SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Supports Waiver (SW) beneficiaries. Support coordination is an organized system by which a support coordinator (SC) assists a beneficiary to prioritize and define his/her 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 (SCAs) are required to perform the following:

1. Intake;

2. Assessment;

3. Plan of ~~C~~care (POC) ~~D~~development and ~~I~~implementation;

4. Follow-~~U~~up/~~M~~monitoring;

5. Reassessment; and

6. Transition/~~C~~closure.

Intake

Intake serves as an entry point into the Waiver and is used to gather baseline information to determine the beneficiary's medical eligibility for waiver services, service needs, appropriateness for services, including 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 information regarding their demographics, preferably through a face-to-face interview 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~~SC requests and gathers medical, social, educational and psychological documentation necessary to complete the POC.

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

The ~~support coordinator~~SC 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~~SCA may be made following waiver certification. Refer to the "Changing Support Coordination Agencies" subsection at the end of this section.

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

1. Was informed of procedural safeguards;

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

~~1.~~3. Was advised of their responsibilities;

4. Accepted support coordination service;

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

~~2.~~6. Was advised that waiver services and support coordination service are an alternative to institutionalization.

If SW services 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, or begin the process for moving to the Residential Options Waiver (ROW) using the ~~T~~tiered ~~W~~waiver ~~P~~process.

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 ~~support coordinator~~SC must conduct the person-centered support assessment ~~. The person-centered support assessment~~which consists of the following:

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

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 uUse of a standardized instrument for certain targeted populations;

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

4. Medical/physical information;

1.5. Psycho social/behavioral information;

6. Developmental/intellectual information;

2.7. 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 information;

11. Employment discussion that includes past and present employment, or if the person has never worked a discussion about looking for employment, including benefits planning and how employment can improve their life;

12. Daily activities, including how they spend their time and in what hobbies they participate (e.g., church, clubs, volunteering, ect.);

13. Housing/physical environment of the beneficiary;

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

15. 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

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

It is the responsibility of the support coordinatorSC 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 his/her desired personal outcomes while ensuring

beneficiary choice. The ~~support coordinator~~SC 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 authorized representative to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

NOTE: Evaluations, tests, and/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 of 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~~SC 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 and the persons who the beneficiary chooses to participate in the process. This may include family, friends or other support systems, the ~~support coordinator~~SC, appropriate professionals/service providers, and others who best know the beneficiary.

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 of their choice;

2. Provide a process for ensuring that the paid medical services and other resources are

deemed medically necessary and meet the needs and desires 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 received are the choice of the beneficiary, are appropriate and available, and are responsive to the beneficiary's changing outcomes, desires, 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 of the beneficiary.

Required Procedures

The initial and annual POC must be completed in a face-to-face home visit at a time that is convenient for the beneficiary. The initial and annual POC must include~~-~~ the beneficiary and the service provider, and may include members of the support network; the support network, may include family members, appropriate professionals, persons, who are well acquainted with the beneficiary, and who the beneficiary chooses to invite. ~~The POC must be held at a time that is convenient for the beneficiary.~~ The POC muste:

1. Be ~~e outcome-oriented~~o~~O~~utcome-oriented, individualized and updated on at least an annual basis. The planning process should include tailoring the POC to the beneficiary's needs and desires 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~~SC, members of the support system, direct service providers, and appropriate professional personnel must be directly involved in the development of the POC;~~.~~

2. ~~The POC must a~~Assist the beneficiary in making informed choices, including the choice to receive services in a non-disability specific setting, and regarding all aspects of supports and services needed to achieve their desired personal outcomes. This 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;~~.~~

3. ~~The POC must i~~Incorporate steps that empower and help the beneficiary to develop independence, growth, and self-management; and~~.~~

4. Be ~~The POC must be w~~w~~W~~ritten in a 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~~SC with the chosen service provider, beneficiary, parent/family and others, at the request of the beneficiary:

1. ~~The b~~Beneficiary's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing foremost 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 outcomes;

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~~SC 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 six-month linkage unless there is "good cause." Any request for a change requires a completion of a ~~Freedom of Choice~~FOC 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~~SC;

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 his/her 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 coordinatorSC include:

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

2. Assisting the beneficiary/beneficiary's 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/beneficiary's family on potential community resources, including formal resources (Supplemental Nutrition Assistance Program (SNAP)SNAP Benefits, Supplemental Security Income (SSI), housing, Medicaid, Bbenefits Pplanning, Louisiana Rehabilitation Services (LRS), etc.) and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining his or her desired personal outcomes;

4. Assisting with problem solving with the beneficiary, supports, and service 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 and desires;

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, supporting and/or connecting the beneficiary in self-advocacy groups, 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;

10. Monthly phone calls with the beneficiary; and

11. Meeting with the beneficiary face-to-face in the beneficiary's home, for each initial and/or annual POC development, and for at least one other quarterly meeting. These quarterly meetings may happen on a more frequent basis if so requested by the beneficiary/beneficiary's family and that such meetings can be completed in the day program. If the beneficiary meets the criteria for virtual visits and requests a virtual

visit, the remaining two quarterly meetings may be completed using a virtual delivery format.

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:**

The initial POC must be completed and received by the 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:**

Revisions must be submitted ten working days prior to the change.

3. **Emergencies:**

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

4. **Reviews:**

At a minimum,

a. the POC should be reviewed on a quarterly basis to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the beneficiary; and

b. At a minimum, the POC must be revised on an annual basis or as otherwise needed, but in no case shall it be revised later than thirty-five (35) days prior to expiration. The POC may be submitted as early as sixty (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 to the POC (i.e., adding or deleting services) in the way that the beneficiary prioritizes his or her personal outcomes, and/or if there are significant changes to the support strategies or service providers, the ~~support coordinator~~SC 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 POC meeting. When an unidentified need is identified 10 or more business days prior to the change, a POC Revision request should be submitted and will be processed within ten (10) business days. The revision should be marked as "routine". If an unanticipated need is identified less than ten (10) business days prior to the needed change, the POC revision request must be identified

as "urgent" and the additional responsibilities for the Provider and SC must be assumed. For "urgent" requests, the box must be checked. An urgent need exists when there is an unplanned/unpredictable event which requires urgent changes to waiver services and/or changes in the service provider. Urgent changes are defined as changes that must begin in fewer than ten (10) business days off receipt by the LGE.

Initiating a Change in the Plan of Care

The beneficiary/beneficiary's family will contact the support coordinatorSC when a change is required. The support coordinatorSC 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 LGE for approval. The support coordinatorSC will notify the service provider 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 agencySCA, and in the service provider's files. The support coordinatorSC is responsible for providing the copies.

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

Follow-up/monitoringPlan of Care Monitoring

POC monitoring should be completed monthly, quarterly and annually using the Support Coordination Documentation form.

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 do 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;

1.2. 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 (7) 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 that the POC is unsatisfactory or is inadequate in meeting the beneficiary's service needs.

Annual Reassessment

A completed annual reassessment package must be received by the LGE no later than thirty-five (**35) calendar days**, but as early as sixty (**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 coordinator~~SCs will be responsible for retrieving incomplete packages from the LGE. Sanctions will be applied.

SSSCA Approval Authority of SW Annual Plan of Care

Support coordinatorSCs 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.

Transition/Closure

The transition or closure of support coordination services must occur in response to the request of the beneficiary or when it is determined that the beneficiary is no longer eligible for services. The closure process must ease the transition to other services or care systems outside of 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;

1.2. 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~~SC 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. As part of the transition/closure procedure, ~~Support coordinator~~SCs must:

1. Notify the beneficiary/beneficiary's 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;

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

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

As part of the transition/closure procedure, the ~~support coordination agency~~SCA must:

1. Notify the LGE of the transition/closure four weeks prior to the closure to allow the LGE 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 when there is a pending appeal. T,he case may be closed only upon receipt of the appeal decisions. If an appeal is requested within ten days, the case remains open. If an appeal is 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.

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 FOC file transfer;
2. Obtain the case record and authorized signature; and
3. Inform the transferring ~~support coordination agency~~SCA.

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 continue to provide services until the records are transferred to the receiving provider and the transferring provider 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 providing 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 Medicaid data management contractor to begin prior authorization immediately after the transfer of records.

Other Support Coordination Responsibilities

Reporting of Incidents, Accidents and Complaints

The support coordinatorSC must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OCDD, Health Standards Section (HSS)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 14.1043.6 – Incidents, Accidents and Complaints of this manual chapter for additional instructions.