1610 GUIDING PRINCIPLES AND COMPONENTS OF SUPPORT COORDINATION

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PURPOSE

This policy establishes an overview of the guiding principles and components of Support Coordination.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
3. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family

members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551
5. "Support Coordination" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. GUIDING PRINCIPLES

1. The Division shall manage and deliver services and supports to Members in a manner which is consistent with the following guiding principles:
   a. Member-Centered Services
      i. The Member is the primary focus.
      ii. The Member and Responsible Person, if other than the Member, are active participants in the planning, identification and evaluation of physical, behavioral,

and long-term services and supports.

iii. Services are mutually selected through person-centered planning to assist the Member in attaining their goal(s) for achieving or maintaining the Member's highest level of self-sufficiency.

iv. Up-to date information about the Arizona Long Term Care System (ALTCS)-DD program, choices of options and a mix of services is readily available to Members and presented in a manner that facilitates the Member's ability to understand the information.

b. Employment First Philosophy:

i. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.

ii. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

iii. Employment First supports an overarching goal that eligible individuals with disabilities will have access

to integrated work settings most appropriate for them, including the support necessary to help them succeed in the workplace.

iv. Employment First does not mean employment only and does not deny individual choice.

v. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.

c. Member-Directed Options

i. Members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making informed decisions about how best to have their needs met including who will provide the service and when and how the services will be provided.

d. Person-Centered Planning

i. Person-centered planning maximizes Member-direction, and supports the Member in making informed decisions, so that the Member can lead or participate in the process to the fullest extent

possible.

ii. The Planning Document developed through this process, safeguards against unjustified restrictions of Member rights and ensures Members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible.

iii. The Member's DDD Support Coordinator, in collaboration and coordination with the DDD Health Plans, ensures responsiveness to the Member's needs and choices regarding service delivery, personal goals, and preferences.

e. Consistency of Services and Supports

i. An accessible and consistently available network of services and supports is developed to ensure the delivery, quality, and continuity of services.

ii. Services and supports are provided in accordance with the Planning Document as agreed to by the Responsible Person and as authorized by the Division, consistent with coverage responsibility.

f. Accessibility of Network

i. Network sufficiency supports choice in individualized Member care and availability of services.

ii. Provider networks are developed to meet the unique needs of Members with a focus on accessibility of services for Members with disabilities, cultural preferences, and individual health care needs.

iii. Services are available to Members to the same extent that services are available to individuals who are not receiving services through the Medicaid system.

g. Most Integrated Setting

i. Members live in the most integrated and least restrictive setting and have full access to the benefits of community living.

ii. Members are afforded the choice of living in their own home or choosing an alternative Home and Community Based Setting (HCBS) rather than residing in an institution.

iii. Members receive comprehensive services in the most

integrated and least restrictive setting, allowing them to be fully integrated into their communities.

iv. Members are afforded the choice to receive HCBS in community settings where individuals who do not have disabilities spend their time.

h. Collaboration with Stakeholders

i. Ongoing collaboration with Members, the Responsible Person, if applicable, and other members of the Planning Team.

i. Alignment of Care

i. Alignment of care for Members is well-coordinated, integrated care.

ii. The Division and stakeholders have established that reducing or eliminating fragmentation of care for Members requires focused efforts to coordinate physical and behavioral health care with long-term services and supports and community support.

iii. To create greater alignment and care coordination, a single, shared person-centered plan, developed by the Division’s Support Coordinator with the

participation of the DDD Health Plans care management staff, as appropriate, serves as the foundation for care and shall be made available to all involved providers.

j. Integrated Services

i. An integrated care system operated to holistically assess and seamlessly to provide needed services within existing community programs.

ii. An integrated system that reflects that successful Member outcomes are a shared responsibility for all involved in the care and treatment of the Member, leveraging the strengths of the Division, the DDD Health Plans and respective provider disciplines.

B. COMPONENTS OF SUPPORT COORDINATION

1. The Support Coordinator, to provide person centered planning, shall:

a. Provide person-centered planning and coordination;

b. Identifies Cost Effective Services based on assessed need;

c. Develop and maintain the Member's Planning Document;

i. Development of the Planning Document shall be

coordinated with the Responsible Person to ensure mutually agreed upon approaches to meet the Member's needs.

d. Ensures the Responsible Person is informed on how to report the unavailability of services or other problems;

e. Coordinates acute, behavioral health, and long-term care services that will assist the Member in maintaining or progressing toward the Member's highest potential;

f. Reassesses needs and modifies the Member's Planning Document as needed;

g. Identifies appropriate non-ALTCS covered community resources and services for Members and families;

h. Obtains all funded services as assessed in accordance with the Planning Document;

i. Offers a substitute service when the assessed service is not available;

j. Provide facilitation and advocacy

   i. Timely addresses and resolves issues which impede the Member's progress and access to needed services (both ALTCS and non-ALTCS covered

services), and

ii. Ensure services provided are beneficial for the Member.

k. Monitors services for continuing appropriateness

i. Assess for medically necessary and cost effective ALTCS services for the Member.

ii. Evaluate the Member's placement, and authorized services, and taking necessary action to ensure that placement, services, and supports are appropriate to meet the Member's individual goals and needs.

l. Be a mandatory reporter

i. Identifies any instances or suspected instances of abuse or neglect of the Member, reports to the appropriate entities.

ii. Report to the Divisions Quality Assurance Unit all Quality Assurance issues related to non-compliance of contractual requirements related to services the Member is receiving from the Division.

2. The Support Coordinator shall:

a. Follow current Division policy;

b. Comply with all Arizona Health Care Cost Containment System (AHCCCS) requirements;

c. Complete Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) requirements and paperwork;

d. Document accurately;

e. Complete assigned tasks;

f. Be punctual and available.

C. NAVAJO NATION CONTRACTED SUPPORT COORDINATION

1. The Division shall have an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to Members that stipulates:

   a. Who are eligible for Arizona Long Term Services (ALTCS);

   b. Enrolled by the Department of Economic Security with the Navajo Nation to receive support coordination (case management) services;

   c. Affiliated as Members of the Navajo Tribe by virtue of being federally recognized Tribal members and who either live on the Navajo reservation or did live on the Navajo reservation prior to placement in an eligible ALTCS setting;

d. American Indians who are not affiliated members with the Navajo Nation by virtue of being federally recognized members, but currently physically reside on the Navajo reservation or did physically reside on the Navajo reservation but were subsequently placed off reservation in an eligible ALTCS setting.

2. The Navajo Nation contracted Support Coordinator, for Members receiving HCBS on the reservation or in a nursing facility on or off reservation, shall:
   a. Develop and implement a Person-Centered Service Plan;
   b. Coordinate medical needs with the Members' Primary Care Provider (PCP);
   c. Assist the Responsible Person with identifying qualified providers for ALTCS services when they are unable to choose a provider without assistance;
   d. Monitor and update the Person-Centered Service Plan in accordance with this Policy Manual;
   e. Assess the cost effectiveness of services and recommend the least most cost effective service alternatives;
   f. Inform Members of alternative services when the HCBS

services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate;

g. Implement necessary corrective action to bring services into compliance.

3. The Division shall retain various Support Coordination activities:

a. The intake process;

b. Determining and re-determining eligibility;

c. Authorizing services;

d. Monitoring service delivery.

D. SUPPLEMENTAL INFORMATION

Service Coordination responsibilities for the Arizona Early Intervention Program (AzEIP) can be found on the AzEIP Policy and Procedures website.