Support Coordination/ Intensive Support Coordination Overview of Changes

DBHDD

DIVISION OF DEVELOPMENTAL DISABILITIES

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

SPRING 2017

Changes to Traditional Support Coordination

UPDATED ROLES AND RESPONSIBILITIES, NEW PROCESSES AND NEW POLICIES

SINCE JULY 2016

A Shift in Priorities – Quality Outcomes

PERSON CENTEREDNESS = MOST VITAL

- **Focus on the individual's satisfaction with services, supports, and quality of life**
- **Focus on minimizing barriers to living a life well lived**
- **Increased engagement of the SC with the individual**
- **Focus on empowering the individual**

What is a Quality Outcome?

- **Basic Quality Outcomes:** Individuals is safe and healthy, crises have been averted, risks have been mitigated, basic needs are met

- **Intermediate Quality Outcomes:** Individuals is satisfied with their services, making progress toward goals, natural supports and community supports are engaged

- **Advanced Quality Outcomes:** Individual is happy, thriving, realizing potential, achieving greater independence, fully integrated into larger community

Recognize, Refer and Act – New Process for Support Coordination

COLLABORATE WITH PROVIDER FIRST TO RESOLVE CONCERNS, ISSUES, DEFICITS.

IF NO RESOLUTION, THEN REFER OUTWARD FOR ADDITIONAL ACTION

Support Coordination Policy Review

NOW/COMP Part III –

Support Coordination and Intensive Support Coordination (separate manual since April 2016)

- www.mmis.georgia.gov → Provider Information → Provider Manuals → Go to 2nd Page for link

DBHDD PolicyStat –

Operating Principles for Support Coordination and Intensive Support Coordination Services

- https://gadbhdd.policystat.com/ → Search 02-430

Individual Quality Outcome Measures Review

AS OF JULY 1, 2016, THE OUTCOME REVIEW IS THE ONLY SC DOCUMENTATION FORM USED FOR ALL WAIVER PARTICIPANTS STATEWIDE

- Replaced SC Monitoring Tool
- Replaced Enhanced SC Monitoring Tool

NEW REVIEW IS *HOLISTIC* - NOT SPECIFICALLY ASSOCIATED WITH A SERVICE OR LOCATION

Outcome Review Frequency

- Completed QUARTERLY, at minimum, for all waiver participants.
- Completed MONTHLY for any participant who:
  - Resides in a CRA
  - Resides in a setting operated through the exclusive use of paid CLS staff (no on-site natural supports)
  - Is assigned to Intensive Support Coordination
- Completed for any participant who spends overnights in an out-of-home placement, such as an extended overnight respite setting (>7 days) WHILE IN that setting.

Individual Quality Outcome Measures Review

25 Questions in 7 Focus Areas

1. **Environment (6)**
2. **Appearance/Health (5)**
3. **Supports and Services (4)**
4. **Behavioral and Emotional (3)**
5. **Home/Community Opportunities (5)**
6. **Financial (1)**
7. **Satisfaction (1)**

Recognize, Refer and Act - New Model of Outcome Evaluation

GOAL IS TO ENCOURAGE A COLLABORATIVE RELATIONSHIP BETWEEN THE SUPPORT COORDINATOR, PROVIDER AGENCY STAFF, NATURAL SUPPORTS AND DBHDD STAFF

Recognize, Refer and Act

Recognizing concerns, unmet needs or risks and responding by:

- Directly advocating for or creating linkages to obtain needed resources
- Providing coaching and working directly with providers/natural supports to develop strategies to resolve issues
- Making referrals to an appropriate party

Step 1: GATHER INFORMATION

- Observe and interact with the individual
- Observe the setting for evidence
- Review documentation
- Engage in discussion with staff members or natural supports
- Observe staff/natural supports' interaction with the individual

Step 2: EVALUATE OPTIONS

1) Acceptable

2) Coaching - *Acceptable with Non-Critical Deficiencies*

3) Non-Clinical Referral - *Unacceptable with Critical Deficiencies*

4) Non-Clinical Referral – Unacceptable with Immediate Interventions

5) Clinical Referral - *Unacceptable with Critical Deficiencies*

6) Clinical Referral - *Unacceptable with Immediate Interventions*

Acceptable

All *essential elements* of the item have been met and services/supports are being provided in an adequate manner

If a Concern/Issue/Deficit is Identified

- Describe it in detail in the Comments box and determine if it should result in Coaching, a Non-Clinical Referral or a Clinical Referral.
- Describe steps already taken by the provider/natural support/ individual for resolution
- Describe any barriers to addressing the concern/issue/deficit
- Determine if the provider/natural support/individual already has a plan is in place to correct the issue
- Encourage the individual to participate in problem-solving, as much as possible

PLEASE NOTE

Opening a Coaching or Referral is NOT necessarily a BAD THING!!!

Provides opportunity to document collaboration efforts!

AND

An opportunity to improve outcomes for the waiver participant!

Coaching

Coaching is selected as the appropriate option for outcome evaluation if a concern/issue/deficit is discovered and SC determines it can be resolved in collaboration with staff members and/or natural supports, without intervention by the Field Office or Clinical staff

Determine the Cause of the Deficit

- Misunderstanding about staff responsibilities
- Lack of awareness of the participant's support needs
- Misinterpretation of the participant's ISP, clinical assessments, healthcare plans, doctor's orders, or BSP.
- Training needs exist; or
- Staff were adequately trained, but nonetheless did not prevent the deficit.

How to Offer Coaching

- Assist staff with understanding individual's needs
- Help interpret ISP goals
- Discuss the interests/preferences & incorporate in planning
- Remind staff of the person's human rights,
- Prompt providers to complete recommendations/ trainings in supporting documentation

How to Offer Coaching

- Reminding provider documentation must remain on-site
- Reminding the provider that its their responsibility if a HRST, BSP or other piece of documentation is expired and/or requires updating
- Providing constructive criticism and reinforcement
- Inquiring about plan to address issues and assisting with developing workable solutions and barrier removal
- Working to problem solve when participant expresses dissatisfaction

Non-Clinical Referral – Unacceptable, Critical

- A SC identified deficits/emerging risks
- SC coached the provider on pathways to resolve the deficits/risks
- Timeframe for completion has passed and deficits/risks remain

Non-Clinical Referral – Unacceptable, Critical

Examples include:

- Unresolved environmental concerns
- Lack of services provided
- Deficits in person-centeredness
- Deficits in documentation responsibilities
- Deficits in ISP implementation
- Need for non-emergency additional support
- Observed violations of participant's rights

Non-Clinical Referral– Immediate Interventions

- SC identifies an urgent non-clinical risk
- The plan to correct the deficit is insufficient compared to the urgency or severity of the risk.

Non-Clinical Referral–Immediate Interventions

Examples include:

- The furnace or air-conditioner is not working and the inside temperature is very cold or very hot
- The residence does not have working plumbing or electricity
- Fire, flood, natural disaster occurs – no plan for alternate residence
- There is evidence of financial exploitation or theft of monies in the person's name – AGAINST THE LAW

Clinical Referral – Unacceptable, Critical

- SC identifies critical health and/or safety risks.
- Risks are required to be addressed immediately by a provider/natural support
- The time frame for completion of a Clinical Referral is typically shorter than that of a Non-Clinical Referral. All matters involving health/safety risk should be resolved as soon as possible!

Clinical Referral – Unacceptable, Critical

Warranted for the following, at minimum:

1) A critical health/safety risk has not yet been addressed by the provider/natural support, but as a result of SC identifying the risk, they address it immediately with proper actions. SC expected to submit a Clinical Referral (No Action Needed) indicating identified risks and actions taken to trigger later follow-up

2) Emerging health and/or safety risks that SC identified during the previous visit were not resolved, despite SC's coaching efforts. Risk(s) are now more imminent.

3) SC identifies a health/safety risk that the provider was unaware of or not in the process of actively addressing to mitigate the risk. (Open referral to track progress toward completion)

Clinical Referral – Unacceptable, Critical

- Warranted if, after "coaching" from the SC, the provider does not update the HRST in a timely manner following a change in health status, diagnosis or medication that should be captured on the HRST

- It is essential that providers keep HRST's current. It is a "living" document intended to be updated as many times as necessary throughout the year as health status, diagnoses or medications change.

Clinical Referral – Immediate Interventions

Occurs when a participant is placed in immediate health and/or safety risk.

Clinical Referral – Immediate Interventions

Examples include:

- Medical appointment is an immediate need and provider/natural support has been non-responsive
- Participant has visible signs of emerging medical needs or vocally complains of a health issue or pain and the provider/natural support is not responding immediately to attend to their health needs
- Participant is demonstrating erratic or dangerous behavior and the provider/natural support's response is not adequate to ensure the safety of the participant and others
- Nursing hours are not being delivered, as ordered in ISP
- Participant with exceptional medical or behavioral support needs not receiving one-on-one/enhanced staffing, as ordered in the ISP

If Coaching or a Referral is Indicated…

- SC's are expected to provide coaching in addition to any referral opened
- SC's must discuss with a provider why a referral is being made and coach them on development of a plan to resolve the issue
  - communicate identified issues with direct staff AND appropriate manager
  - Some issues – may be more appropriate to just relay to manager
- For every open Coaching or Referral, the SC is responsible for adding a Follow-Up note in CIS on progress made toward resolving the issue at a minimum of every month until it is closed.

AGAIN, PLEASE NOTE

Opening a Coaching or Referral is NOT necessarily a BAD THING!!!

Provides opportunity to document collaboration efforts!

AND

An opportunity to improve outcomes for the waiver participant!

What Happens Next with Referrals?

DBHDD Reorganization:

- DBHDD's Division of Accountability & Compliance (DAC)
  - Office of Incident Management and Investigations (OIMI)
  - Office of Provider Certification and Service Integrity (OPCSI)
  - Office of Results Integration
- DBHDD's Division of Performance Management & Quality Improvement (PMQI) –
  - Office of Provider Network Management (PNM) and Office of Quality Improvement
  - Centralized Account Managers within PNM now hold provider contracts, not the Field Offices
- Division of DD Office of Health & Wellness (OHW)

Intensive Support Coordination

NEW WAIVER SERVICE

IMPLEMENTATION BEGAN OCTOBER 2016

Intensive Support Coordination (ISC)

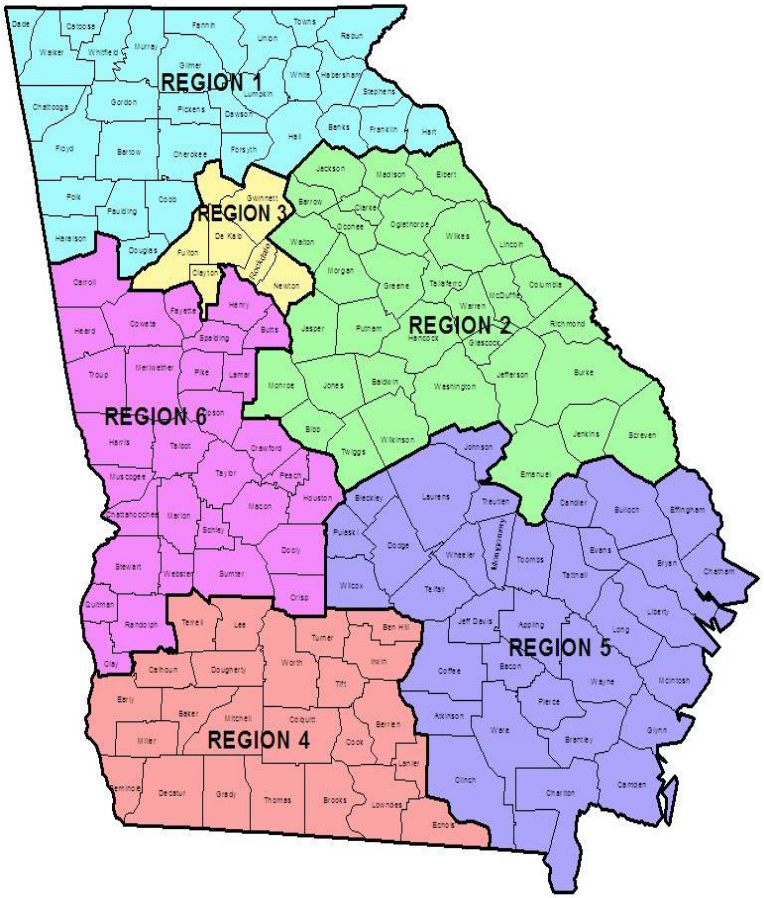
Assists NOW and COMP waiver participants who have complex medical and behavioral needs with specialized coordination of services and supports

Individual Eligibility Criteria

A NOW or COMP waiver participant who:

1. Has an HRST HCL score of 5 or 6
2. Has an SIS-A Section 1 rating total of 16-26
3. Has transitioned from a state hospital into the community since July 1, 2010
4. Is on the active list to transition from an institutional setting into a community residence

Intensive SC Eligible Individuals



- Approximately 2,000 in Georgia

Elevated Expectations for ISC

Intensive Support Coordination teams are responsible for leading the effort to resolve any clinical concerns, from the time of identification until the time of resolution

Elevated Expectations for ISC

- ISC is a more INTENSIVE service than traditional SC.
  - Addition of clinical supervision and medical director
  - ISC activities have elevated standard, as a result of reduced caseloads (20)

- ISC's expected to be the **leader** of coordination of all supports (healthcare-related and other)
  - For traditional SC, history of delegating to provider or others more often than not due to workload constraints

Elevated Expectations for ISC

More involved, more proactive case management activities

- Increased time spent researching resources that can improve outcomes and contacting to coordinate access
- Increased contacts with support team
- Increased time spent working directly with waiver and community providers
  - Initiate or complete actions steps on the spot during visits
  - Designate specific actions steps and timelines for follow-up for both ISC and provider between now and next contact
  - If consistent problems with cooperation present, elevate to supervisor to assist

Elevated Expectations for ISC

ISC Contact Frequency

- **Only** for those individuals who have had long-term stability should minimum frequency of contacts occur *(monthly visit/monthly ancillary contact)*
- Contacts should be 3-4 times per month for individuals for whom there are any risks to mitigate, services/supports to connect them to or new needs identified.
- Visits should occur while individual is in hospital/acute care site/crisis respite
- Additional contacts based on circumstances outlined in 02-433 https://gadbhdd.policystat.com/policy/3230659/latest/

Intensive SC Clinical Supervisor Role

- Supporting ISC's with problem-solving around CLINICAL issues
- Navigating Medicaid State Plan/Medicare covered services and guiding referrals within the healthcare and/or behavioral services system
- Conducting joint visits, at minimum annually per participant, to provide clinical consultation.

Intensive SC Clinical Supervisor Role

Provide leadership and guide follow through of discharge planning activities following discharge from acute or crisis settings:

- Actively engaging in locating a new provider when the individual is unable to return to their previous provider.
- Promote continuity of an individual's health care and support maintenance of the individual's level of functioning
- Take **active** steps to lower readmission rates to medical/crises facilities

Intensive SC Clinical Supervisor Role

Collaborate continuously with natural supports to promote prompt response to health risks, intervening when necessary.

- Educate the participant, their family about the participant's health status, health care needs, and the importance of proactively addressing concerns
- Coach natural supports on healthcare advocacy efforts for their waiver participant.
- Encouraging prompt decision-making when there is an imminent health need. If unsuccessful, attempt to take action on the participant's behalf

Implementation of ISC

- All ADA in Regions 2, 4, 5, 6 began ISC on October 1

All ADA in Region 1 & 3 began ISC on November 1.

- Beginning November 1, ISC admission began for other eligible waiver participants based on:
  - Point of entry into COMP/NOW waiver services
  - Annual reassessment by I&E Clinicians
  - An urgent/emerging support need that results in the participant meeting eligibility criteria
  - Expedited enrollment of those eligible, based on availability of Field Office staff availability

Intensive SC Providers

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Benchmark Human Services						
CareStar						
Columbus Community Services						
Compass Coordination						
Creative Consulting Services						
Georgia Support Services						
Professional Case Management Services of America (PCSA)						

ISC Provider Selection

- Only individuals, their representatives and their family members (if individual permits) can make selection of ISC provider
- Providers cannot select an ISC provider for an individual
- Choice is facilitated by the Field Offices (not current SC)

What if Participant Cannot Make Selection?

- If the participant has no legal guardian or family involved, Field Office is to make every effort to reach out to any other natural support who may be able to assist with provider selection.

- If there is NO natural support that can assist:
  - If the same Support Coordinator has been assigned to a participant for at minimum of one year and there are no current concerns with the SC, the participant will remain with the current agency for ISC
  - If there has not been a consistent Support Coordinator in the past year, an ISC agency will be assigned to the participant based on the rotation method.

QUESTIONS?

ROBERT BELL
DIRECTOR OF COMMUNITY SUPPORTS
ROBERT.BELL@DBHDD.GA.GOV

JOELLE BUTLER, LCSW
INTENSIVE SUPPORT COORDINATION MANAGER
JOELLE.BUTLER@DBHDD.GA.GOV