers most involved with day-to-day services also fulfill the role of service coordination. In some situations, an agency provides the majority of the day-to-day interventions and the service coordination function is assigned to a member of that agency. The agency assumes responsibility for service coordination funding. | Each agency or program involved with the individual/family can be chosen to provide service coordination. The choice is determined by the overriding needs of the individual/family or by individual/family choice. | This is any combination of the first three models. For example, some areas may utilize a dedicated model for the initial intake and development of the intervention plan. Other areas may creatively use all of the models or create a new system of service delivery. |
| Individuals/families may choose from an existing pool of dedicated service coordinators. | Individuals/families have limited choice in selecting who will carry out service coordination, as providers are typically assigned by a program. However, there may be choice within the program and can select another service provider if dissatisfied with their assigned coordinator. | Individuals/families have a greater pool of personnel from which to choose and a greater opportunity to make a choice that meets their specific needs. |  |

**Why have current case management practices been insufficient in meeting the needs of youth with disabilities and their families?**

Case management approaches are typically agency-specific; that is, a plan is developed based on eligibility criteria and the services available through one agency. There is little consideration for additional services, programs, or resources available through other agencies. Case managers rarely communicate with each other across agencies. Moreover, agencies differ widely in terms of public-professional orientation, institutional mandates, and private-sector regulations. Communication styles within agencies, as well as political and financial issues, may contribute to a lack of collaboration. Providers typically concentrate on what they are able to provide rather than on what individuals need. Children, youth, and families in such a system bounce from one agency to the next with little cooperation, follow-up, or evaluation of services from the agencies.

Case management can result in services that are fragmented, duplicated, or insufficient. When case managers concentrate on a single solution to an area of need, they can lose site of how services can be cohesive and holistic to better meet the needs of youth with disabilities and their families. When services and supports are fragmented, duplicated, or insufficient due to gaps, they lose effectiveness both in terms of outcomes and cost. For example, a young person who receives mental health services through a school and a mental health provider that do not communicate with each other may be receiving two contradictory interventions at the same time. The effect of the uncoordinated interventions may adversely impact the person’s mental health and the agencies’ resources.

**Who is currently doing service coordination for youth with disabilities, their families, and professionals?**

There are no legislative requirements for service coordination for youth with disabilities. Across the country models and services have been developed to meet this need in various ways. Some transition programs that serve youth ages 18-21 are providing service coordination because they are working with youth in the community, on the job, and at home. They have developed relationships with physicians, mental health workers, social security personnel, probation officers, postsecondary staff, rehabilitation services staff, and human services professionals. Since service coordination is not policy-driven, much of the training for service coordinators is learned on the job. In addition, some private providers are marketing service coordination (for example, the Arc’s Independent Living Centers and some waivered service providers). These would be funded either through federal and state grants, private foundations, or through Medicaid waivered dollars.

In most situations, however, families are attempting to coordinate the services for their son or daughter with a disability. Some parents have Consumer Directed Support Services (CDSS), also referred to as self-determination waivered dollars. For some parents who have received a Mental Retardation or Related Conditions (MR/RC) waiver to pay for in-home and community-based supports, this funding also can pay for job supports, service coordination, and a variety of services. Check with the local department of health and human services to determine if it includes service coordination as part of its waivered programs.