A.4.8 Support Coordination Guideline

Responsible Office: DDD HCBs Waiver Service Providers/Support Coordination Services/ADMH-DDD Central/Regional Offices
Reference: Alabama Administrative Code 580-1-2, 580-3-26, 580-5-30; Appendix D - ID/LAH Waivers; Support Coordination Quality Review and Certification Standards; Support Coordination Scope of Service; A.4.3 Redetermination; A.4.7 Conflict Free Support Coordination/Case Management Services; A.7.5 Comprehensive Support Systems CSS Teams; Targeted Case Management Chapter 106
Effective: February 1, 2022
Revised: July 1, 2023
Purpose/Intent: The purpose of this policy is to provide direction and information on Support Coordination operational requirements and procedures. Support Coordination operations will conform to all applicable Federal and State Medicaid Waiver and Home and Community Based Services Setting rules.
HCBS Waivers: ID, LAH
Procedures:

1. **Support Coordination Agency Operational Requirements**: The following operational requirements are established for all Support Coordination Agencies.
    a. SCAs will comply with the operational requirements found in the Scope of Service.
    b. SCAs will comply with the Administrative Standard for 310 Boards.
    c. SCAs will provide conflict free Support Coordination/Case Management services in accordance with HCBS Setting Rule.
    d. SCAs will have written policies and procedures for recruiting and hiring staff in accordance with all applicable laws and meet requirements outlined in AC 580-5-30.
2. **Support Coordination Qualification and Training Requirements:** The following education and trainings required to be a SC:
    a. Possess a bachelor’s degree in a human services field: Preference should be given for experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities. Human Service field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill-Development, or Basic Human Care Needs.
    b. SCs must complete a Support Coordination training program approved by DDD and the Alabama Medicaid Agency within six (6) months of beginning employment unless training is needed before the staff can safely provide the service.
3. **Effective Person-Centered Planning Practices:** The following practices are established for all SCAs
    a. SCs are to support individuals to direct their own plans to the extent they desire, as well as be offered the opportunity to determine who will participate in their PCP meeting.

b. Use of most integrated and non-disability specific setting:
    i. Service selection, as part of identifying strategies to achieve the person's desired life and defined outcomes during the person-centered planning process, will focus on community-based service options prior to exploration of residential placement or facility-based services.
    ii. Service delivery includes paid and unpaid services and supports by waiver and/or other service providers (e.g., Medicaid State Plan providers, ADRS providers, special/general education provider, and generic community service providers), friends, family, and other natural support networks.

c. SCs will assist people with maintaining eligibility for the waiver and provide education and support as needed.

d. Assessment resources and procedures:
    i. SCs will utilize assessment and planning resources and procedures approved by DMH-DDD.
        - Resources, procedures, and other training information are listed on the ADMH website: https://mh.alabama.gov/training/
    ii. SCAs will conduct assessments using person-centered and strength-based approaches including: involving the person in all assessment activities; exploration (with the person) of preferences and what works well for the person, identification of the person's own strengths and other positive attributes, and encouragement of self-determination and self-direction. *(see SC Guideline Appendix 1)*
    iii. Assessments will be completed with the person and, as applicable, their legally authorized representative, within 30 days of enrollment in the waiver program, prior to redetermination or change in services and thereafter as appropriate to the person, but at least annually.
        - Any identified initial health and safety concerns will be addressed within 14-days of waiver program enrollment.
    iv. Assessment documentation will include the person's desired outcomes, in their own words, and capture the exploration of hopes and dreams from the assessment conversation.
    v. Assessment documentation will include the agreed strategies to achieve the person's desired outcomes and meet their assessed needs related to these outcomes that will appear on the PCP noting how the strategies will be implemented (including in what settings the individual selected) by the person, natural support network, community supports, and paid services and supports. In addition, any information related to the person that address HCBS requirements (Setting Specific Transition to Compliance Plan for ID and LAH waivers) should be included.

vi. Assessment documentation will include exploration and determination of back-up and contingency plans for situations where identified supports associated with the defined strategies are not available, and these back-up and contingency plans will appear on the PCP.

vii. The SC will schedule and hold premeeting (s) with the individual, family members, and direct support providers DSP either individually or with everyone. The premeeting is to ensure that all necessary assessments and information has been provided and identify the goals/outcomes for individuals. The premeeting should occur at least 14 days prior to the Team Meeting.

viii. SCs will recognize all people possess unique abilities and attributes that contribute to the achievement of their goals and independence.

- PCPs will document the strategies agreed upon by the person from the assessment process noting how the strategies will be supported by the individual, natural support network, community supports, and paid services and supports, along with the frequency of support, units of support, and cost per unit of support.
- Assessment and Person-Centered Planning (PCP) will focus on the combination of the person's strengths, needs, and community of supports in determining strategies to compliment and assist in the attainment of goals for each person to live his/her best life, as defined by the person after exposure to all options and support for informed choice.
- Planning needs to address all person identified, desired outcomes incorporating strengths and capacities to build on and barriers to be overcome
- Planning will address SC or other clinical professional identified risks associated with not utilizing/building on strengths, risks identified with not overcoming barriers to desired life and outcomes, and other risks that may be identified by the SC or other clinical professionals.
- If a person does not agree or recognize one or more risks identified by the SCs or other clinical professionals, SCs will follow the Risk Management direction found below in this policy.

ix. **A Team Meeting will occur**, including the person, and legal representative if applicable, to review, discuss and finalize all aspects of the PCP.

- Members of the Team, invited to the Team Meeting, will receive a copy of the draft person-centered plan 7 business days before the Team Meeting.
- PCPs will be finalized with the person and, as applicable their legally authorized representative within 30 days of enrollment in the waiver program. Then 30 days for updates as appropriate to the individual.

- As required for TCM, the PCPs will be updated at least every 6 months and at redetermination (within 365 days). The PCP must be signed by all team members and uploaded in electronic database.

x. The PCP is a living document, therefore changes occurring within the review period will be updated in real time within the assessment and plan. Person-centered assessments and plans, and updates to the assessments and plans, will be signed, and dated by the person, their legally authorized representative, the provider(s) responsible for implementing strategies, and the SC.

xi. Signed completed person-centered assessments and plans will be provided to the individual and sent to providers via email within 30 calendar days of the Team Meeting.

e. Re-assessment and Monitoring:

i. SCs will assess progress as needed, but at least every 90 calendar days and document within the person-centered assessment/plan.

ii. SCs will document progress as needed at least every 90 calendar days within the progress note and quarterly narrative.

iii. SCs will document the level of progress as needed with a minimum of every 90 calendar days in the PCP. If there are no changes to the PCP needed, then the SC will update the PCP, review the updated PCP with the team and obtain all Team members' signatures on the new plan.

iv. Through interviews and observations, the SC evaluates the individual's progress toward accomplishing the goals listed in the PCP at a minimum quarterly. In addition, the SC contacts persons or agencies providing services to the individual and reviews the results of these contacts, together with the changes in the individuals needs shown in the reassessments and revises the person-centered plan if necessary.

v. The SC determines what services have been delivered and whether they adequately meet the needs of the individual. The PCP may require adjustments as a result of monitoring.

vi. SCs will annually assess and document updates to the PCP and assessment, minimally completing the reassessment section in the information management system.

vii. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process.

f. Back-up and contingency planning:

i. Assessment and planning documentation will include back-up and contingency exploration for situations where supports of identified strategies are not available.

ii. SCs will report lack of supports for a service to the appropriate Regional Office.

iii. SCs will work with the appropriate Regional Office to build capacity for this service.
iv. SCs will research existing providers and explore the possibility of providing the service to support the person.
v. SCs will ensure a short-term person-centered plan is developed in accordance with person-centered planning practices to support individual's receiving temporary respite supports. The short-term plan will outline what goals will be achieved, what individual's preferences, strengths, and needs are, and their back-up plan.
vi. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process.

g. Promotion and Protection of Individual Rights and preventing abuse of individuals:
i. SCs will implement operational practices that promote and protect the rights of individuals as defined by all applicable Federal and State of Alabama regulations, laws, acts, and other legal authority.
ii. SCs and the provider agency will participate in a discussion at the annual meeting to ensure people are informed of their rights. The SC documents the conversation and provide a copy of the Rights & Responsibilities form to the provider agency.
iii. SCs will work with providers and communities to ensure people have meaningful work and activity choices. These choices should encourage and promote age-appropriateness, a positive self-image, and consider the person's cultural background and/or preferences.
iv. SCs will implement operational practices to ensure individuals receive only the level of support needed for the individual to make their own decisions, including assisting the individual to advocate for themselves.
v. SCs will provide individuals and their legally authorized representatives an oral and written summary of their rights and responsibilities and how to exercise those rights and responsibilities.
vi. SCs will maintain practices for due process, including review and documentation, in the event of a proposed restriction of an individual's rights.
vii. SCs will provide education and/or resources on voter registration and the voting process to people age eighteen or older that express interest and assists with registering and voting, as needed.
viii. SCs obtain written informed consent from the individual or their legally authorized representative prior to
- any intrusive medical or behavioral intervention,
- participation in research, and
- sharing information about the individual

ix. Materials presented to individuals, or their legally authorized representative is provided in language the individual can understand.
x. SCs provide individualized supports/services that are free from discrimination by race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.

h. Fraud, waste, and abuse:
   i. SCs will comply with all provisions of Chapter 560-X-4.04 and Chapter 560-X.4.05.
   ii. SCs will monitor the person's financial situation and ensure individuals are not paying for anything covered by a waiver service.

i. Behavioral Support Plans (BSP):
   i. If appropriate, individuals have a BSP that reduces, replaces, or eliminates specific behaviors and are implement according to DMH-DDD's Behavioral Services Procedural Guidelines.
      - BSPs are created by the provider agency. The provider agency will submit a copy of the BSP to the SCs to be documented within the Person-Centered Assessment and Plan.
      - SC will document any restrictions or need for restraints in the Person-Centered Assessment and Plan
      - Changes to the BSP are made and implemented by the provider agency with the agreement of all team members.
   ii. BSPs are approved by the Support Team.
      - BSPs with level 2 or 3 procedures are reviewed and approved by the Behavior Review Committee, the Human Rights Committee, and the individual or individual's legally authorized representative.
   iii. BSPs are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.
   iv. Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a BSP are not permitted.

j. Crisis planning and intervention:
   i. SCs will follow the CSS Team operation guideline.

k. Risk Management:
   i. Every person has the right to make informed decisions of their choosing necessary for individual growth and development. SCs will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.
   ii. The assessment, development, planning and implementation of risk mitigation strategies are discussed and agreed upon by all team members at the annual meeting.
   iii. SCs are responsible for:

- Identifying and evaluating potential positive and negative risks associated to choices made by the individual.
- Assess and or address risk identified through analysis of the individual's incident history via review general event record (GER). (Requirement by Alabama Medicaid Agency)
- Identifying the person's tolerance for accepting and taking that associated risk related to the person's goals and preferences.
- Development and communication of risk strategies for choices the person determines are worth accepting and taking.
- Identifying methods and processes to monitor the effectiveness, updates, and continued use of risk mitigation strategies.
- Documenting the risks identified and risk mitigation strategies for each person as part of the person-centered assessment and plan.

l. Natural Support Networks:
   i. SCs ensure there are a variety of methods for helping people stay connected to their natural supports.
   ii. SCs will work with provider agencies to identify strategies to meet the desired level of contact with natural supports identified during the person-centered planning conversations.
   iii. SCs ensure the person is provided education to develop and/or improve skills to support people's communication with natural supports, especially families and friends.

m. Conflict of interest:
   i. SCs will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of people enrolled in waiver programs.
   ii. At a minimum, SCs and provider agencies will adhere to the Conflict Free Support Coordination/Case Management Services outlined in Scope of Service section 2.1.

4. **Collaboration:** SCs will collaborate with service and agency providers to identify, assess, and implement person-centered plans and community resources to enhance service options, and document such within the Person-Centered Assessment and Plan.
   a. SCs will maintain knowledge of applicable waiver service options, community resources, and a person's natural supports.
   b. SCs will identify gaps in contracted service capacity for improvement and development.
   c. SCs will address any environmental and safety concerns with provider agencies and ensure education is provided to the individual on how to mitigate any safety concerns.

   d. SCs will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with all applicable Support Team members.
   e. SCs will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
   f. SCs will monitor the implementation of PCP strategies and partner with providers to improve effectiveness and address any training gaps.
5. **Self-Directed Services:** SCs must complete the Person-Centered Assessment and Planning Process with all self-directed individuals. This includes the assessments (Appendix 1), person-centered assessment and plan.
6. **Individual Experience Assessment (IEA) Survey**: The IEA is the approved assessment that describes and measures the participant's experience with ADMH HCBS Waiver services.
   a. Support Coordination Agencies (SCAs) SCs are required to complete the IEA annually
   b. SCs are to address all "No" IEA responses in the PCP.
   c. Support Coordination Liaisons will use the Person-Centered Assessment and Plan Feedback and Monitoring tool to review PCPs to verify the IEA was completed and the issues addressed in the PCP
7. **Quality Improvement Plan**: **ALL Support Coordination Providers must be in FULL COMPLIANCE with all HCBS regulations.** Noncompliant findings will result in a mandated HCBS Quality Improvement Plan (QIP) developed by ADMH to be implemented by the provider.
   a. Non-compliant findings should be corrected across all settings, IEA/PCPs and other documents.
   b. Providers must respond in agreement with the HCBS QIP, and dates TA will be provided within 5 business days of receipt of plan.
   c. Providers must address ALL findings within 30 days of receiving HCBS QIP.
   d. Providers who fail to implement strategies to meet compliance will be considered noncompliant with the HCBS requirements.
   e. All Support Coordination providers must meet 100% compliance with all HCBS requirements beginning 8/1/22
   f. The ADMH-DDD will employ its progressive discipline procedures, as needed, to address any failures on the part of staff to implement actions as outlined in the QIP. Such procedures may include further staff training to termination of employment. Similarly, the ADMH-DDD will take enforcement actions, where needed, to address providers failure to perform and provide services in accordance with this QIP and related ADMH policies, procedures and operational guidelines. Such enforcement actions may range from mandated technical assistance to monetary penalties and termination of service contract. Actions may also include notification to Medicaid of areas of non-compliance.

Appendix 1: For Self-Directed Support, the Support Coordinator is responsible for completing the assessment. This list is not all-inclusive, provider agencies should continue to follow current approved administrative standards.

Current Form/ Process	Provider Responsibility	SC Responsibility
* Functional Assessment	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings for assistance with ADLs and IADLs within the barriers (core issues) section of each domain as appropriate within the PCP
Nursing Assessment	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Overall Health subsection of the Healthy Living Domain
*Financial Assessment or Money Management Assessment	Provide necessary information to SC	Support Coordinator completes, uploads assessment into the information management system and summarizes findings within the Finances subsection of the Community Living Domain
Fall Risk Assessment	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Safety subsection of the Community Living Domain
Behavior Support Plan	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the MH & AODA subsection of the Healthy Living Domain
Medication Reduction Plan or Psychotropic Medication Plan	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Medications subsection of the Healthy Living Domain
*Safety Assessment	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Safety subsection of the Community Living Domain
*Rights Assessment	Provide necessary information to SC	Support Coordinator completes, uploads assessment into the information management system and summarizes findings within the Exercising Rights subsection of the Self-Determined Domain
Key Assessment	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Access to Possessions subsection of the Community Domain
Lease Contract	Complete and submit to SC	Uploads assessment into the information management system and summarizes findings within the Living Situation subsection of the Community Living Domain
Employment	Provide necessary information to SC	Support Coordinator completes the employment assessment in the information management system and the employment survey. Summarizes findings within the employment section of person-centered assessment and plan.
*These documents are always required regardless of services received. For Self- Directed Supports, the SC is responsible for completing these forms.		