TN Department of Disability & Aging

MEDICAID ALTERNATIVE PATHWAYS TO INDEPENDENCE ("MAPs") COMMUNITY NAVIGATOR SERVICE DEFINITION

Outcome Area:
Community

Service Area:
Community Navigator

Description:

Community Navigator services are designed to strengthen individuals' socially valued roles in their communities and assist them to identify, connect, participate, and fully engage in integrated community activities and resources of interest in accordance with their goals. Community Navigator services emphasize, promote, and coordinate the use of community resources and natural supports as alternatives to paid services.

Community Navigator services recognize the valuable importance of "Self Determination and "Dignity of Risk." In person-centered language, "Dignity of Risk" can be defined as: Supporting an individual's right to make his/her own decisions and take chances, understanding that learning and growth often come from facing challenges and experiencing the outcomes of our choices. It is about empowering people with intellectual and/or developmental disabilities ("ID/DD") to have control over their lives, just like anyone else, and recognizing that taking risks is a natural part of being human.

Community Navigator services are designed to be temporary or intermittent, phasing out as people become more independently engaged in their neighborhood and/or community. This approach includes a gradual release expectation. These supports will be faded using a person-centered and individual achievement approach, which may look different for each person supported.

Definition:

1. The Community Navigator works with individuals, their families, and other people in their support network with the aim of helping the person to identify and make connections with their chosen activities, resources, and interests, of the individual as defined, and illustrated in their **Virtual Community Resource Map ("VCRM")**. These supports may include, but are not limited to, travel training, assistance to participate in drivers' education courses, providing coaching/modeling of soft skills needed for typical social interactions, facilitating development of both geographic

familiarity of the community and site-specific awareness of Points of Interest ("POIs"), as identified within the VCRM, and the development of "routines" which promote comfort in both scheduled and impromptu community interactions.

2. **Virtual Community Resource Map ("VCRM")** is a person-centered digital map that is developed through a process that integrates customizable digital asset maps aligned with an individual's strengths and goals. As such, it serves as the Person-Centered Plan. The VCRM can be used to support individuals with intellectual and developmental disabilities as they establish support networks and pursue competitive integrated employment, self-employment, continuing education, independent living, and community inclusion.

3. The Community Navigator assists the person in moving beyond a focus on simply being "out of the home" during certain pre-defined periods of the day, and instead encourages and supports meaningful engagements and connections within the community and POIs.

4. The Community Navigator teaches and guides the planning, exploration, and attainment of community membership. Community Navigator supports are focused on helping the person develop the community awareness and social connections which are the foundation of work outcomes, competitive integrated employment, self-employment, and/or participation in post-secondary education opportunities.

5. The Community Navigator assists someone in their identification and pursuit of interests and goals which are unique to each person, being assisted to locate the opportunities in their local communities that are relevant to each person's unique interests and goals and identify other people with similar interests and goals.

6. The Community Navigator helps a person to engage with other members of his/her community in truly meaningful ways, not simply being present in the same places at the same time. By being able to participate in opportunities in the local community which truly match a person's unique interests and goals, the person will be able to meaningfully engage and connect with other members of the community *with whom he/she shares something in common* (e.g., work, a shared interest, a shared desire to learn or do something, a shared desired to contribute, etc.). This creates the potential for real and valuable connections and relationships to form, enabling a person to develop connections and relationships outside of paid staff, immediate family, and other people receiving services.

7. The Community Navigator supports the person to develop decision making skills, which includes, but is not limited to, connecting the person and his/her family and

support network to Supported Decision Making resources. Supported Decision-Making (SDM) allows individuals with disabilities to make choices about their own lives with support from a team of people they choose. Individuals with disabilities choose people they know and trust to be part of a support network to help with decision-making. For more information, visit the TN Center for Supported Decision Making.

8. Community Navigator services are intended to be phased out – the service is intended to help the person reach a specific, targeted, and attainable outcome(s); including helping the person to build skills and natural supports which will empower him/her to be able to maintain that outcome as independently as possible.

9. Community Navigator services are encouraged to be implemented with the use of Enabling Technology. These Enabling Technologies include but are not limited to, AbleLink Wayfinder application, GPS guidance devices, wearable and virtual technologies, and software to support communication with people along a person's route or destinations.

10. Virtual Services are an acceptable promotion of Community Navigator Services.

Community Navigator service outcomes include, but are not limited to:

1. Teaching and assisting the person to pursue opportunities and learn skills needed to engage in truly integrated community activities of his/her choice and interest. Integrated community activities happen within the greater community, are open and utilized by all members of the community and are where the person has opportunities to meet and form relationships with other people who aren't providing paid supports.

2. Giving the person a chance to explore opportunities in the community and learn how to become involved with more people, groups, and activities.

3. Helping the person identify and locate community resources and Places of Interest ("POI") to inform and develop the person-centered VCRM.

4. Assisting in the identification of potential relationships which promote community inclusion and support the person and, if applicable, the person's Circle of Support ("COS") in developing those relationships within each identified POI.

5. Supporting the person to travel independently within their community through travel training, learning how to use public transportation or ride-share services (i.e.: Uber, Lyft), learning how to drive, learning how to walk to preferred destinations safely and independently, and learning how to safely use a bicycle or scooter.

6. Identifying the steps needed to increase the person's opportunity to expand valued social relationships and build connections within the local community through unpaid supports.

7. Valued Social Roles include person-centered relationships which add meaning to the person's life. This could include relationships with people and/or groups and roles within the community which are valued by the person and/or others in the community (e.g., volunteer, employee, homeowner/renter, member of church/faith institution, various community activities).

8. Determining the person's interest in continuing their education, educating the person and his/her COS on higher education options, connecting the person to educational financial resources, and/or assisting the person with submitting applications to higher education programs of interest.

The Department recognizes Dignity of Risk and Person-Centered Planning Practices as a function of Community Navigator services to ensure all parties are informed of the risks associated.

Community Navigator outcomes will be achieved by:

1. Reviewing each person's existing social network, people he/she likes seeing, community activities he/she enjoys, and the places he/she currently visits and would like to visit in the future to develop the person-centered VCRM.

2. Using existing networks to help the person develop and further expand the pool of places and opportunities which offer potential for meaningful community membership all while continuing to maintain an updated VCRM, as desired by the person.

3. Providing travel training instruction and/or support to participate in drivers' education training to facilitate self-initiated travel.

4. Supporting the further development of the person's social network and relationships by cultivating soft skills, behavioral self-management skills, and building confidence to overcome social concerns or barriers.

5. Providing instruction and training on the use of available enabling technologies which support social engagement, community membership, and independent travel.

6. Providing information about available local activities and sources of support and practical help to access activities. This can also include, but is not limited to, helping with phone calls, application forms, researching new community activities, etc.

7. Acting as an advocate within the system and community, by empowering and supporting participants to access community resources and build networks of support.

Milestones:

All milestones may be achieved with the assistance of Enabling Technology, as outlined in the person's VCRM and Enabling Technology Plan ("ETP"). Innovation Coordinators will validate the achievement of these milestones. The achievement of milestones is person-centered. Some people may already be proficient in the milestones listed below; therefore, no additional training or assistance will be required. Other people may require additional training or instruction related to these milestones to achieve their personal goals associated with community relationships, memberships, travel, and participation.

1. **Independent Travel -** Over a month-long observation period, the person engages in independent and consistent initiation of transportation to preferred community locations. This includes but is not limited to, the ability to identify desired locations, either through the VCRM or spontaneously, and then to schedule or self-initiate transportation to the locations.

    Validation examples:

    - Verify the VCRM or WayFinder application is set up with people with whom the person supported engages regularly and places frequently visited. Has the person supported completed the Travel Training curriculum? VCRM review.

    - Use of Google Forms/Microsoft Forms for a quick survey the person supported could complete embedded in the VCRM.

      Has the person completed Driver's Education Training to complete the self-initiated travel? The person supported can submit photo

evidence of a driver's permit as an example. Video evidence that the person supported can safely and successfully use the WayFinder (or other independent modes of transportation) application for independent travel in the community is also an option. NOTE: This milestone will require observation over a month-long period.

- **Additional innovative evidence can be accepted.**

2. **Community Relationships -** Over a month-long observation period, the person is observed having established, recurring, and natural relationships or contacts, either with unpaid supports or with other community members in POIs. This includes but is not limited to, showing independent, naturally occurring, and regular contact with his/her social network and/or POIs and showing proficiency in navigating social engagements and challenges to maintain sustainable relationships and/or memberships.

   Validation examples:

   - VCRM could include confirmation of relationships developed over the period and that there is evidence using the VCRM that the person is participating in activities in the community socially.

     NOTE: Initial VCRM Validation is confirmed using the VCRM Implementation and Validation directions. Ongoing VCRM implementation should include the continued build-out of new acquaintances developed within the community (as person-supported chooses) and the identification of chosen milestones.

   - MAPs Provider agencies may submit photo evidence of a person supported and social acquaintances in the community.

   - MAPs Provider agencies may submit a video of the person supported engaging the community with social acquaintances.

   - **Additional innovative evidence can be accepted.**

3. **Community Activities -** The person leverages information or relationships within the POIs to develop new interests, and opportunities, and broadens his/her natural network within the community.

   Validation examples:

- MAPs Provider agencies may submit monthly calendars which show the person supported engaging in his/her community on a routine basis. These locations should coincide with locations identified within the VCRM, as well as the people identified within those locations (i.e., natural supports, acquaintances, friends, etc.).

- VCRM can be reviewed for confirmation that the person supported is meeting with people of their choosing at the location by adding descriptions within the VCRM Asset.

- Additional evidence can include confirmation of joining groups, clubs, church associations, etc., on documentation OR video evidence of the person supporting attending these locations to develop relationships.

- MAPs Provider agencies can submit evidence of completing a survey with the person/person's family confirming there have been increased opportunities for engagement in community activities.

- **Additional innovative evidence can be accepted.**