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.** ~~A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as defined in~~

~~A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative.~~

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.~~ A group of individuals that shall include the member, responsible person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined

~~by the objectives of the planning team to best meet the needs and individual goals of the member.~~

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.** ~~- A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost effective outcomes~~.

POLICY

A. GUIDING PRINCIPLES~~Guiding Principles~~

1. The Division shall~~will~~ manage and deliver services and supports to ~~m~~Members in a manner which is consistent with the following guiding principles:

a. Member-Centered Services

i. The ~~m~~Member is the primary focus.

ii. The ~~m~~Member and Responsible person, if other than Member ~~as appropriate~~, are active participants in the planning, identification and evaluation of physical, behavioral, and long-term services and supports.

~~ii.~~iii. Services are mutually selected through Person-Centered Planning to assist the ~~m~~Member in attaining their~~his/her~~ goal(s) for achieving or maintaining the Member's ~~his/her~~ highest level of self-sufficiency.

~~iii.~~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 ~~m~~Members and presented in a manner that facilitates the ~~m~~Member's ability to understand the information.

b. Employment First Philosophy ~~The Division supports Employment First Principles, Policy and Practice, which~~

~~include the following~~:

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. ~~To the maximum extent possible, m~~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 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 ~~m~~Member-direction, and supports the Member in making informed decisions, so that he/she can lead or~~/~~ participate in the process to the fullest extent possible.

ii. The Planning Document~~Person-Centered Service Plan~~ developed through this process, safeguards against unjustified restrictions of ~~m~~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 ~~m~~Member's needs and choices regarding service delivery, personal goals, and preferences. ~~The Responsible Personmember/Health Care Decision Maker shall have immediate access to the mMember's Planning Document.~~

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~~Person-Centered Service Plan~~ as agreed to by the Responsible Person~~member/Health Care Decision Maker~~ and as authorized by the ~~-~~Division, consistent with coverage responsibility.

f. Accessibility of Network

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

services.

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

~~i.~~iii. Services are available to ~~m~~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. ~~To that end, m~~Members are afforded the choice of living in their ~~o~~Own ~~h~~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. ~~To that end, m~~

~~ii.~~iv. Members are~~shall be~~ 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 ~~m~~Members, the Responsible Person, if applicable, and other members of the Planning Team./~~Health Care Decision Makers, Designated Representatives, family members, service providers, community advocates, other member-serving agencies, and the Division facilitates continuous improvement of the ALTCS-DD Program.~~

i. Alignment of Care

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

ii. The Division and stakeholders have established that reducing or eliminating fragmentation of care for ~~m~~Members requires focused efforts to

coordinate physical and behavioral health care with long-term services and supports and community support.

~~i.~~iii. To create greater alignment and care coordination, a single, shared person-centered plan, developed by the DDD 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 ~~shall~~ operated to holistically assess and seamlessly to provide needed services within existing community programs.

~~i.~~ii. An integrated system that~~shall~~ reflect ~~that~~ successful ~~m~~Member outcomes are a shared responsibility for all involved in the care and treatment of the ~~m~~Member, leveraging the strengths of the Division, the DDD Health Plans

and respective provider disciplines.

B. COMPONENTS OF SUPPORT COORDINATION ~~**Components of Support Coordination**~~

1. The Support Coordinator, to provide person centered planning, shall:~~s' roles include, but are not limited to the following:~~

   a. ~~A.~~ Provide Person-Centered planning and coordination

   b. ~~Based on assessed need~~, ~~i~~Identifies Cost Effective Services based on assessed need;

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

      i. Development of the Planning Document shall be coordinated with the ~~member/~~Responsible ~~p~~Person to ensure mutually agreed upon approaches to meet the ~~m~~Member's needs.

   d. Ensures the ~~member/~~Responsible ~~p~~Person is informed on~~know~~ how to report the unavailability of services or other problems;

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

f. Reassesses needs and modifies the members Planning Document as needed. B. Brokering of Services

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

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

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 ~~to~~

~~i.~~ii. ~~e~~Ensure services provided are beneficial for the ~~m~~Member.

k. Monitors services for continuing appropriateness

i. Assess for~~To determine~~ medically necessary and cost effective ALTCS services for the ~~m~~Member.

ii. ~~This includes e~~Evaluat~~eing~~ 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. Mandatory Reporting

i. Identifies any instances or suspected instances of abuse or neglect of the ~~m~~Member, reports to the appropriate entities~~, i.e., police officer or protective services~~.

ii. Report to the Divisions Quality Assurance Unit all Quality Assurance issues related to non-compliance of contractual requirements related to services the ~~m~~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; and

f. Be punctual and available

~~**C. SUPPORT COORDINATION/ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)**~~

~~Service Coordination responsibilities for the AzEIP can be found on the~~

~~AzEIP Policy and Procedures~~

webpage~~:(https://des.az.gov/services/disabilities/early-intervention/azeip-policies-and-procedures)~~

~~D.~~C. NAVAJO NATION CONTRACTED SUPPORT COORDINATION

1. The Division shall have ~~has~~ an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to ~~m~~Members that stipulates~~.~~ ~~This includes Members~~:
   a. Who are eligible for Arizona Long Term Services (ALTCS), and ~~are:~~
   b. Enrolled by the Department of Economic Security with the Navajo Nation to receive support coordination (case management) services;
   c. Affiliated as ~~m~~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; and,
   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. ~~For members receiving Home and Community Based Services (HCBS) on the reservation or in a nursing facility on or off reservation~~, ~~t~~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 ~~m~~Members' Primary Care Provider (PCP).

   c. Assist the Responsible Person~~members/families~~ with identifying qualified providers for ALTCS services when~~, if~~ 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 ~~m~~Members of alternative services when the HCBS services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate; ~~and,~~

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

3. The Division shall retain various Support Coordination activities~~: including completing~~

a. T~~t~~he intake process;

b. ~~d~~Determining and re-determining eligibility;

c. ~~a~~Authorizing services; ~~and~~

d. ~~m~~Monitoring service delivery.

D. SUPLLEMENTAL INFORMATION

~~3.~~ Service Coordination responsibilities for the Arizona Early Intervention Program (AzEIP) can be found on the AzEIP Policy and Procedures website.