SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Louisiana Children's Choice (CC) Waiver beneficiaries. Support coordination is an organized system by which a support coordinator assists a beneficiary to prioritize and define their personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Beneficiaries may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

1. Intake;
2. Assessment;
3. Plan of care development and implementation;
4. Follow-up/monitoring;
5. Reassessment; and
6. Transition/closure.

Intake

Intake serves as an entry point into the CC Waiver and is used to gather baseline information to determine the beneficiary's medical eligibility for waiver services, service needs, appropriateness for services, and desire for support coordination.

Intake Procedures

Referrals for support coordination services are only made from the Office for Citizens with Developmental Disabilities (OCDD) through the Medicaid data management contractor. The applicant must be interviewed to obtain the required demographic information, preferably face-to-face in the applicant's home, within three working days of receipt of the Freedom of Choice (FOC) form.

The plan of care (POC) process begins with an initial face-to-face meeting in the beneficiary's home. The support coordinator requests and gathers medical, social, educational, and psychological documentation necessary to complete the POC.

The local governing entity (LGE) will transfer eligibility documents with the transfer of records to the support coordination agency. Prior authorization to cover services from the beginning date of the POC will be issued upon approval of the POC.

The support coordinator must determine whether the applicant:

1. Has a need for immediate support coordination intervention; and

2. Is receiving support coordination service or other services from another provider or community resource.

   NOTE: If the applicant is receiving support coordination from another OCDD provider, the OCDD state office support coordination program manager must be contacted to correct the linkage. (See Appendix C for contact information).

Applicants who are receiving support coordination from another provider must remain with their current provider until approved for the waiver. Requests to change to a different support coordination agency may be made following waiver certification. Refer to "Changing Support Coordination Agencies" at the end of this section.

The support coordinator must obtain signed release forms and have the applicant/family sign a standardized intake form that documents the applicant/family:

1. Was informed of procedural safeguards;

2. Was informed of their rights along with grievance procedures;

3. Was advised of their responsibilities;

4. Accepted support coordination service;

5. Was advised of the right to change support coordination providers, support coordinators, service providers; and

6. Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the Children's Choice Waiver are not appropriate to meet the applicant's needs, or if the applicant does not meet the eligibility requirements for waiver services, the applicant should be notified immediately, given appeal rights, and directed to other service options or to the source of the initial referral.

Assessment

Assessment is the process of gathering and integrating informal and formal/professional information relevant to the development of an individualized POC. The information should be based on, and responsive to, the beneficiary's current service needs, desired personal outcomes and functional status. The assessment provides the foundation for support coordination service by defining the beneficiary's needs and assisting in the development of the POC.

Assessment Process

The person-centered support assessment must be conducted by the support coordinator and consist of the following:

1. Face-to-face home interviews with the beneficiary/beneficiary's family or guardian;

2. Direct observation of the beneficiary;

3. Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the beneficiary; and

4. Freedom of choice of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

1. Identifying information (demographics);

2. The use of a standardized instrument for certain targeted populations;

3. Personal outcomes identified, defined and prioritized by the beneficiary;

4. Medical/physical information;

5. Psycho social/behavioral information;

6. Developmental/intellectual information;

7. Socialization/recreational information including the social environment and relationships that are important to the beneficiary;

8. Patterns of the beneficiary's everyday life;

9. Financial resources;

10. Educational/vocational information;

11. Housing/physical environment of the beneficiary;

12. Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes;

13. Information relevant to understanding the supports and services needed by the beneficiary to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes); and

14. Identification of areas where a professional evaluation is necessary to determine appropriate services or interventions.

It is the responsibility of the support coordinator to assist the beneficiary to arrange any professional/clinical evaluations that are needed to develop strategies for obtaining the services, resources, and supports necessary to achieve their desired personal outcomes while ensuring beneficiary choice. The support coordinator must identify, gather, and review the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences, and desired personal outcomes. A signed authorization must be obtained from the beneficiary or guardian (if the beneficiary is a minor) to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

NOTE: Evaluations, tests, or reports are not covered support coordination activities. The necessary medical, psychological, psycho social, and/or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.

Time Frame for Initial Assessment

The initial assessment must begin **within seven calendar days** and be completed **within 30 calendar days** following the referral/linkage.

Ongoing Assessment Procedures

The assessment must be ongoing to reflect changes in the beneficiary's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities, and the resources of the beneficiary. If there are significant changes in the beneficiary's status or needs, the support coordinator must revise the POC.

Plan of Care Development and Implementation

The POC is the analysis of information from the formal evaluations and the person-centered supports assessment and is based on the unique personal outcomes identified, defined and prioritized by the beneficiary.

The POC is developed through a collaborative process involving the beneficiary, family, friends or other support systems, the support coordinator, appropriate professionals/service providers, and others who know the beneficiary best.

The purpose of the POC is to:

1. Establish direction for all persons involved in providing supports and services for the beneficiary by describing how the needed supports and services interact to form overall strategies that assist the beneficiary to maintain or achieve the desired personal outcomes;

2. Provide a process for ensuring that the paid medical services and other resources are deemed medically necessary and meet the needs of the beneficiary including health and welfare as determined by the assessment, and that these services and supports are provided in a cost-effective manner; and

3. Represent a strategy for ensuring that services are appropriate, available, and responsive to the beneficiary's changing outcomes and needs as updated in the assessment.

The POC should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the POC should be considered a "master plan" consisting of a comprehensive summary of information to aid the beneficiary to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining the desired personal outcomes.

Required Procedures

The POC must be completed in a face-to-face home visit with the beneficiary, service provider, and members of the support network, which may include family members, appropriate professionals, and others who are well acquainted with the beneficiary. The POC must be held at a time that is convenient for the beneficiary.

The POC must be outcome-oriented, individualized, and time limited. The planning process should include tailoring the POC to the beneficiary's needs based on the on-going personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports, and appropriate formal paid services. The beneficiary, support coordinator, members of the support system, direct service providers, and appropriate professional personnel must be directly involved in the development of the POC.

The POC must assist the beneficiary to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes, which involves assisting the beneficiary to identify specific, realistic needs and choices for the POC. It must also assist the beneficiary in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates, and individuals who will be responsible for specific steps.

The POC must incorporate steps that empower and help the beneficiary to develop independence, growth, and self-management.

The POC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the beneficiary must be clearly explained. The POC must be approved prior to issuance of any prior authorization.

Required Components

The POC must incorporate the following required components and shall be prepared by the support coordinator with the chosen service provider, beneficiary, parent/family and others, at the request of the beneficiary:

1. The beneficiary's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services;

2. Budget payment mechanism, as applicable;

3. Target/resolution dates for the achievement/maintenance of personal outcome;

4. Assigned responsibilities;

5. Identified preferred formal and informal support/service providers and the specific service arrangements;

6. Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services;

7. Ensured flexibility of frequency, intensity, location, time, and method of each service or intervention and is consistent with the POC and beneficiary's desired outcomes;

8. Change in a waiver service provider(s) can only be requested by the beneficiary at the end of a 12-month linkage unless there is "good cause." Any request for a change requires a completion of a Freedom of Choice form. A change in support coordination providers is to be made through the Medicaid data management contractor. A change in direct service providers is to be made through the support coordinator;

9. All participants present at the POC meeting must sign the POC;

10. The POC must be completed and approved as per POC instructions; and

11. The beneficiary must be informed of their right to refuse a POC after carefully reviewing it.

Building and Implementing Supports

The implementation of the POC involves arranging for, building, and implementing a continuum of both informal supports and formal/professional services that will contribute to the achievement of the beneficiary's desired personal outcomes.

Responsibilities of the support coordinator include:

1. Building and implementing the supports and services as described in the POC;

2. Assisting the beneficiary/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;

3. Being aware of and providing information to the beneficiary/family on potential community resources, including formal resources (SNAP Benefits, Supplemental Security Income, housing, Medicaid, etc.) and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;

4. Assisting with problem solving with the beneficiary, supports, and services providers;

5. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet the beneficiary's individual needs;

6. Advocating on behalf of the beneficiary to assist in obtaining benefits, supports, or services, e.g., to help establish, expand, maintain and strengthen the beneficiary's informal and natural support networks by calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;

7. Training and supporting the beneficiary in self-advocacy, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes;

8. Overseeing the service providers to ensure that the beneficiary receives appropriate services and outcomes as designed in the POC;

9. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities; and

10. Meeting with the beneficiary face-to-face in the beneficiary's home between a six and nine-month period and for each annual POC development, or more often if requested by the beneficiary/family.

NOTE: Advocacy is defined as assuring that the beneficiary receives appropriate supports and services of high quality and locating additional services not readily available in the community.

Required Time Frames

1. Linkage

   a. The POC must be completed and received by the local governing entity (LGE) within 35 calendar days following the date of the notification of

linkage by the data management contractor. All incomplete packages will be returned.

2. Revisions to the POC

   a. Routine changes, such as vacations or when school is not in session, must be submitted ten working days prior to the change.

3. Emergencies

   a. Emergency changes must be submitted within 24 hours or the next working day following the change.

4. Reviews

   a. The POC must be reviewed between the sixth and ninth month of implementation to ensure that the personal outcomes and support strategies are consistent with the needs of the beneficiary; and

   b. The POC must be revised at least annually and/or as needed, and submitted to the LGE no later than 35 days prior to expiration. The POC may be submitted as early as 60 days prior to expiration, provided the form 90-L does not expire prior to the POC expiration date.

Changes in the Plan of Care

If there are significant changes (adding or deleting services) in the way the beneficiary prioritizes their personal outcomes, and/or if there are significant changes in the support strategies or service providers, the support coordinator must revise the POC to reflect these changes. A revision request must be submitted to the LGE for approval on all beneficiaries.

Whenever possible, additional service needs should be anticipated and planned for in the initial/annual POC during the plan of care meeting. If an unanticipated need is identified 10 or more business days prior to the change, a POC Revision request should be submitted and will be processed within 10 business days. The revision should be marked as "Routine". If an unanticipated need is identified less than 10 business days prior to the needed change, the POC Revision request must be identified as "Urgent", and the additional responsibilities for Provider and Support Coordinator must be assumed. For "urgent" requests, the relevant box must be checked. An urgent need exists when there is an unplanned/unpredictable event which requires

urgent changes(s) to waiver services and/or changes in the service provider. Urgent changes are changes that must begin less than 10 business days from receipt by the LGE.

Initiating a Change in the Plan of Care

The beneficiary/family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider(s) to complete the POC revision form. All participants attending the meeting will sign the POC revision, and it will be submitted to the Local Governing Entity (LGE) for approval. The support coordinator will notify the service provider(s) and beneficiary of the approval/disapproval.

NOTE: The annual expiration date of the POC should never change.

Documentation

A copy of the approved POC must be kept at the beneficiary's home, in the beneficiary's case record at the support coordination agency, and in the service provider's files. The support coordinator is responsible for providing the copies.

A copy of the POC must be made available to all staff directly involved with the beneficiary.

Plan of Care Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the POC and should be completed monthly, quarterly, and annually following the guidelines and using the Support Coordination Contact Documentation form. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the POC in meeting the beneficiary's needs, but identifies when changes in the beneficiary's status necessitate a revision in the POC. The purpose of the follow-up/monitoring contacts is to determine:

1. If services are being delivered as planned;

2. If services are effective and adequate to meet the beneficiary's needs; and

3. Whether the beneficiary is satisfied with the services.

The support coordinator and the beneficiary develop an action plan to monitor and evaluate strategies to ensure continued progress toward the beneficiary's personal outcomes.

Every calendar month after linkage, the support coordinator must make contact with the beneficiary to address the following:

1. Does the beneficiary/family feel the outcomes are being met;

2. Are the times the services are being provided convenient and satisfactory to the beneficiary/family;

3. Does the beneficiary/family have any problems or changes that may require additional services;

4. Are the providers actually present at the times indicated; and

5. Are the provided services adequate and of good quality?

The beneficiary/family should be informed of the necessity to contact the support coordinator when there are significant changes in beneficiary's status or if problems arise with service providers. A major change in status requires a reassessment. If the change is determined to be a long-term situation, refer to Crisis Provisions.

All visits and contacts should be documented in the case record using monthly progress notes. Progress notes may be brief as long as all components are addressed. Information documented in the progress notes does not need to be duplicated in the case record.

Monthly progress notes must address personal outcomes separately and reflect the beneficiary's interpretation of the outcomes. Monthly progress notes shall include:

1. Desired personal outcomes;

2. Strategies to achieve the outcomes;

3. Effectiveness of the strategies;

4. Obstacles to achieving the desired outcomes;

5. New opportunities; and

6. Developing a new action plan.

Reassessment/Working Plan of Care

Assessment must be ongoing to reflect changes in the beneficiary's life and the changing prioritized personal outcomes over time such as strengths, needs, preferences, abilities, and the beneficiary's resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the "working" POC.

A reassessment is required when a major change occurs in the status of the beneficiary, the beneficiary's family, or the beneficiary's prioritized needs. A reassessment must be completed **within seven calendar days** of notice of a change in the beneficiary's status.

NOTE: The beneficiary/family may request a complete POC review by the LGE at any time during the POC year if it is felt the POC is unsatisfactory or is inadequate in meeting the beneficiary's service needs.

Six-month Reassessment

Between six and nine months after POC implementation, the support coordinator shall review the POC with the beneficiary to determine if the needs of the beneficiary continue to be addressed.

Annual Reassessment

A completed annual reassessment package must be received by the LGE no later than **35 calendar days**, but as early as **60 calendar days,** prior to expiration of the POC, provided the form 90-L does not expire prior to the POC expiration date. Incomplete packages will not be accepted. Support coordinators will be responsible for retrieving incomplete packages from the LGE. Sanctions will be applied.

SCA Approval Authority of the Annual Plan of Care

Support coordinators have limited POC approval authority as authorized by OCDD. Approval of a POC for an annual reassessment shall be limited to those cases where:

1. The beneficiary's health and welfare can be assured;
2. There are no changes in waiver services; and
3. The current waiver services are meeting the needs of the beneficiary.

NOTE: All necessary documentation must be submitted to the LGE with a copy of the approved POC.

Support coordinators **do not** have authority to approve a POC when any of the following occurred during the previous POC year:

1. Skilled nursing care;

2. Direct service worker given delegation for medication administration or delegation for a complex or non-complex task;

3. Crisis or non-crisis designation was requested;

4. There were three or more critical incident reports during the POC year; or

5. There was any report with a substantiated investigation to the Department of Children and Family Services' Child Welfare Division or the Louisiana Department of Health's Adult Protective Services.

Transition/Closure

The transition or closure of support coordination services must occur in response to the request of the beneficiary, or if the beneficiary is no longer eligible for services. The closure process must ease the transition to other services or care systems outside of the waiver.

Closure Criteria

Criteria for closure of waiver and support coordination services include, but are not limited to, the following:

1. The beneficiary requests termination of services;

2. Death;

3. Permanent relocation of the beneficiary out of the service area (transfer to another region) or out of state;

4. Long term admission to an institution or nursing facility;

5. The beneficiary requires a level of care beyond that which can safely be provided through waiver services; or

6. Beneficiary refuses to comply with support coordination.

Procedures for Transition/Closure

The support coordinator must provide assistance to the beneficiary and to the receiving agency during a transition to assure the smoothest possible transition. Transition/closure decisions should be reached with the full participation of the beneficiary/family. Support coordinators must:

1. Notify the beneficiary/family immediately if the beneficiary becomes ineligible for services;

2. Complete a final written reassessment identifying any unresolved problems or needs and discuss methods of negotiating their own service needs with the beneficiary/family ;

3. Notify the service provider(s) immediately if services are being transitioned or closed; and

4. Assure the receiving agency, program or support coordinator receives copies of the most current POC and related documents. (**NOTE:** The form 148-W must be completed to reflect the date on the transfer of records and submitted to LGE).

The support coordination agency must:

1. Notify the LGE of the transition/closure four weeks prior to the closure to allow the LGE time to establish a transition plan;

2. Follow their own policies and procedures regarding intake and closure; and

3. Serve as a resource to beneficiaries who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities. All closures must be entered into the database immediately.

NOTE: An agency shall not close a beneficiary's case that is in the process of an appeal. Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within ten days, the case remains open. If not requested within ten days, the case will be closed.

The agency shall not retaliate in any way against the beneficiary for terminating services or transferring to another agency for support coordination services.

Transition at Age 21

When the beneficiary reaches age 21, as long as they remain eligible for waiver services, they will transfer to an appropriate home and community-based waiver for adults who meet the level of care requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Support coordinators must begin the transition process no less than 90 days prior to the beneficiary's 21st birthday and submit the transition plan to the LGE no less than 35 days prior to the beneficiary's 21st birthday.

Changing Support Coordination Agencies

When a beneficiary selects a new support coordination provider, the data management contractor will link the beneficiary to the new provider. The new support coordination provider must:

1. Complete the Freedom of Choice file transfer;
2. Obtain the case record and authorized signature; and
3. Inform the transferring support coordination agency.

Upon receipt of the completed form, the transferring provider must provide copies of the following information:

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the calendar year;
4. Most recent six months of progress notes; and
5. Form 90-L.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services after the dated notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within three days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. The receiving agency must submit the required documentation to the LGE/and the Medicaid data management contractor to begin prior authorization immediately after the transfer of records.

Other Support Coordination Responsibilities

Coordination of Family Support and Personal Care Services

The personal care service (PCS) provider must submit information to the Medicaid fiscal intermediary for prior authorization. Support coordinators will send a copy of the PCS prior authorization to the family support provider (if different from the PCS provider) to ensure that service times are not overlapping. Clear documentation of each service is required in the family support and PCS providers' files. (See Appendix D for information on obtaining the "Comparison Chart Louisiana Children's Choice Family Support – PCA & EPSDT-PCS").

Assistance with Self-Direction Option

Support coordinators are responsible for providing assistance to beneficiaries who select to participate in the self-direction option with the following activities:

1. Training beneficiaries on their responsibilities as an employer;
2. Completing required forms for participation in the self-direction option;
3. Assisting with development of the back-up service plan;
4. Assisting with development of budget planning;
5. Verifying potential employees meet program qualifications;
6. Ensuring the beneficiary's needs are being met through services; and
7. Monitoring the beneficiary's self-directed services each quarter.

Reporting of Incidents, Accidents, and Complaints

The support coordinator must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OCDD, HSS, and other appropriate agency as mandated by law. All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. Refer to Section 14.10 – Incidents, Accidents and Complaints for additional instructions.