AE-207

Clinical Services Summary

Service model, coordination approach, and documentation practices for clinical partners.

Aeternum provides residential support and care coordination. Clinical treatment — prescribing, therapy, and medical care — is delivered by each resident's own community providers, with whom we coordinate closely. This document describes exactly what we provide directly and what we coordinate.

Model of care

Principle	In practice
Trauma-informed	Safety, choice, collaboration, trustworthiness, and empowerment shape every interaction. We ask what happened, not what is wrong.
Person-centered	The resident names the goals; the plan and the household adapt around them.
Recovery-oriented	Progress is defined by the resident's own life goals — work, school, relationships, independence — not by symptom checklists alone.
Least restrictive	Unlocked home, community access, and no seclusion or restraint as behavior management.
Culturally responsive	Language, faith, food, identity, and family structure are actively accommodated.

Provided directly by Aeternum

- 24-hour awake residential support
- Medication storage, administration, documentation, and monitoring
- Person-centered support plan development and review
- Individual safety planning and crisis de-escalation
- Daily living skills instruction and practice
- Health monitoring and communication with prescribers about observed changes
- Appointment scheduling, transportation, and follow-through
- Documentation of services, incidents, and progress

- Family communication and care conferences
- Transition and discharge planning

Coordinated with community providers

- Psychiatric evaluation and medication prescribing
- Individual and group therapy
- Substance use treatment and peer recovery support
- Primary care, dental, vision, and specialty medical care
- Laboratory work and diagnostic testing
- Occupational, physical, and speech therapy
- Vocational rehabilitation, supported employment, and education
- Benefits, housing, and legal services

3 Individual safety plan built collaboratively, including early warning signs and preferred responses
4 Regular scheduled plan reviews with the resident, staff, family, and outside providers as consented
5 Immediate plan update after any significant change in health, function, or circumstances

Documentation

- Daily progress notes tied to support plan goals
- Medication administration records with real-time documentation
- Incident reports with leadership review and required reporting
- Health monitoring logs, vitals, and appointment outcomes
- Communication logs for provider and family contacts
- Records retained and released consistent with HIPAA, 42 CFR Part 2 where applicable, and Oregon law

Outcome focus

- Stability in housing and daily routine
- Consistent engagement with chosen providers
- Reduced emergency department and hospital use
- Growth in independent living skills
- Meaningful daily activity — work, school, volunteering, or community involvement
- Strengthened family and social connection
- Movement toward the least restrictive setting the resident wants

Quality assurance

- Incident review and root-cause analysis
- Medication error tracking and corrective action
- Grievance tracking with pattern review
- Staff supervision, competency checks, and annual training
- Resident and family satisfaction input
- Cooperation with Oregon Health Authority licensing review and corrective action