2001 PLANNING TEAM MEMBERS

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36.551.01; A.A.C. R6-6-101.

The membership of the Planning Team will vary depending upon the needs and wishes of the member and/or family.

The Planning Team will include at a minimum:

A. The member;

B. The member's parent if the member is a minor or legal guardian, if any;

C. The Division Support Coordinator or other appropriate Division representative, who shall serve as plan facilitator and coordinator;

D. Representatives of any service currently authorized or assessed;

E. Any other persons the member/responsible person or the Division select;

F. Additional team members may participate in the planning team meeting:

1. Direct support professionals who work directly with the member served in Residential, Employment, or Day Program services;

2. A person qualified to address the health and medical needs of a member who is medically involved. The Support Coordinator and District/Division nurse will determine which Division staff or providers meet this qualification;

3. Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID):

   a. A Qualified Intellectual Disabilities Professional (QIDP), who typically is the Division Support Coordinator;

   b. The member's Primary Care Provider (PCP), who may participate by means of written reports, evaluations, and recommendations;

   c. The Division/District nurse assigned to the facility;

   d. Therapists when there is an indication of need and/or where services are currently being provided; and,

   e. Providers of direct service in other programs received or needed by the member, such as Day Treatment and Training, or educational programs.

4. Nursing Facilities (NF):

   a. The member's PCP, who may participate by means of written reports, evaluations, and recommendations;

   b. The Division/District Nurse assigned to the NF;

   c. Therapists when there is an indication of need and/or where services are currently provided;

   d. Staff from NF; and,

   e. The member's primary caregiver(s).

2002 PLANNING MEETINGS

REVISION DATE: 10/10/18, 4/18/18, 10/21/16, 10/01/14
EFFECTIVE DATE: July 3, 1993

Member Attendance

The member must be present at all planning meetings. *If the responsible person requests an alternate site for the planning meeting, the Support Coordinator must document the request and the reason in the progress notes. Planning meetings at an alternative site should be the exception and should not be at the convenience of the Support Coordinator or provider. If the planning meeting occurs at an alternate site, the member must be present. If the member is not present for this alternative site meeting the Support Coordinator must visit the member's residence and the member must be present for this visit. Both the planning meeting and the visit to the member's residence, must occur prior to the planning meeting due date.*

Initial Planning Meeting (Newly Eligible)

The timeframe requirements for the initial planning meeting are based on the date the Division is notified of the member's eligibility. Eligibility notification may be delivered via Focus, Focus Reports, telephonically or email from AHCCCS or Pre-Admission Screening (PAS) Report. All initial planning meetings must be completed following the timeframes below.

A. Arizona Long Term Care Service (LTC)

The Support Coordinator will:

1. Contact the responsible person within five days of eligibility notification to schedule the meeting;

2. Hold the planning meeting in person within ten days of eligibility notification;

3. Complete the following documents as appropriate:

    a. The ALTCS ISP Packet, when Targeted/DD Annual Plan has already been completed;

    b. The Reassessment of the Planning Document and Service Evaluation, when ALTCS ISP Packet has already been completed;

    c. The ALTCS ISP Packet when the member is Newly DD eligible and became ALTCS eligible prior to the initial meeting.

    d. Any other required paperwork.

B. Targeted Support Coordination (TSC)

The Support Coordinator will:

1. Contact the responsible person within five days of eligibility notification to schedule the Targeted Planning Meeting;

2. Hold the Targeted Planning Meeting in person within ten days of eligibility notification:

   a. When the member is newly TSC eligible, and the other scenarios do not apply complete Targeted/DD Annual Plan;

   b. When Targeted/DD Annual Plan has already been completed, and the next scheduled planning meeting is due, complete Reassessment of the Planning Document. When the next planning meeting is not due, complete a narrative of the Targeted Planning Meeting and file with the Targeted/DD Annual Plan;

   c. When ALTCS ISP Packet has already been completed, and the member becomes eligible for TSC, and the next scheduled planning meeting is not due within the initial 10-day timeframe, complete a narrative of the planning meeting and file with the ALTCS ISP Packet; and,

   d. Complete any other required paperwork, as appropriate.

C. DD Only (DDD).

The Support Coordinator will:

1. Contact the responsible person within ten days of eligibility notification to schedule the meeting;

2. Hold the planning meeting in person within 30 days of Focus eligibility notification; and,

3. Complete the Annual Plan for Targeted/DD Only.

Subsequent Planning Meetings

The Support Coordinator will complete all subsequent Planning Meetings following the time frames below.

A. ALTCS

1. Acute Care Only (No long-term care services.)

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

2. Home and Community-based Services (HCBS).

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

3. Child/Adult Developmental Home - regardless of age.

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

4. Group Home – age 12 and under.

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment /Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

5. Group Home – over age 12, no Regional Behavioral Health Authority (RBHA) involvement

   The Support Coordinator will:

   a. Hold meetings every 180 days after initial/annual meeting;

   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, RBHA involvement

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

7. Group Home – over age 12, medically involved

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

8. Nursing Facility or Intermediate Care Facility

   The Support Coordinator will:

   a. Hold meetings every 180 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

9. Assisted Living Centers

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

10. Foster Care

    The Support Coordinator will:

    a. Hold meetings as required by the member's placement and eligibility;

    b. Complete required paperwork as required by the member's placement and eligibility; and,

    c. Complete any other required paperwork, as appropriate.

11. Member starts a new day or employment program; within 30 calendar days of starting a new program.

12. Member moves from one placement type to a different placement type; within 10 business days of the move.

13. Member moves from a placement type to the same placement type; within 30 calendar days of the move.

B. Targeted Support Coordination (TSC)

1. All TSC members.

The Support Coordinator will:

a. Hold face-to-face meetings every 90 days (two visits) for the first six months after initial eligibility; and,

b. Ask the member/responsible person the preference for type and frequency of ongoing meetings at the second 90-day review.

2. No Long-term Care Services

The Support Coordinator will contact the responsible person by the type and frequency of contact requested:

a. In-Person Contact

The Support Coordinator will:

i. Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and,

ii. Complete any other required paperwork, as appropriate.

b. Letter Contact

The Support Coordinator will:

i. Send a letter to the member/responsible person that is appropriate to the member's needs/circumstances. The letter may contain:

- Follow up questions based on previous meetings.
- Questions about any changes since the member's last meeting, such as contact information and member's needs;

ii. Mail the letter by regular and registered mail, return receipt requested; and,

iii. Update the review/ISP date in Focus with the date the letter was mailed.

c. Phone Contact

The Support Coordinator will:

i. Complete the Annual Plan – Targeted/DD Only or Reassessment;

ii. Mail completed paperwork to member/responsible person for

signature within 15 working days of the phone call; and,

iii. Update the review/ISP date in Focus with the date of the phone call.

3. Home and Community-based Services (HCBS)

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

4. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

5. Group Home – age 12 and under

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, no RBHA involvement

The Support Coordinator will:

a. Hold meetings every 180 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

7. Group Home – over age 12, RBHA involvement

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

8. Group Home – over age 12, medically involved

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

9. Nursing Facility or Intermediate Care Facility

The Support Coordinator will:

a. Hold meetings every 180 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

10. Assisted Living Centers

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

11. Foster care

The Support Coordinator will:

a. Hold meetings as required by the member's placement and eligibility;

b. Complete required paperwork as required by the member's placement and eligibility; and,

c. Complete any other required paperwork, as appropriate.

12. Member starts a new day or employment program: Within 30 calendar days of starting a new program.

13. Member moves from one placement type to a different placement type: within 10 business days of the move.

14. Member moves from a placement type to the same placement type: within 30 calendar days of the move.

C. DD Only (DDD)

1. No Long Term Care services:

The Support Coordinator will:

a. Ask the member/responsible person the contact preference for ongoing meetings after one year of eligibility (two face to face 180-day meetings);

b. Hold type of preferred meeting at least annually after one year of eligibility; and,

c. The Support Coordinator will contact the responsible person by the type of contact requested:

i. In-Person Contact

The Support Coordinator will:

- Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and,

- Complete any other required paperwork, as appropriate.

ii. Letter Contact

The Support Coordinator will:

_ Send a letter to the member/responsible person that is appropriate to the member's needs/circumstances. The letter may include:

- Follow up questions from previous meetings.
- Any changes since the last meeting?
- Any changes to contact information?

Mail the letter by regular and registered mail, return receipt requested.

_ Update the review/ISP date in Focus with the date the letter is mailed.

iii. By Phone Contact

The Support Coordinator will:

- Complete the Annual Plan – Targeted/DD Only or Reassessment;

- Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call; and,
- Update the review/ISP date in Focus with the date of the phone call.

d. After the first year of eligibility (two face to face 180 day reviews), a file review will be completed 180 days after the annual. The file review is not completed based on the contact preference; however, a phone call may be required to obtain information. A file review shall consist of a review of the Annual Plan and:

i. Re-determination of eligibility;

ii. Updating Focus with the date of the file review and any other relevant information. Obtaining school records, if school age;

iii. Referrals to community resources; and,

iv. Documentation that the file review was completed.

2. Home and Community-based Services (HCBS)

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

3. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

4. Group Home – age 12 and under

The Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

c. Complete any other required paperwork, as appropriate.

5. Group Home – over age 12, no RBHA involvement

   The Support Coordinator will:

   a. Hold meetings every 180 days after initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, RBHA involvement

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

7. Group Home – over age 12, medically involved

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

8. Nursing Facility or Intermediate Care Facility

   The Support Coordinator will:

   a. Hold meetings every 180 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

9. Assisted Living Centers

   The Support Coordinator will:

   a. Hold meetings every 90 days after the initial/annual meeting;

   b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

   c. Complete any other required paperwork, as appropriate.

10. Foster care

    The Support Coordinator will:

    a. Hold meetings as required by the member's placement and eligibility;

    b. Complete required paperwork as required by the member's placement and eligibility; and,

    c. Complete any other required paperwork, as appropriate.

11. Member starts a new day or employment program: within 30 calendar days of starting a new program.

12. Member moves from one placement type to a different placement type: within 10 business days of the move.

13. Member moves from a placement type to the same placement type: within 30 calendar days of the move.

14. Inactive Status: The Support Coordinator will contact the member/responsible person annually by phone.

Scheduling Subsequent Meetings

With the exception of the initial planning meeting, subsequent meetings shall be scheduled and written notice given at the end of each planning meeting. The date and time of the meetings should be at the convenience of the responsible person. In addition, the Support Coordinator shall provide the team members written notice of upcoming annual planning meetings at least 10 days in advance. The Support Coordinator shall document all attempts to schedule planning meetings at the required or requested TSC intervals. The Support Coordinator shall document the reason in the progress note when the responsible person delays, cancels, or reschedules the meeting.

Focus ISP Date (Set in stone date)

The meeting date on which the initial plan was developed becomes the Focus ISP date. The annual planning meeting may be held up to 5 working days before the Focus ISP date every subsequent year. An annual meeting held more than five working days prior to the Focus ISP date is considered a review meeting, not the annual planning meeting. Review meetings may be held at any time prior to their due date. All planning meeting due dates are based on the mandated review cycle.

Meeting Location

(Reference: Arizona Health Care Cost Containment System Medical Policy Manual [AMPM] Chapter 1620 - E)

Review visits are to be conducted where the member receives services, including service settings both inside and outside of the member's home as described below. At a minimum, Support Coordinators will conduct review visits with a member in the member's home at least twice annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs. If a member receives services outside of the home, at a

minimum, a review visit must be conducted at one of the member's service setting locations. At the election of the member or member's responsible person, remaining visit may be conducted at an alternate location that is not a service setting. If the responsible person requests an alternate site for the planning meeting, the Support Coordinator must document the request and the reason in the member's progress notes. The location of each review visit, whether at a service setting location or an alternate site, must be determined by the member or member's responsible person and not for the convenience of the Support Coordinator or providers.

If a Support Coordinator is unable to conduct a review visit as specified above due to the refusal by the member or member's responsible person to comply with these provisions, services cannot be evaluated for medical necessity and therefore will not be authorized. A Notice of Adverse Benefit Determination must then be issued to the member setting forth the reasons for the denial or discontinuance of services.

Special Meetings

The Planning Team may meet to review and revise the Planning Document at any time when there is change. The planning team must reconvene in the following circumstances:

A. When there is a change in the member's medical treatment or physical condition that significantly affects daily living and is not of a short-term or emergency nature;

B. Prior to any transfer to/from a residential setting operated or funded by the Division;

C. When there is a change that affects the continued implementation of the planning document;

D. When the results of a grievance/appeals process require a review and/or revision of the current Planning Document; and,

E. For members living in a licensed residential setting, when an emergency measure, including a one-time emergency use of behavior-modifying medication ordered by a Doctor, is used to manage a behavior two or more times in a 30 day period or with any identifiable pattern, or when required by the results of Program Review Committee (PRC) or Human Rights Committee (HRC) reviews of behavior plans.

Mandatory Reporting

A. Abuse/Neglect

If, during the course of a Plan Review or any other contact with the member, the Support Coordinator identifies any instance of abuse or neglect, she/he is required, by law, to report this to a police officer or protective services worker.

B. Quality Assurance

Support Coordinators may become aware of quality assurance issues during the course of their work, i.e., residential licensing standards that are out of compliance; inappropriate implementation of individual programs; untimely medical check-ups; or serious incidents not being reported. The Support Coordinator must verbally report problems to provider relations or quality assurance staff.

2003 PLANNING DOCUMENT

REVISION DATE: 6/13/2018, 6/10/2016, 2/12/2016, 7/3/2015, 3/2/2015, EFFECTIVE DATE: July 31, 1993

Support Coordinators, when completing a Planning Document, must use a person-centered approach, taking into consideration natural and community resources, acute care services, home and community based services, behavioral health services, and what is important to the member now (priorities) and in the future (vision), and:

A. Provide information to assist members/responsible persons in making informed decisions and choices.

B. Provide members with flexible and creative service delivery options.

C. Provide service options that support the member's priorities and outcomes.

D. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member.

E. Provide necessary information to providers about any changes in the member's functioning to assist the provider in planning, delivering, and monitoring services.

F. Review all professional evaluations.

G. Assume responsibility for completion of all components of the planning document in conjunction with the team.

H. Provide copies of the completed Planning Document (e.g., Annual Plan, Reassessment of the Planning Document, Changes in the ISP, cover sheet) to all team members and service providers within 15 working days of the date of the Planning Team meeting, or revision resulting in a change in the Planning Document, and ensuring that copies of the Planning Document are available in all settings where the individual receives services.

A critical component of the person-centered approach is the assessment process. This process involves the member and their family as appropriate in the identification of support needs and includes their participation in decision-making. In designing the plan, the Planning Team must consider the unique characteristics of the member as expressed by the member or documented by others who know the member. For the member, the planning process will:

A. Recognize and respect rights.

B. Encourage independence.

C. Recognize and value their competence and dignity.

D. Promote social inclusion.

E. Preserve integrity.

F. Support strengths.

G. Maintain the quality of life.

H. Enhance all areas of development.

I. Promote safety and economic security.

Annual Plans

An annual plan is required for all members. The member's eligibility and placement determines the type of plan to be completed.

Reassessment of the Planning Document

Reassessments of the planning document are completed based on the member's eligibility and placement. The reassessment is a review of the annual plan.

Changes to the Planning Document

Any team member may recommend changes in the Planning Document/Individual Support Plan (ISP) by forwarding the proposed change to the Support Coordinator using the *Changes in the ISP* form. Examples may include:

A. New or changes to outcomes

B. New action items

C. Changes in medications

D. Changes to the spending plan.

The Support Coordinator must sign the *Changes in the ISP* form signifying that the recommended change does not require a Planning Team meeting as outlined in this policy manual, obtain the member/responsible person's signature, file the original with the

ISP/Planning Document in the member's file and forward a copy of the form to each team member. Any team member who disagrees with the change may request a special team meeting.

Attendance Sheet

The *Attendance Sheet* is required at every planning meeting to record who was present. Signatures are required from all team members. If a team member refuses to sign or is unable to sign, the Support Coordinator will print their name and indicate they were present. Signing the *Attendance Sheet* does not indicate agreement or disagreement with the planning document.

Acknowledgement of Publications/Information

Acknowledgement of Publications/Information highlights important information the Division is required to provide to members/responsible persons. Based on the member's eligibility, the Support Coordinator must provide or offer the following publications annually:

A. Statement of Rights

B. Notice of Privacy Practices

C. Arizona Long Term Care Service (ALTCS) Member Handbook (for ALTCS members)

D. Decisions About Your Healthcare (for members age 18 and older)

E. Voter Registration (for members who do not have a legal guardian and who are or will be 18 by the next general election).

Additionally, there are acknowledgements the member/responsible person must make when reviewing this form. This form is reviewed at the initial planning meeting and annually thereafter and signed by the member/responsible person.

Team Assessment Summary/Working with Me

The *Team Assessment Summary* captures a complete picture of the member's capacities, resources, challenges, and supports needed. The Support Coordinator obtains this information through a discussion with the team at the annual planning meeting.

Support Information

The *Support Information* page captures adaptive equipment, behavioral health information, and medications for members. Advance directive and burial plans information is captured on this page for members age 18 and older.

Risk Assessment Plan

Every member enrolled in the Division must be assessed for potential risks. The *Risk Assessment* identifies behaviors or conditions that may compromise the member's health, safety, well-being, or quality of life. The Planning Team must develop steps to minimize or eliminate the potential risks. The emphasis on prevention must not result in disregard of rights, preferences, or lifestyle choices. Age appropriate developmental skills must be taken into consideration for infants and children when assessing potential risks. The *Risk Assessment* is reviewed at every planning and revised as needed.

Managed Risk Agreement

A document that the District Nurse/ Support Coordinator must develop with the member or member's responsible person which outlines risks to the member's safety and well-being as a result of choices or decisions made by the member or his/her responsible person. These risk which would require a managed risk agreement may be associated with the member or member's responsible person's choices and decisions regarding services, placements or caregivers.

This agreement should document:

A. The amount and type of service the Division can provide cost effectively

B. The placement, service and caregiver options offered to the member

C. The member's choices regarding those options

D. The risks associated with the refusal of medically assessed services, placement, decrease in service amounts or potential gaps in services

E. Any plans the member/responsible person has to address those risks (e.g., paying

privately for services above 100%, using volunteer services).

The member or member's responsible person acknowledge and agree to the service limitations and risks by signing the *Managed Risk Agreement.* If the member or member's responsible person refuses to sign the Managed Risk Agreement, the agreement should be placed in the case file with documentation of the refusal.

Vision and Priorities

The member's *Vision and Priorities* page provides direction for the plan. The Vision identifies the desired future for the member. The Priorities are what the member/responsible person would like to focus on in the upcoming year to help members reach their vision for the future.

Service Considerations/Evaluation

The *Service Considerations* page assists the team in evaluating the appropriate services a member may need. The *Service Evaluation* documents a member's abilities, current needs, and future support needs. Outcomes identified for members assessed for Habilitation Hourly are also documented on this form. Services other than Habilitation Hourly are documented on the *Additional Service Outcome* page.

Service Outcomes

Based on the person's *Vision and Priorities*, the Support Coordinator facilitates the development of attainable, observable, measurable, and time-limited outcomes. Members who receive Habilitation, Day Treatment and Training, employment-related programs, behavioral health supports, or therapy must have outcomes identified on the *Planning Document*. If progress on an outcome is not made within the designated timeframe, the team must consider changing the teaching strategy, developing a new outcome, offering a different service, or stopping the service.

The selected provider must develop a teaching strategy for each outcome, which describes the methodology to be used to support the member to achieve the outcome. The strategy must identify the time needed to implement the methodology described and define the data to be recorded regarding progress. Support Coordinators are responsible for ensuring continuity of teaching strategies related to outcomes that occur in more than one setting.

Service Plan

The *Service Plan* document assesses the services to be authorized, other services requested by team members, and/or indirect services. A *Service Plan* is completed at every meeting for all members eligible for the Division, excluding children who are Non-ALTCS Arizona Early Intervention Program (AzEIP) eligible.

Contingency Plan (Back-up Plans)

Development of the *ISP - AHCCCS/ALTCS/DDD Member Contingency/Back -Up Plan* (*Contingency Plan)* is required when any of the following critical services are authorized:

A. Attendant Care

B. Homemaker

C. Respite

D. Habilitation – Individually Designed Living Arrangement

E. Nursing.

Contingency Plans ensure continuous provision of services when the direct care worker is unable to work when scheduled. Family members should not be considered as a substitute for a *Contingency Plan*. The agency authorized must offer a substitute direct care worker.

The member/family may decline a substitute direct care worker and not receive the critical service from an agency direct care worker or may to elect to provide the service informally. When only Independent Providers are authorized to provide services, the Planning Team must consider an agency as a backup. The *Contingency Plan* should include the back-up person identified and a reasonable option for alternative supports. Multiple back-ups must also be identified.

The *Contingency Plan* requires a member to select and document their preference level. The preference level is the time a critical service needs to be provided when the scheduled provider is unable to work a scheduled shift. The preference level may be changed by the responsible person at any time.

The *Contingency Plan* is completed annually and reviewed at each meeting.

Action Items

Each *Planning Document* includes action items to be completed, the person responsible for completing each action item, and the date by which the action item must be completed.

This form is completed annually and reviewed at each planning meeting.

Summary of Professional Evaluations

The *Summary of Professional Evaluations* captures medical appointments and medical issues. This form is required annually for members who live in licensed residential settings.

Rights, Health and Safeguards

The *Rights, Health and Safeguards* form documents exceptions to residential licensing. This form is required annually for all members residing in licensed residential settings.

Spending Plan

The *Spending Plan* determines how the member's money will be spent in the upcoming year. The form is required annually for all members for whom the Division is the Representative Payee and for all members living in licensed residential settings.

Transfer Plan

Prior to transfer of a non-medically involved member from a residential setting operated or financially supported by the Division, the Planning Team must meet to plan the transfer.

The transfer plan will be documented on the *Residential Transfer Checklist.*

Cost Effectiveness Studies

Home and Community Based Services (HCBS) provided under the ALTCS Program must be cost-effective when compared to the cost of providing care to the member in an institutional setting. It is the responsibility of the Planning Team to identify if the member's costs will exceed 100% of the institutional cost and develop a plan to reduce ALTCS costs. Written Cost Effectiveness Studies (CES) are also required by Arizona Health Care Cost Containment System (AHCCCS), for ALTCS eligible persons whose costs exceed 80% of their approved rate.

The CES is a three-month projection of costs. The Support Coordinator must complete a *Cost Effectiveness Study Worksheet (CES Worksheet)* if the member's name appears on the quarterly report "Client_0060 – Members Exceeding 80% Cost Effectiveness." This report identifies members whose costs exceeded 80% of their approved rate in previous quarters. When the Support Coordinator identifies the need for a CES, the *CES Worksheet* should be submitted to the Area Manager or District Designee within 30 days. A copy is maintained in the member's file. Collaboration should take place with identified District staff to obtain information.

Completion of a *CES Worksheet* must be done quarterly until costs are reduced below 80%. In addition, a CES is required within 30 calendar days for the following services:

A. Nursing services (including nursing respite) in excess of 200 hours monthly

B. Habilitation – Nursing Supported Group Home

C. Concurrent services of residential Habilitation (Individually Designed Living Arrangement or Group Home) when the staff ratio is 1:1 or 1:2 at either program

D. Habilitation, Community Protection.

The Division receives a monthly report from AHCCCS identifying members who had previously been above 80% of their approved rates. For these members who are now below 80%, a new *CES Worksheet* must be completed and entered on the CA160 screen in the AHCCCS computer system (PMMIS/CATS) within 60 days of the report. The CA160 screen will be printed and placed in the member file.

Each *CES Worksheet* must be signed by the Support Coordinator and their Supervisor (for members below 100%) and the District Program Manager/Lieutenant Program Manager (for members above 100%). This signature assures that all appropriate CES policies and procedures have been followed.

When a member is discharged from an institutional placement (e.g., an ICF/IID, the Arizona State Hospital or, a Skilled Nursing Facility) the Support Coordinator must complete a CES prior to the move. The costs used for the CES should be those proposed for the new placement, not from the institutional placement.

The completed *CES Worksheet* will be reviewed by District placement personnel. If the costs are below 100% of the appropriate institutional level and the move is approved, copies will be sent to Area Manager or District Designee and maintained in the member's case record. The Area Manager or District Designee will ensure the CES is entered into the AHCCCS computer system at CA160.

In addition to the CES, a *Discharge Plan* consistent with Division policy must be in place prior to any move.

Note: It is advisable to complete an analysis of costs prior to any and all placement changes (e.g., Group Home, Developmental Home).

The completed *CES Worksheet* and the cost reduction plan must be maintained in the member's case record. A copy of the *CES Worksheet* must be submitted to the Area Manager or District Designee. The Area Manager or District Designee will ensure that the CES is entered in the AHCCCS computer system.

Until the CES is brought below 80%, the Support Coordinator will be required to complete and submit a *CES Worksheet* quarterly. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

When the completed *CES Worksheet* generates a result over 100%, the following options should be pursued:

A. Request a higher medical rate.

B. Request a higher behavioral health rate.

C. Reconvene the Planning Team to review services.

Request A Higher Medical Rate Through the Health Care Services Office

Support Coordinators and ALTCS Specialists submit documentation for the Division's Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinators and ALTCS Specialists must complete a justification packet that includes the following:

A. Narrative describing how the person meets the criteria

B. Current *CES Worksheet*

C. Plan To Reduce Costs.

Request a Higher Behavioral Health Rate Through the Behavioral Health Unit

The Support Coordinator submits documentation for the Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinator must complete a justification packet that includes the following:

A. Narrative describing how the person meets the criteria

   This narrative must contain the person's psychiatric diagnosis, most recent psychiatric and psychological evaluations, description of how the person has difficulty adapting to community life, description of substance abuse issues (if applicable) and a description of criminal offenses (if applicable);

B. Current *CES Worksheet*

C. Plan To Reduce Costs

D. Current *Behavior Plan*

E. Any other information that will assist the Behavioral Health Unit in evaluating the request

F. Current *Planning Document*.

The Division's Health Care Services or the Behavioral Health Unit will inform the ALTCS Specialist of authorizations for higher institutional rates (medical and/or behavioral) with the approval time period. If costs continue at the higher level, a request should be resubmitted in advance of the approval expiration. Should the approval expire or be denied, the institutional rate will revert back to the regular institutional rate. The Support Coordinator must initiate review of the other remaining options listed above.

Procedures for Reducing Cost Below 100% within 6 months

The AHCCCS Medical Policy Manual provides that when the cost is expected to be below 100% within the next six months, justification must be added to the *CES Worksheet* and documented in the case file.

When/if services are reduced, the Support Coordinator must follow the Notice of Action (NOA) requirements in policy. If it is unlikely that costs can or will be reduced in the next six-month period, the Support Coordinator is responsible for initiating a review of other options.

Once the Support Coordinator completes the *CES Worksheet* and costs are found to exceed 100%, the Support Coordinator must submit the calculation to the District ALTCS Specialist so it can be entered in the AHCCCS computer system at CA160. In addition, the Support Coordinator should immediately consult with their supervisor, area manager, nurse, contract staff, etc. The Support Coordinator may need to call special team meetings to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced by the end of the six- month period. The Planning Team may discuss the following:

A. Reducing service units (reducing staffing levels)

B. Alternative placements.

If, at the end of six months, costs have not been reduced below 100%, the Support Coordinator must notify the ALTCS Specialist, the District Program Manager (DPM)/Lieutenant Program Manager (LPM), and the ALTCS Program Administrator.

If the DPM/LPM approves home and community based services above 100% of the cost of serving the member in an institutional setting, these costs must be paid with State funds. The Support Coordinator will advise the CES Manager/Business Operations to adjust payments accordingly. The revised *CES Worksheet* (below 100%) is filed in the case record, and a copy is submitted to the ALTCS Specialist. The *CES Worksheet* calculation previously entered in the AHCCCS computer system at CA160 will be adjusted to reflect Medicaid approved costs up to, but not exceeding 100% of institutional cost.

State funds may be available for members residing in licensed residential settings such as Group Homes and Child or Adult Developmental Homes.

If District administration denies the use of State funds, the Support Coordinator should initiate termination of service costs in excess of 100%. The Support Coordinator must

advise the member/responsible person of the cost effectiveness limitations and discuss other options. The Support Coordinator must also follow the NOA requirements in policy.

If the member chooses to remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member's Primary Care Provider), a *Managed Risk Agreement* is completed.

Considerations for Possible Institutional Placement

When considering institutional placement, the Support Coordinator must first document all other options considered and reasons why these options were not chosen, and submit for review by the DPM/LPM. The Planning Team must discuss the lack of appropriate, cost - effective alternatives for the member and discuss the potential placement.

The Support Coordinator will submit a completed *CES Worksheet* to the ALTCS Specialist. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

District administration may continue current costs while any of the above options are being pursued. After six months, if costs continue beyond 100% without AHCCCS approval, the CES calculation in the AHCCCS system must be adjusted to reflect AHCCCS approved costs up to, but not exceeding, 100% of institutional cost.

2004 SERVICE AUTHORIZATION

REVISION DATE: 6/10/2016, 7/3/2015
EFFECTIVE DATE: July 31, 1993

All services funded by the Division require authorization prior to delivery. Support Coordinators may authorize services in certain circumstances. Some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services, which require prior authorization by Health Care Services (HCS). Other services may require authorization by the Assistant Director or designee.

Authorization by the Division Support Coordinator shall be documented by the Support Coordinator's signature on the service plan.

For members who are eligible for Arizona Long Term Care System (ALTCS), the Support Coordinator shall authorize long term care services only when the assessment and planning process outlined in this policy manual determines the services to be medically necessary, cost effective, and federally reimbursable. Services are cost effective when the total cost does not exceed 100% of the cost of an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID). Non-covered services and services provided to members who are not ALTCS-Long Term Care shall be authorized only when the same processes determine them to be developmentally necessary and cost effective and state funding is available.

Prior to authorization, the Support Coordinator shall ensure that other potential resources for meeting the identified needs have been explored, and are either not available or not sufficient to meet the documented need for both ALTCS and non-Long Term Care services. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in this policy manual.

Support Coordinators shall follow the steps outlined below in authorizing services:

A. Members who are eligible for ALTCS receive identified services within thirty (30) days of eligibility. The Focus system will be updated within 5 days of the team meeting, unless a Utilization Review is required;

B. A Utilization Review is required for any new or increase in service including Attendant Care, Respite, Habilitation and Day Treatment and Training. This Utilization Review process must be completed within 10 days;

C. Entry of approvals in Focus shall be approved or denied following Support Coordinator authorization, other District management staff authorization if needed, and HCS authorization or other Division staff, if needed; and,

D. Within five days of approval by the appropriate authority, the Support Coordinator ensures authorization information for the needed service, the amount of units, the start/end dates, and the preferred provider are entered in Focus.

Other Authorizations

Therapies require prior authorization through the District Administration and the Central Office. Home Health Aide, Home Health Nurse, Hospice, and Respiratory Therapy services require prior authorization through Health Care Services. Home modifications require prior authorization through the Home Modification unit.

2005 REFERRAL AND PLACEMENT IN SERVICES

REVISION DATE: 7/15/2016, 10/1/2014
EFFECTIVE DATE: July 3, 1993

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to a member starting a service, the Support Coordinator shall send a copy of the Planning Documents to the identified provider.

Preschool-age children shall not be placed in a Child Developmental Home without a stay-at-home parent, unless all other alternatives have been exhausted and the Assistant Director has given approval. There may be exceptions to this requirement for children whose cases have been transferred to the Division from Department of Child Safety (DCS). All other alternatives include currently available Child Developmental Homes.

The Division staff shall also make every attempt to develop an appropriate home if one is not available. The Assistant Director will consider the need for expansion of a Child Developmental Home after the family's situation and family dynamics have been thoroughly explored. Child Developmental Home expansion will not occur unless it is determined that the child can fully benefit from this placement, and that the quality of care and supervision of other members who reside in the home will not be adversely affected.

For members being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

A. Demographic information that includes the member's name, address, telephone number, date of entry into the Division system, Focus identification number, legal competency status, language spoken and understood, name of parent/responsible person or next of kin (with address and telephone number), physician's name, address and telephone number, and Third-Party Liability (TPL) information (e.g., company, policy number). Printouts of the appropriate Focus documents and/or Planning Documents should contain most of this information, and will be acceptable documentation for referral purposes;

B. Current and appropriate consents and authorizations;

C. Description of special needs and how these should be met (e.g., medical or behavioral), if not thoroughly documented on the most recent Planning Documents;

D. A copy of most recent physical examination;

E. Medical history, including results of Hepatitis B, tuberculosis tests, and immunization records, if available;

F. Current medications and medication history, if not thoroughly recorded on the most recent Planning Documents; and,

G. Copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, or psychological evaluations.

In the event these records are not available, the Support Coordinator should assist the provider in scheduling appointments or obtaining the records needed to meet minimum residential licensing requirements.

For members being placed in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), a physician's order, and the approval of the Assistant Director shall accompany the above information. The Assistant Director may delegate selective authority.

The Planning Team shall schedule a pre-placement meeting with the provider to introduce the member, review the Planning Documents and other records, and discuss any other information necessary to provide safe and effective services. The Support Coordinator shall coordinate and attend pre-placement meetings for residential and day program settings. The Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on the circumstances of each case.

2006 ARIZONA LONG TERM CARE NON-USERS

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

The Support Coordinator shall offer the member/responsible person the option to voluntarily withdraw from Arizona Long Term Care System (ALTCS) and seek services through an Arizona Health Care Cost Containment (AHCCCS) Acute Care Plan through other programs when there is no assessed service need, or no intent to pursue ALTCS services. If the individual voluntarily withdraws from ALTCS, the Support Coordinator shall inform the responsible person of the right to reapply for ALTCS at any time.

If the individual/responsible person chooses not to voluntarily withdraw from the ALTCS program, Acute Care status may be appropriate. The Division will notify the member/responsible person that a change from ALTCS to Acute Care status is being requested and AHCCCS may contact them to complete a financial redetermination.

2007 CASE CLOSURE

REVISION DATE: 3/25/2016, 7/3/2015
EFFECTIVE DATE: July 31, 1993

Causes for Division Case Closure

The following situations may require Division case closure. The member:

A. No longer meets the eligibility requirements defined in this policy manual;

B. Requests case closure verbally, in writing, or the responsible person requests such action;

C. Reaches the age of eighteen (unless an application for continuation of services has been filed);

D. Moved from previous residence and cannot be located via a certified letter, return receipt requested;

E. Moved out of state; or,

F. Has passed away.

All contact attempts must be documented in the case file. Prior to case closure, the Support Coordinator/Supervisor shall ensure due diligence to make contact and determine why attempts were unsuccessful. Additionally, the following must be considered:

A. *Arizona Long Term Care Services (ALTCS) eligibility* – These cases cannot be closed until the Division receives a roster disenrollment from Arizona Health Care Cost Containment System (AHCCCS); and,

B. *Inactive Status* – An option to consider if the person has a history of being unable to contact.

If the Support Coordinator/Supervisor determines case closure will be necessary, this should occur within 30 calendar days. Any Focus authorizations must be end dated when a case closure occurs.

Members who are eligible for the ALTCS cannot be placed in inactive status or discharged from the Division until the AHCCCS dis-enrolls them via a roster transmission. As long as the person remains ALTCS eligible, the Support Coordinator must continue attempts to schedule a meeting. AHCCCS will not dis-enroll the member if AHCCCS is able to contact with the member.

Notification of Case Closure

A *Notice of Service System Discharge* must be sent by certified mail, return receipt requested, to the member/responsible person informing him/her of the case closure at least

35 days prior to the date of the case closure. A copy shall also be sent to the local ALTCS office if the member is ALTCS eligible. The notice shall also discuss the opportunity for administrative review as described in this policy manual. If the member is ALTCS eligible, a case cannot be closed until AHCCCS dis-enrolls the member.

A *Notice of Service System Discharge* shall not be sent in instances where the member has passed away.

Documentation of Case Closure

The following steps shall be taken at the time a member's case is closed:

A. Include a copy of the applicable *Notice of Service System Discharge* in the case record;

B. Close the record in Focus including the appropriate reason code. If the member is ALTCS eligible, the case cannot be closed until AHCCCS dis-enrolls the member; and,

C. Store the record in accordance with this policy manual.