SUPPORT COORDINATION

Support coordination, also referred to as case management, is an organized system by which a support coordinator assists a recipient to prioritize and define his/her personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Recipients may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

- Intake,
- Assessment,
- Plan of Care Development and Implementation,
- Follow-Up/Monitoring,
- Reassessment, and
- Transition/Closure.

Intake

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

Intake Procedures

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 from the data management contractor.

The Plan of Care process begins with an initial face-to-face meeting in the applicant's home. The support coordinator requests and gathers demographic, medical, social, educational and psychological information necessary to complete the Plan of Care. Prior authorization to cover services from the beginning date of the Plan of Care will be issued upon approval of the Plan of Care.

The support coordinator must determine whether the applicant:

- Has a need for immediate support coordination intervention, and
- Is receiving support coordination service or other services from another provider or community resource.

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 provider may be made following waiver certification. Refer to "Changing Support Coordination Providers" 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:

- Was informed of procedural safeguards,
- Was informed of their rights along with grievance procedures,
- Was advised of their responsibilities,
- Accepted support coordination service,
- Was advised of the right to change support coordination providers, support coordinators, service providers, and
- Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the Community Choices 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 will be notified in writing, given appeal rights and directed to other service options, as applicable.

Assessment

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

Assessment Process

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

- Face-to-face home interviews with the recipient/recipient's family or guardian,
- Direct observation of the recipient,
- Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the recipient, and
- Freedom of choice of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

- Identifying information (demographics),
- The use of a standardized instrument for certain targeted populations,
- Personal outcomes identified, defined and prioritized by the recipient,
- Medical/physical information,
- Psycho social/behavioral information,
- Socialization/recreational information including the social environment and relationships that are important to the recipient,
- Patterns of the recipient's everyday life,
- Financial resources,
- Educational/vocational information,
- Housing/physical environment of the recipient,

- Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes, and

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

It is the responsibility of the support coordinator to assist the recipient to arrange any professional/clinical evaluations that are needed to develop strategies for obtaining the services, resources and supports necessary to achieve his/her desired personal outcomes while ensuring recipient choice. The support coordinator must identify, gather and review any information/documents that are relevant to the recipient's needs, interests, strengths, preferences and desired personal outcomes. A signed authorization must be obtained from the recipient/responsible representative to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

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 recipient's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities and the resources of the recipient. If there are significant changes in the recipient's status or needs, the support coordinator must revise the Plan of Care.

Plan of Care Development and Implementation

The Plan of Care is the analysis of gathered information from the recipient/responsible representative and the person-centered assessment process, and is based on the unique personal outcomes identified, defined and prioritized by the recipient.

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

The Plan of Care serves to:

- Establish direction for all persons involved in providing supports and services for the recipient by describing how the needed supports and services interact to

form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

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

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

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

Required Procedures

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

The Plan of Care must be outcome-oriented, individualized and time limited. The planning process should include tailoring the Plan of Care to the recipient'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 recipient, support coordinator, members of the recipient's support system, including appropriate professional personnel, must be directly involved in the development of the Plan of Care.

The Plan of Care must assist the recipient to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes, which, involves assisting the recipient to identify specific, realistic needs and choices for the Plan of Care. It must also assist the recipient 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 Plan of Care must incorporate steps that empower and help the recipient to develop independence, growth, and self-management.

The Plan of Care 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 recipient must be clearly explained. The POC must be approved prior to issuance of any prior authorization.

Required Components

The Plan of Care must incorporate the following required components and shall be prepared by the support coordinator with the recipient, personal representative/family and others, at the request of the recipient:

- The recipient'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,
- Budget payment mechanism, as applicable,
- Target/resolution dates for the achievement/maintenance of personal outcome,
- Assigned responsibilities,
- Identified preferred formal and informal support/service providers and the specific service arrangements,
- Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services,
- Ensured flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the Plan of Care and recipient's desired outcomes,
- Change in a waiver service provider(s) can only be requested by the recipient 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,
- All participants present at the Plan of Care meeting must sign the Plan of Care,
- The Plan of Care must be completed and approved as per Plan of Care instructions,
- The recipient must be informed of his/her right to refuse a Plan of Care after carefully reviewing it.

Building and Implementing Supports

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

Responsibilities of the support coordinator include:

- Building and implementing the supports and services as described in the Plan of Care,
- Assisting the recipient/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 recipient in the Plan of Care,
- Being aware of and providing information to the recipient/family on potential community resources, including formal resources (Food Stamps, Supplemental Security Income, housing, Medicaid, etc.) and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his or her desired personal outcomes,
- Assisting with problem solving with the recipient, supports, and services providers,
- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs,
- Advocating on behalf of the recipient to assist in obtaining benefits, supports or services, e.g., to help establish, expand, maintain and strengthen the recipient's informal and natural support networks by calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient,
- Training and supporting the recipient in self-advocacy, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes,
- Overseeing the service providers to ensure the recipient receives appropriate services and outcomes as designed in the Plan of Care,

- Assisting the recipient to overcome obstacles, recognize potential opportunities and develop creative opportunities, and

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

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

Required Time Frames

- Linkage

  The Plan of Care must be completed and received by the OAAS designee or OAAS regional office, as applicable within 35 calendar days following the date of the notification of linkage by the data contractor. All incomplete packages will be returned.

- Changes

  Routine changes, such as vacations, must be submitted seven working days prior to the change.

- Emergencies

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

- Reviews

  The Plan of Care 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 recipient.

  The Plan of Care must be revised annually (and as required) and submitted to the OAAS designee or OAAS regional office no later than 35 days prior to expiration. The Plan of Care may be submitted as early as 90 days prior to Plan of Care expiration.

Changes in the Plan of Care

If there are significant changes in the support strategies or service providers, the support coordinator must revise the Plan of Care to reflect these changes. A revision request must be submitted for approval/disapproval to the OAAS designee or OAAS regional office, as applicable.

There is flexibility in the Plan of Care for the family to use the services as needed as long as the reimbursement from Medicaid remains within the waiver cap. Therefore, changes will occur only when a service is added or removed from the Plan of Care.

Initiating a Change in the Plan of Care

The recipient/family will contact the support coordinator when a change is required. The support coordinator will call a meeting to complete the Plan of Care revision form. All participants will sign the Plan of Care revision and it will be submitted to the OAAS designee or OAAS regional office, as applicable, for approval/disapproval.

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

Documentation

A copy of the approved Plan of Care must be kept in the recipient's home, in the recipient's case record in the support coordination provider and service providers' files. The support coordinator is responsible for providing copies.

A copy of the Plan of Care must be made available to all staff directly involved with the recipient.

Support Coordination Follow-Up/Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the Plan of Care. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the Plan of Care in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the Plan of Care. The purpose of the follow-up/monitoring contact is to determine:

- If services are being delivered as planned,
- If services are effective and adequate to meet the recipient's needs, and
- Whether the recipient is satisfied with the services.

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

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

- Does the recipient/family feel the outcomes are being met,
- Are the times the services are being provided convenient and satisfactory to the recipient/family,
- Does the recipient/family have any problems or changes that may require additional services,
- Are the providers actually present at the times indicated, and
- Are the provided services adequate and of good quality.

The recipient/family should be informed of the necessity to contact the support coordinator when there are significant changes in the recipient's status or if problems arise with service providers. A change in the recipient's status may require a reassessment.

Notify service providers within three working days of written changes in the Plan of Care.

Meet with the recipient between the sixth and ninth month of implementation of the Plan of Care to determine the effectiveness of the support strategies, and, if necessary, to revise the Plan of Care.

All visits and contacts should be documented in accordance with OAAS documentation and data-entry requirements. (Refer to Section 7.7 of this manual chapter)

Reassessment

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

A reassessment may be required when a recipient experiences a change in status, or there is a change in the recipient's family, or the recipient's prioritized needs. A reassessment must be complete **within seven calendar days** of notice of a change in the recipient's status.

Six-month Review

Between six and nine months after Plan of Care implementation, the support coordinator shall review the Plan of Care with the recipient to determine if the needs of the recipient continue to be adequately addressed.

Annual Reassessment

A completed annual reassessment package must be received by the OAAS designee or OAAS regional office no later than **35 calendar days**, but as early as **90 calendar days** prior to the expiration of the Plan of Care.

Transition/Closure

Transition or closure of support coordination services must occur in response to the request of the recipient, or if the recipient is no longer eligible for services.

Closure Criteria

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

- The recipient requests termination of services,
- Death,
- Permanent relocation of the recipient out of the service area (transfer to another region) or out of state,
- Long term admission to a hospital, institution or nursing facility
- The recipient requires a level of care beyond that which can safely be provided through waiver services,
- 30-day hospitalization/institutional rule (Continuity of Stay Rule), or
- Recipient refuses to comply with support coordination.

Procedures for Transition/Closure

The support coordinator must provide assistance to the recipient and to the receiving provider during a transition to assure a smooth transition process. Transition/closure decisions should be reached with the full participation of the recipient/family. Support coordinators must:

- Notify the recipient/family immediately if the recipient becomes ineligible for services,
- Complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs,
- Notify the service provider immediately if services are being transitioned or closed,
- Assure the receiving provider, program or support coordinator receives copies of the most current Plan of Care and related documents. (The form 148-W must be completed to reflect the date on the transfer of records and submitted to the OAAS regional office),
- Follow their own policies and procedures regarding intake and closure, and
- Serve as a resource to recipients 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.

Note: A support coordination provider shall not close a recipient's case that is in the process of an appeal. Only upon recipient of the appeal decision may the case be closed. If an appeal is requested within ten days, the case remains open. If an appeal is not requested with ten days of adverse action notice, the case will be closed.

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

Changing Support Coordination Agencies

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

- Complete the Freedom of Choice file transfer,
- Obtain the case record and authorized signature, and
- Inform the transferring support coordination provider.

Upon receipt of the completed form, the transferring provider must provide copies of the following information to the receiving support coordination provider:

- Most current Plan of Care,
- Current assessment on which the Plan of Care is based,
- Number of services used in the calendar year, and
- Most recent six months of progress notes.

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 provider. In the month the transfer occurs, the receiving provider 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 provider must submit the required documentation to the OAAS regional office to begin prior authorization immediately after the transfer of records.

Other Support Coordination Responsibilities

The support coordinator is responsible for coordination of the recipient's Community Choices Waiver services in a way that does not duplicate services when the recipient is also receiving other services such as home health, or hospice services.

Incidents, Accidents and Complaints

The support coordination provider must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OAAS and appropriate agency as mandated by law and OAAS policies and procedures. (Refer to Section 7.10 of this manual chapter for additional information)