Chapter 5 : OhioKAN Service Delivery

Support Plan Check-Ins and Revisions

The Support Plan check-in frequency and contact type (in-person, web meeting, or phone call) is determined in partnership with the OhioKAN Family upon initial development of the Support Plan. Bi-weekly check-ins are generally a good starting point. The frequency can change as the family's needs change. For example, a family may want to meet bi-weekly initially, but then decrease the frequency to monthly as the service episode progresses. Or a family who has wanted monthly contact may need more frequent support in response to an unforeseen situation.

The purpose of these check-ins is to ensure that OhioKAN Families receive appropriate advocacy support and additional referrals for the needs they have identified, and that Navigators learn about barriers to access, provide support, and verify that all needs are met. During each check-in, the Navigator confirms with the caregiver or parent if substantive changes and revisions are needed. Small updates to the plan are expected, however, revising the entire Support Plan at every check-in is not required.

Preparing to Check In

Prior to initiating a check-in with the OhioKAN caregiver or parent, the Navigator reviews the documentation for the case, paying specific attention to the needs identified on the BASICS and the Support Plan, notes from the previous check-in on the Support Plan, the household composition, and the family strengths and supports. Navigators are encouraged to use names of household members and ask strengths-based open-ended questions whenever possible. For example, instead of saying, "Does your niece like the new school?" say, "How is Brittany doing with her transition to the new school?"

During the Check-In

During the check-in, greet the caregiver or parent by name and identify yourself as a Navigator from the OhioKAN program. State the purpose of the check-in:

- To follow up on the Support Plan and check-in on identified action steps and referrals.
- To hear how their experience has been accessing or engaging with the services identified in the Support Plan.
- To see if any other needs have come up.

Priorities for the Check-In

Review the caregiver or parent's priorities for the check-in and ask which needs and referrals the caregiver or parent would like to discuss first. Due to time constraints, it may not be feasible to discuss each need and referral on the Support Plan during each check-in. It is acceptable to focus on addressing a single need during a check-in, for example spending an entire check-in completing a benefits application with a parent or caregiver. A full review of all needs should be completed once the service episode has been open for 90 days or more, see section titled Quarterly Support Plan Review.

Priority Needs and Referrals

Starting with the needs and referrals the caregiver or parent prioritized, ask about each referral made and summarize the caregiver's or parent's response in the Support Plan's Notes section. The response notes should be brief.

When discussing each referral, keep the following in mind:

- Has the person attempted to access the referral resource or take the action step?
    - If not, were there any barriers that prevented them from doing this?
    - If the person did not have time to act on the referral, help them think through a plan to do so by asking questions like, "Is there a time within the next week when you will have time to reach out to this organization?"
        - If the person has a plan to access a referral they have not yet attempted to connect with, ask them if they would like you to follow up again. Specify a best date or time of day to reach them and set yourself a reminder.
- If the caregiver or parent did attempt to access the referral resource, what was the result?
    - If the organization does not provide the service or has a waitlist, ensure this is documented and provide an alternative referral if possible. If an alternative referral is not possible because no other services are available, document this and elevate the service gap to the Regional Coordinator.
    - If the caregiver or parent was told they were not eligible for a service, clarify eligibility.

Since the last conversation, ask if any new needs have arisen.

- If new needs have arisen, document these in the Support Plan and provide additional referrals to address these needs.

Ask if the person feels all their needs have been met at this time and if no longer require Collaborate advocacy and navigation services.

- If yes, close the service episode.
- If no, explore additional needs and potential referrals with them. Document any new needs and referrals in the Support Plan.

After the Check-In

Ensure all documentation, including the Support Plan, is completed and saved in a secure HIPPA compliant location. All documentation is updated within two working days of the check-in. If revisions were made to the Support Plan, indicate the revision date on the Support Plan and share the revised Support Plan with the OhioKAN caregiver or parent within two working days by phone, electronically, or hard copy. Notes added to the Support Plan during the check-in do not constitute revisions. Be sure to document if a service gap was discovered or information needs to be added to the resource data system. Revisions are defined as substantive changes to the Support Plan, such as adding, removing, or editing the following elements: individuals involved, action steps, needs, referrals.