PART III

POLICIES AND PROCEDURES

FOR
SUPPORT COORDINATION SERVICES
AND
INTENSIVE SUPPORT COORDINATION SERVICES
(COMP & NOW Waiver Programs)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

Revised: July 1, 2016

Policy Revision Record

Part III, Policies and Procedures Manual for Support Coordination and Intensive Support Coordination Services, July 2016

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE A = Added D = Delete M = Modified	CITATION (Revisions required by Regulation, Legislation, etc.)
7/1/16	602	Staff Hiring and Training Requirements	D	Moved to Policy Stat 7.01.16
7/1/16	603	Covered Services Coordinating Non-Waiver Services, Community Engagement and Resource Development	A	
7/1/16	603	Evaluating the Quality and Outcome of Services and Identifying Unmet Needs	A	New method of Outcome Evaluation
7/1/16	603 (April 2016 version was 603)	Assessment Related Tasks	D	Moved to Policy Stat 7.01.16
7/1/16	604	Individual Service Plan Requirements	D	Waiver policy here, entire policy on ISP within PolicyStat
7/1/16	606	Contact Frequency-CLS and Respite visit requirements	M	Waiver policy here, entire policy on ISP within PolicyStat
7/1/16	607	Documentation Requirement-Individual Quality Outcome Measures Review tool usage	A	Waiver policy here, entire policy on ISP within PolicyStat
7/1/16	607	Contact Requirements Monitoring Requirements	D	Moved to Policy Stat 7.01.16
7/1/16	607	Incident Reporting Fair Hearing Notification Agency Policy and Procedures DBHDD Contract/LOA and DBHDD Community Service Standards	D	Moved to Appendix A
7/1/16	608	Quality Outcome Evaluation – Recognize, Refer and Act	A	Required

7/1/16	APPENDIX G	Quality Outcome Measures Review form	A	New Outcome Measures Tool
7/1/16	APPENDIX G-2	Quality Outcome Measures Review: User's Guide	A	Required
7/1/16	APPENDIX G-3	Fact Sheet: Quality Outcome Evaluation	A	Required

PART III - POLICIES AND PROCEDURES
FOR
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APPENDIX H **Fact Sheet: Quality Outcome Evaluation**

This manual is to be used with the Department of Behavioral Health and Developmental Disabilities OPERATING PRINCIPLES FOR SUPPORT COORDINATION & INTENSIVE SUPPORT COORDINATION, found at: https://gadbhdd.policystat.com/
for supplemental information and standards.

PART III - CHAPTER 600

SPECIFIC PROGRAM REQUIREMENTS
FOR
SUPPORT COORDINATION SERVICES
And
CHAPTER 700
SPECIFIC PROGRAM REQUIREMENTS
FOR INTENSIVE SUPPORT COORDINATION SERVICES

SCOPE OF SERVICES

This chapter 600, Part III of the New Options Waiver and the Comprehensive Supports Waiver Programs replaces Chapter 2800 in the NOW Waiver Policy, Part III and Chapter 2900 in the COMP Waiver Policy, Part III.

600 General

Support Coordination services are a set of interrelated activities for identifying, coordinating, and overseeing the delivery of services to enhance the health, safety and general wellbeing of waiver participants within the context of the person's goals toward maximum independence. Support Coordination services include the following:

1. **Facilitating the Service Planning Process and Individual Service Plan Development**

2. **Coordinating Waiver Services**

3. **Coordinating Non-Waiver Services, Community Engagement and Resource Development**

4. **Evaluating the Quality and Outcome of Services and Identifying Unmet Needs**

5. **Assessment and Evaluation Related Tasks**

Support Coordination services assist participants in coordinating all services, whether Medicaid reimbursed services or services provided by other funding sources. These services include completing the Individual Service Plan (ISP) document and any revisions or reviews, and monitoring the implementation of the ISP, the health and welfare of participants, and the quality and outcome of services. The frequency of Support Coordination services is based on the individual needs of the participant and as required to address any identified health and safety risks or service provider issues.

Support Coordination services are provided by agencies that employ a sufficient number of Support Coordinators to meet the Support Coordination services needs of participants served by the agency. Support Coordinators are responsible for monitoring the implementation of the ISP, assisting in the coordination of ISP revisions, and assist the waiver participant and/or representative in locating a service provider. Monitoring includes direct observation, review of documents, and follow up to ensure that services plans have the intended effect and approaches to address challenging behaviors, medical and health needs, and skill acquisition. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of participants and their families with the ISP and services delivery. Support Coordinators assist participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment and management of this option for service delivery.

601 Special Requirements of Participation

In addition to those conditions of participation in the Medical Assistance Program as outlined in Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid providers, Section 106 (General Conditions of Participation), and Part II, Chapter 600 Policies and Procedures for the COMP Program, Support Coordination Services agency providers must meet the following requirements:

Agency Experience

Provider agencies rendering Support Coordination services must:

1. Have at minimum five (5) years' experience in providing home and community based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person centered planning;

2. Have established or will establish working relationships with local community and advocacy groups, experience advocating for individuals in the community, and preparing individuals for self-advocacy;

3. Have experience and demonstrated success with outcome based planning, and developing plans based on the individual's goals, choices and direction;

4. Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;

5. Demonstrate experience in serving diverse cultural and socioeconomic populations.

6. Assure compliance with the conflict-free case management requirement outlined in the 2014 HCBS Rule.

602 Staff Qualifications and Responsibilities

Rev 07 2016 Provider agencies rendering Support Coordination Services must have staffing the meets the following requirements:

1. One individual may perform one or more of the following functions for the agency.

2. A designated Agency Director who must have either a bachelor's degree in a human service field (such as social work, psychology, education, nursing, or closely related field) or business management and three years of experience in service delivery to persons with developmental disabilities, with at least three years in a supervisory capacity.

   Duties of the Agency Director include, but are not limited to:

   a. Oversees the day-to-day operation of the agency;

   b. Manages the use of agency funds;

   c. Ensures the development and updating of required policies of the agency;

   d. Manages the employment of staff for the agency; and

   e. Designates another agency staff member to oversee the agency, in his or her absence.

3. At least one employee with the agency must:

   a. Have responsibility for overseeing the quality of Support Coordination Services to participants.

   b. Be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for COMP, Appendix I)*

4. Have a sufficient number of supervisory staff to train, support and supervise Support Coordinators.

5. Have a sufficient number of quality assurance staff to review a sample of ISPs for quality and outcome indicators and to provide oversight to Support Coordinators in instances where health and safety risks are identified for participants in effort to improve health outcomes.

6. The agency must have an adequate number of Support Coordinators to meet the needs of the assigned participants. Support Coordinators provide the covered services in Section 603 at a minimum. The agency is responsible for documenting support coordinator's qualifications and maintaining that documentation in individual

personnel files prior to provision of waiver services. Support Coordinators must meet the following qualifications:

a. Be at least 21 years of age;

b. Have a minimum of a bachelor's degree in a human service field, such as social work, psychology, special education, nursing, or closely related field.

c. Have at least one year of experience in serving persons with developmental disabilities or related disabilities in a case management or coordination role;

7. Have for each DBHDD region served a designated on-call system which:

a. Provides liaison assistance to the DBHDD Regional Field Office 24 hours a day, 7 days a week.

b. Provides emergency assistance as directed by the regional field office in coordination of services and supports

c. Provides supervision to support coordinators while on call

8) Must have a current Organization Chart showing lines of authority and responsibility for all staff within the agency and includes position descriptions for all staff.

603 Covered Services

Rev 07 2016 Reimbursable Support Coordination Services include the following based on the assessed need of the participant and as specified in the approved ISP:

1. Facilitating the Service Planning Process and Individual Service Plan Development

a. Update Personal Profile and hold pre-meetings with participant, support network, and service providers for development of the annual Individual Service Plan (ISP) to respond to the assessed needs of the participant.
b. Convene ISP development/amendment meetings and facilitate the development of the written ISP document.
c. Include edits or revisions that reflect assessed needs and include the goals to be achieved through support from specific waiver services and other non-waiver services needed by the participant.
d. Coordinate and facilitate ISP development among both professionals and non-professionals who provide individualized supports.
e. Document action plans or ISP team discussion, addressing any conflict between preferences and issues of health and safety.

2. Coordinating Waiver Services

a. Linking the participant to needed waiver services to address identified needs and to achieve goals specified in the ISP.
b. Assisting the participant with reviewing service provider options.
c. Providing information and assistance that helps the participant and his or her family or representative in making informed decisions about the participant-direction option and assisting each participant who opts for participant-direction with enrollment in this option.

3. Coordinating Non-Waiver Services, Community Engagement and Resource Development

a. Taking active measures to gather information about non-waiver funded services or supports in the participant's community that may assist in addressing their needs and/or goals.
b. Participating in activities that help link eligible participants with medical, social, and/or educational providers or other programs and services that are capable of providing needed services to address identified needs and to achieve goals specified in the ISP.

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4. Evaluating the Quality and Outcome of Services and Identifying Unmet Needs

a. Contacting participants as needed to address any identified health and safety risks and progress toward personal goals.
b. Monitoring service delivery and determining if there are unmet needs
c. Referral for additional or different services and follow-up activities
d. Evaluation of the satisfaction of participants and their families with the ISP and its implementation.
e. Monitoring of the health and welfare of the participant, through direct observation, review of documents, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome

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5. Assessment and Evaluation Related Tasks

a. Conduct or facilitate the completion of the SIS assessment for any participant, as needed.
b. Review the HRST, including all service considerations and training recommendations, in order to incorporate assessed needs and individual specific health and safety considerations in the ISP.
c. Review all clinical evaluations and support responsible parties in coordinating action responsive to the recommendations.
d. Review all healthcare plans, Positive Behavior Support Plans (PBSPs), crisis plans and safety plans, including a review tracking documentation maintained by providers to determine if it meets standards.

e. Complete the annual DMA-7 level to facilitate level of care re-evaluation for each participant.

604 Non-Covered Services

1. Support Coordinators cannot provide other direct waiver services, including Community Guide Services, to any waiver participant.

2. Payment is not made, directly or indirectly, to members of the participant's immediate family.

3. Services provided to participants during full-month periods of institutionalization may not be billed unless specified as transition coordination. Discharge planning during periods of institutionalization must continue in order to safely and effectively transition individuals from institutions back into community settings.

4. The provision of services to enrolled participants in Institution for Mental Diseases (IMD) units.

5. Services that duplicate case management services provided to an eligible participant through a Targeted Case Management Program as prohibited by Medicaid.

6. Payment is not made for those goods and services covered by the State Medicaid Plan except where a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

605 Individual Service Plan Requirements

Rev 07 2016

It is a requirement that each waiver participant to have an Individualized Service Plan (ISP) written on the document specified by DBHDD Division of DD. The plan is to be developed by a planning team of appropriate persons to include, but not be limited to, the participant, the Support Coordinator, and the participant's parent, guardian or other natural support representative. This plan, developed based on assessed needs identified through the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), clinical assessments, and additional documents as needed, identifies the participant's outcomes and planning goals and describes the services and supports needed to assist the participant in attaining the goals and outcomes identified in the plan. An approved ISP authorizes the provision of safe, secure, and dependable support and assistance in areas that are necessary to promote achievement of full social inclusion, independence, and personal and economic well-being for the participant.

606 Contact Frequency

Rev 07 2016

A face-to-face visit must occur to every waiver participant, at minimum of quarterly. Anyone who resides in or spends overnights in an out-of-home placement (CRA, extended overnight respite, or settings operated through the exclusive use of paid CLS

staff), must have a minimum of one face-to-face visit from their Support Coordinator per month. One *Individual Quality Outcome Measures Review* must be completed monthly for waiver recipients meeting this condition.

A visit to the overnight respite setting is required for any length of stay 7 calendar days or greater, during the time of out-of-home respite support.

607 Documentation Requirement

Rev 07 2016

Support Coordination documentation should reflect the course of services/supports provided to the waiver participant and skills that the participant has learned during the time those services are being provided. It is used to communicate between agencies contributing to the participant's support.

All documentation must be HIPAA compliant. For example, paper documents/case records must be stored securely with appropriate safeguards, and the participant's written authorization for release of information must be obtained before any protected health information can be shared.

Information gathered/observed during a face-to-face visit with the participant must be documented on the *Individual Quality Outcome Measures Review*. The Support Coordinator must document any additional contact beyond the required frequency through Support Notes in CIS. Follow-up that has occurred based on the contacts must also be documented in Support Notes or subsequent *Individual Quality Outcome Measures Review*. The ISP must be revised as necessary to include changes in the participants support needs and services.

Support Coordination Documentation is captured through the following methods:

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1. *Individual Quality Outcome Measures Review*

Support Coordinators will evaluate outcomes for all waiver recipients through use of the *Individual Quality Outcome Measures Review*. This review will be completed at a minimum of quarterly for all waiver participants, based on a face-to-face visit.

2. *Support Notes*

A Support Note must be entered monthly in CIS, at minimum, based on either a successful face-to-face visit or a successful ancillary contact.

Support Notes are to be entered into CIS for all contacts made on behalf of the participant, including:

- Face-to-face visits with the participant, the participant's natural supports, the participant's provider agency (if the participant was discussed)
- Phone calls to the participant, the participant's natural supports, the participant's provider agency (if the participant was discussed)

- E-mails with the participant, the participant's natural supports, the participant's provider agency (if the participant was discussed)
- Contacts made in effort to "close the loop" on referrals
- Research conducted or contacts made to seek resources for the participant
- Contacts made to the Regional Field Office or Central Office about the participant

608 Quality Outcome Evaluation – Recognize, Refer and Act

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The Recognize, Refer, and Act Model replaces the previous Rating Model for use by Support Coordinators, effective July 1, 2016. Recognize Refer and Act engages in the interaction of case management skills involved in the recognition of unmet needs and impending risks and responding by either providing coaching, making referrals to an appropriate party, or directly linking or advocating on behalf of the participant to obtain the most appropriate resources.

The model relies on effective observation skills, the ability to gather information from all pertinent sources, tactful interviewing skills, enhanced problem solving skills, and a sound knowledge of community resources. When there are deficits in any of these skill areas, it is DBHDD's expectation that Support Coordinators seek supervision as indicated. Recognize, Refer and Act often involves a team approach for risk recognition, but relies on Support Coordinators ability to identify the most appropriate team discipline for each referral related to a particular risk area.

A primary goal of the Recognize, Refer and Act Model is to encourage a collaborative relationship between the Support Coordinator, provider agency staff, natural supports and DBHDD staff. This collaboration serves as a pathway to effectively identify any unmet needs for the waiver participant, work together to reduce or eliminate any associated risks, and ultimately achieve the best outcomes for the waiver participant. The Quality Outcome Measures Review document and accompanying User's Guide, included as Appendix H and H-2, facilitate the implementation of the Recognize, Refer and Act model by prompting recognition through a series of questions and providing information about referral and intervention strategies.

609 Prior Approval

Support Coordination Services must be authorized prior to service delivery by the applicable DBHDD Regional Office at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

610 Basis for Reimbursement

1. The unit of service is monthly.

2. Reimbursement Rate: The reimbursement rate for Support Coordination Services is found in Appendix A.

SPECIFIC PROGRAM REQUIREMENTS
FOR
INTENSIVE SUPPORT COORDINATION SERVICES
SCOPE OF SERVICES

CONTENTS

700. General

Intensive Support Coordination is a waiver service that includes all of the activities of Case Management Support Coordination (See Chapter 600), but the activities reflect specialized coordination of waiver, medical and behavioral support services on behalf of waiver participants with exceptional medical and/or behavioral needs**.** The need for Intensive Support Coordination is determined at initial and annual assessment and is provided as an alternative to traditional Support Coordination. Intensive Support Coordinators assist waiver participants with complex needs through: identifying and addressing barriers to care; accessing needed resources and services offered through the waiver as well as the larger healthcare system; taking active measures to address complex needs; and fostering and maintaining family and other informal relationships and support.

The provision of intensive support coordination requires advanced training, knowledge and skills required to address the severity of medical, behavioral and related needs that present in the management of physical and behavioral health, as well as interventions and activities that foster prevention of health deterioration and prevention of exacerbation of medical/behavioral conditions. Examples of conditions which may require Intensive Support Coordination include: tracheostomy care; complex suctioning, risk of choking and aspiration, dually diagnosed individuals with challenging behaviors, complex diabetes management, presence of gastrointestinal complications, and history of low trauma fractures. This list is not all-inclusive but provides examples of the level of participant risk ameliorated through the provision of Intensive Support Coordination.

Documentation must support the presence of continued need with the expectation that Intensive Support Coordinators will work closely with physicians, other healthcare providers, and waiver service providers in the management of complex conditions. The condition must support frequent and enhanced level of monitoring, intervention and follow-up which is described and clearly documented. The need for Intensive Support Coordination is determined at the initial assessment, change in condition, and annual review. Intensive Support Coordination services may be provided to individuals scheduled for transition from institutions for a period of sixty (60) days prior to the discharge date; however, community-based claims will not be submitted for reimbursement until after the waiver participant has been transitioned to the community.

For maintenance of provider eligibility, providers must meet conditions established by Department of Human Services, Department of Behavioral Health and Developmental Disabilities and contained in the DBHDD Provider Manual as well as all conditions specified in the contract with the DBHDD.

701. Member Eligibility

Services are targeted for Medicaid eligible members who are intellectually or developmentally disabled and who currently receive or are on the short-term planning list to receive community based services through the State of Georgia, DHS, and DBHDD.

The following criteria must be met for admission to service:

1. The member is a categorically eligible recipient of Medicaid and

2. The member meets the requirements for the DBHDD Most-In-Need status, and

3. The member has a diagnosis of intellectual disability and/or developmental disability; and

4. Two or more of the following:

   a. The member is currently receiving services that are financially supported by the Department of Human Services, Department of Behavioral Health and Developmental Disabilities (DBHDD)

   b. The member has multiple needs as documented in the intake and assessment process and requires coordination of those multiple needs

   c. The member has a lack of or inadequacy of natural supports as documented in the intake and assessment process

   d. The member is currently placed on the short-term planning list awaiting services

5. A physician order for Intensive Support Coordination is obtained to substantiate admission within 30 days of enrollment; **and**

6. Evidence substantiating the need for Intensive Support Coordination is found based on one of the following:

   a. Member has a Health Risk Screening Tool (HRST) HCL score of 5 or 6; **or**
   b. Member has a Supports Intensity Scale rating total of 16-26 in Section 3A and/or 3B (Exceptional Medical Support Needs and Exceptional Behavioral Support Needs); **or**
   c. Member has transitioned from a state hospital into the community since July 1, 2010; **or**

d. Member is on the active list to transition from an institutional setting into a community residence (mandatory enrollment upon transition).

702 Special Requirements of Participation

An Intensive Support Coordination Agency is selected through the enrollment process described in *Part II Chapters 600 – 1200 Policies and Procedures for Comprehensive Supports Waiver Program (COMP), Sections 602, 603 and 604.* Enrolled members and their Families will be able to choose any provider authorized to provide Intensive Support Coordination in Georgia if the provider agrees to provide services in the region in which the consumer lives and has the clinical expertise to meet the specific needs of the individual. The provider must meet the conditions established by the Department of Community Health as outlined in The Policy and Procedures Manual Part I, Part II cited above, and the Provider Manuals for Community Developmental Disabilities Providers found via policy #02-1201 at https://gadbhdd.policystat.com/.

In addition to the general provider enrollment criteria outlined in Part II, Comprehensive Waiver Program, the Intensive Support Coordination provider agency must meet the following enrollment criteria specific to the provision of Intensive Support Coordination.

1. A minimum of five(5) years of experience in:

   a. the health care, behavioral health or case management field;

   b. providing home and community based case management services for individuals with disabilities or similar HCBS populations, and demonstrate success in supporting individuals in community inclusion and person centered planning;

   c. serving individuals at risk due to medical, functional, and/or behaviorally complex conditions.

2. Agrees to participate in completion of DBHDD Provider Performance Unit Review within six months of enrollment.

3. Have established or will establish working relationships with local community and advocacy groups, experience advocating for individuals in the community, and preparing individuals for self-advocacy;

4. Have experience and demonstrated success with outcome based planning, and developing plans based on the individual's goals, choices and direction;

5. Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;

6. Demonstrate experience in serving diverse cultural and socioeconomic populations.

7. The applicant agency must assure compliance with conflict free case management as outlined in 42 CFR §441.301(b) (1).

8. Meets all DBHDD provider requirements as specified either through DBHDD contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DBHDD.

9. If licensed, the agency will maintain their license as applicable in home health, private homecare, neurobehavioral center, or other. If out-of-state, must provide a letter of recommendation from current oversight agency along with the last audit/review.

10. The provider must have access to a Medical Director (MD or Psychologist), with consultation expertise for both Medical and Behavioral Intensive Support Coordination available.

11. Proof of licensure is required for Intensive Support Coordination Clinical Supervisors in the designated specialty area.

Certifications of all Intensive Support Coordinator Supervisors and Intensive Support Coordinators are required to be submitted annually. New hires must be certified to provide Intensive Support Coordination within a grace period of ninety (90) days.

Eligible members will have choice of Intensive Support Coordination Agency or Intensive Support Coordinator within the applicable region's single agency in areas or counties where only one ISC Agency is enrolled.

Eligible members will have free choice of the providers of other medical care and services.

Payment for Intensive Support Coordination services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

National accreditation is preferred, as indicated in *Appendix I - Glossary of Terms - of the COMP Part II Medicaid Policy Manual*, or other national accrediting body relevant to the provision of case management or coordination of services.

703 Staff Qualifications and Responsibilities

In addition to the base requirements for Support Coordination Services, Intensive Support Coordination in Section 602, the following staff qualifications and patterns represent requirements specific to Intensive Support Coordination Services:

Clinical Director:

The provider must employ or contract with a Medical Director (MD or Psychologist), with consultation expertise for both Medical and Behavioral Intensive Support Coordination available. Role of the Medical/Clinical Director is to facilitate communication with members of the medical/behavioral community for the purpose of interpreting orders, direction from other clinicians, and facilitating specialist referrals. The Medical/Clinical Director will oversee and provide expertise in elements of the individual service plan as it relates to specialized medical and behavioral risk. The Medical/Clinical Director may also assist in facilitating transition from acute or crisis settings such as community hospitals or crisis respite centers.

Intensive Support Coordination Clinical Supervisor:

ISC-Medical Clinical Supervisor:

- Registered Nurse (R.N. with a B.S. or M.S. in Nursing), physical or occupational therapist, physician assistant or other mid-level healthcare provider
- Minimum of 2 years' experience in acute care, ICF/ID long term care, or medical rehabilitation.
- Must have at minimum three (3) years' experience providing home and community-based case management services for individuals with disabilities or other related disabilities.

ISC-Behavioral Clinical Supervisor:

Must be one of the following: Board Certified Behavior Analyst, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker or a Registered Nurse.

- Must have a minimum of 2 years professional experience with individuals with complex behavioral issues in a behavioral health setting related to individuals with ID/DD (i.e. ICF/IDD, psychiatric inpatient hospital/facility, specialty clinics, or other rehabilitation/habilitation settings.
- Must have at minimum three (3) years' experience providing home and community-based case management services for individuals with disabilities or other related disabilities.

DBHDD Oversight & Certification:

- DBHDD will certify each ISC Clinical Supervisor for a five year period, if they meet education and experience requirements. Thirty (30) hours of continuing education in supervision and support coordination topics will be required annually for the renewal of the certificate, each of five years.

Developmental Disabilities Professional

At least one employee with the agency must:

1. Have responsibility for overseeing the quality of Intensive Support Coordination Services to participants.

2. Be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for COMP, Appendix I);*

Duties of the DDP include, but are not limited to:

a. Overseeing the Intensive Support Coordination services provided to participants;

b. Document and report on any identified health and safety issues for participants; and

c. Providing training and support to intensive support coordinators.

3. Have sufficient number of supervisory staff whose duties include, but are not limited to, training, support, and supervision of intensive support coordinators.

4. Have sufficient number of quality assurance staff whose duties include, but are not limited to:

a. Reviewing a 10% sample Individual Service Plans for quality and outcome indicators;

b. Providing oversight to intensive support coordinators in instances where health and safety risks are identified for participants in effort to improve health outcomes.

Intensive Support Coordinator

ISC Medical –

- Minimum bachelor's degree in human service field, such as, social work, psychology, special education, nursing, or closely related field required.
- Minimum two years of experience serving persons with DD/IDD or related disabilities and two years' experience in a healthcare, habilitative/ rehabilitative, residential or similar setting required. Experience providing care management/coordination preferred.

ISC Behavioral –

- Minimum bachelor's degree in human service field, such as, social work, psychology, special education, nursing, or closely related field required.
- Minimum two years of experience serving persons with DD/IDD or related disabilities, including two years' experience in a behavioral health setting, such as, ICF/IDD, psychiatric inpatient hospital/facility, specialty clinic or program, special education department, or similar setting required. Experience providing care management/coordination preferred.

DBHDD Oversight & Certification:

DBHDD will certify each ISC Coordinator for a five year period, if they meet education and experience requirements. Twenty (20) hours of continuing education in supervision and support coordination topics will be required annually for the renewal of the certificate, each of five years.

Staff Responsibilities

ISC Clinical Supervisor Responsibilities:

- Responsible for supervising not more than five (5) ISC Coordinators who will provide direct oversight and coordination services to a maximum caseload of twenty (20) individuals.
- Supervise ISC Coordinators and provide ongoing consultation to consist of joint visits, determining risk and unmet needs, and collaboration in identifying and securing resources.
- Hold weekly supervisory sessions with each of the five (5) ISC Coordinators to review their caseload and the level of risk of each individual served.
- Complete a review of 10% of caseloads on a quarterly basis to determine if all ISC services and protocols are being followed. This review will be documented and available for review by DBHDD staff.

Additional expectations include:

- Demonstrated understanding of the healthcare and/or behavioral services system and ability to coordinate waiver services, Medicare and Medicaid State Plan funding, and other acute care and community services.
- Have established or will establish working relationships with local advocacy groups. Have experience advocating for community inclusion of individuals with disabilities and preparing individuals for self-advocacy.
- Have experience and demonstrated success with outcome-based person-centered planning and developing plans based on the individual's assessed needs, goals, choices and direction.

Have experience with measuring quality of services and satisfaction with services and ensuring that services are consistent with quality measures and expectations of the individual.

704 Covered Services

Intensive Support Coordination Services includes those tasks related to assessment, development of the individual service plan and documentation requirements as described in Support Coordination Services, Sections 603, 604 and 605 of this document. In additional to those requirements, Intensive Support Coordination services include:

1. Maximizing the health and safety of each individual member of Intensive Support Coordination services.

2. Identifying and/or recruiting a primary care physician, medical or behavioral health specialists and any ancillary health professionals that are indicated.

3. Including healthcare or behavior support plans in the ISP development and follow up considerations.

4. Providing information and referrals for community services, healthcare and behavioral/psychiatric services and other supports identified in the ISP.

5. Developing and linking the participant to services and supports set forth in the ISP.

6. Assisting the participant to choose a service provider agency to deliver their services and supports identified in the ISP. This includes arranging and attending meetings as necessary to coordinate with other providers and/or community organizations.

7. Successfully navigating the implementation of the ISP for all planned services including carrying out the type and frequency of contacts as prescribed in the ISP.

8. Monitoring the participant's on-going needs and quality of the services outlined in the ISP and the ISP's effectiveness. This includes monitoring, evaluation and determining quality of additional behavioral supports or health care services.

9. Monitoring for changes in participant's health and well-being that indicate a need for reassessment and/or a revision of the ISP, coordination of crisis services.

10. Coordinating the annual review with the DBHDD Field Office Intake and Evaluation Team and attending clinical assessments, as requested.

11. Facilitating collection of documentation to support renewal of Level of Care for waiver eligibility to include, but not limited to the DMA-7.

12. Conducting site visits and other contacts as prescribed in the ISP:

    - All participants must minimally receive one face-to-face home visit and one ancillary contact per month from their Intensive Support Coordinator.

    - Ancillary contacts are any contact made to or on the behalf of the person served and may include the following:

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. Telephone contacts made to the person served
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- Person-to-person or telephone contact made to another individual/ company/social entity on a waiver participant's behalf to secure needed services/benefit, or

- Contacts otherwise necessary to provide appropriate and sufficient support coordination services or arrange healthcare or community services.

- Additional points of contact may be needed based on the following conditions:

  - The interdisciplinary team determined that more contact was needed and documented an increased ancillary contact or visit frequency in the participant's ISP

  - Based on case consultation, joint visit with the ISC Coordinator, or contact with a healthcare provider the Intensive Support Coordination supervisor determined that increased ancillary contact or visit frequency is needed.

13. Assisting the DBHDD Regional Field Office staff to move or remove a member from harm's way in a crisis or emergency.

14. Coordinating the transition of specific individuals institutionalized in a nursing facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICFMR) who are targeted and funded for placement in home and community based services within 90 days.

15. The Intensive Support Coordination Supervisor has administrative authority over their Intensive Support Coordination team. They will act as a clinical consultant for each of the maximum 100 participants served within the team's caseload. To help meet service and participant goals, Intensive Support Coordination Supervisor's role includes:
    a. Regular conferencing to review case management activity around each participant.

    b. Availability between team supervisory conferences to help Intensive Support Coordinators solve problems around key participant issues, resolve service problems, and visit participants as part of their interdisciplinary team for clinical consultation and planning.

    c. Administrative support for Intensive Support Coordinators making significant decisions or recommendations.

705 <u>Non-Covered Services</u>

1. Services provided in nursing homes or prisons with the covered exception as designated in #14 listed above.

2. Separately reimbursed counseling services for participants or family members.

3. The provision of services to enrolled members in an Institution for Mental Diseases (IMD) Units.

4. Services that duplicate case management services provided to eligible members through other Targeted Case Management Programs as prohibited by Medicaid.

706. Prior Approval

Prior approval for Intensive Support Coordination services is authorized by the Department of Behavioral Health and Developmental Disabilities' (DBHDD) Regional Offices.

707. Basis for Reimbursement

Reimbursement is based on a monthly unit of service. A unit of service is individually defined for each member in their Individualized Service Plan. A minimum unit must include one face-to-face contact per month, but some ISP's may dictate that a member must be seen at a higher frequency. The provider must bill only for the months of service during which the specified contacts are delivered.

The rate of reimbursement for a unit of service is a flat fee of $461.00 per month with a limit of 12 units per year per member ($5,532 annual maximum). The Intensive Support Coordinator must meet and document the frequency of contacts defined in the ISP in order to bill for the services.

Intensive Supports Coordination – T2022 U1: $461.00 per member per month

The following apply to both Support Coordination Services and Intensive Support Coordination Services:

Participant-Direction Options

Support Coordination and Intensive Support Coordination Services are not eligible for delivery through the participant-direction option.

For details on participant-direction, see *Part II Policies and Procedures for COMP/NOW Waiver Program Chapter 1200*.

Incident Reporting Requirements: In addition to the incident reporting requirements for all providers specified in *Part II Policies and Procedures for COMP*, Support Coordination Providers must require Support Coordinators to complete a critical incident report if it is questionable that a service provider completed the necessary report.

Fair Hearings Notification Requirements: Support Coordination Providers must require Support Coordinators to provide notification to participants of their rights to request a Fair Hearing if there are any denials, suspensions, reductions or terminations of waiver services, as a result of Support Coordination action.

Agency Policies and Procedures: Support Coordination Providers must develop written policies and procedures to govern the operations of Support Coordination services in accordance with all requirements for these services. These policies and procedures must address how the agency assures Support Coordination services meet participant and family preferences.

DBHDD Contract/LOA and DBHDD Community Service Standards: Support Coordination Providers must adhere to DBHDD Contract/LOA, all applicable DBHDD Community Service Standards and other DBHDD Standards, including certification by the DBHDD (see *Part II Policies and Procedures for COMP, Chapter 603*).

Participant-Direction Options

Support Coordination and Intensive Support Coordination Services are not eligible for delivery through the participant-direction option.

For details on participant-direction, see *Part II Policies and Procedures for COMP/NOW Waiver Program Chapter 1200*.

General Reimbursement Guidelines for Support Coordination and Intensive Support Coordination

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications
- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

Click on "Provider Enrollment/Provider Contract Status." Enter Provider ID or NPI and provider's last name.

CMS 1500 Claim Form

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information." Providers will be required to use the revised CMS 1500 claim form (version 02/12) for claims. The revised CMS 1500 form contains a number of changes. These changes includes but are not limited to references to ICD-10 codes, identification of Ordering, Prescribing, and Referring providers, and the expansion of number of possible diagnosis codes on a claim.

APPENDIX A

GEORGIA HEALTH PARTNERSHIP (GHP)

HP Enterprise Services

Provider and Member Services
P.O. Box 105200
Tucker, GA 30085-5200

Electronic Data Interchange (EDI)
1-877-261-8785

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/ Internet Protocol (TCP/IP)

Provider Inquiry Numbers:

~ 800-766-4456 (Toll free)

The web contact address is http://www.mmis.georgia.gov

APPENDIX B

REGIONAL OFFICE OF DBHDD CONTACT LIST

DBHDD Region 1	DBHDD Region 2	DBHDD Region 3
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
Allen.Morgan	Karla Brown	
Allen.Morgan@dbhdd.ga.gov	KBBrown8@dbhdd.ga.gov	
1230 Bald Ridge Marina Road	3405 Mike Padgett Highway	3073 Panthersville Rd
Suite 800	Building 3	Building 10
Cumming, Georgia 30041	Augusta, Georgia 30906	Decatur, Georgia 30034
Phone 678-947-2818	Phone 706-792-7733	Phone 404-244-5050
Fax 678-947-2814	FAX 706-792-7740	
Toll Free 1-877-217-4462	Toll Free 1-866-380-4835	

DBHDD Region 4	DBHDD Region 5	DBHDD Region 6
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
Michael Bee	Katherine McKenzie	**Valona Baldwin**
MBee@dbhdd.ga.gov	Katherine.McKenzie@dbhdd.ga.gov	vjbaldwin@dbhdd.ga.gov
P.O. Box 1378	1915 Eisenhower Dr., Building 2	3000 Shatulga Rd., Bldg. 4
Thomasville, Georgia 31799-1378	Savannah, GA 31406	P.O. Box 12435
Phone 229-225-5099	Phone: 912-303-1670	Columbus, Georgia 31907-2435
FAX 229-227-2918	FAX: 912 303-1681	Phone (706)565-7835
Toll Free 1-877-683-8557	Toll Free 1-800-348-3503	FAX (706)565-3565

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APPENDIX C
GEORGIA FAMILIES

Georgia Families (GF) is a statewide program designed to deliver health care services to members of Medicaid and PeachCare for Kids®. The program is a partnership between the Department of Community Health (DCH) and private Care Management Organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes. In addition, each CMO may contract with a behavioral health or therapy service organization in order to coordinate physical and mental health services to improve member care, coordination, and efficiency.

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid as well as new services. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education.

The Department of Community Health has contracted with three CMOs to provide these services: **Amerigroup Community Care, Peach State Health Plan and WellCare of Georgia**.

Members can contact Georgia Families at **www.georgia-families.com** or call **1-888-GA-ENROLL** (1-888-423-6765) for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

CMOs

Amerigroup Community Care	**Peach State Health Plan**	**WellCare of Georgia**
800-600-4441	800-704-1484	866-231-1821
www.myamerigroup.com	www.pshpgeorgia.com	www.wellcare.com

Children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families.

Georgia Families Regions

Region	Counties	Health Plans
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
East	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Southeast	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Southwest	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth	Amerigroup Community Care Peach State Health Plan WellCare of Georgia

Georgia Families Eligibility Categories

Included Populations	Excluded Populations
PeachCare for Kids®	**Nursing home**
Low-Income Medicaid (LIM)	**Federally Recognized Indian Tribe**
Right from the Start Medicaid (RSM)	**Georgia Pediatric Program (GAPP)**
Women's Health Medicaid (WHM)	**Community Based Alternative for Youths (CBAY)**
Transitional Medicaid	**Children's Medical Services program**
Refugees	**Medicare Eligible**
Planning for Healthy Babies	**Supplemental Security Income (SSI) Medicaid Medically Needy**
Resource Mother's Outreach	**Long-term care**
Children (Newborn)	
Breast and Cervical Cancer	

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
800-454-3730 (general information) 888-821-1108 (provider recruitment) www.amerigroupcorp.com	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact Hewlett Packard (HP) at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:
The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. HP will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

A Medicaid provider makes a business decision whether to participate in one, two or all three health plans. To participate in a health plan, the provider must be enrolled in Medicaid and sign a contract and be credentialed by the health plan. Each health plan has its own contracting procedures and credentialing requirements. If a provider is interested in participating with a health plan, he/she should contact the plan's provider enrollment department.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to HP in error:

HP will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. **Monday** Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Tuesday and Friday.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare

Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy:** Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day).	For further information, please refer to the Peach State website, or the Peach State provider manual.	website, the WellCare provider manual, or contact Customer Service at 866-231-1821.

How often can a patient change his/her PCP?

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
Anytime	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Anytime

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
Next business day	PCP changes are updated in Peach State's systems daily.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about the who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
888-821-1108	866-874-0633	866-231-1821
www.amerigroupcorp.com	www.pshpgeorgia.com	https://georgia.wellcare.com/

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup	Caremark	610415	PCS
Peach State Health Plan	US Script	008019	Not Required
WellCare	CatamaranRx	603286	01410000

If a patient does not have an identification card:
Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through HP by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. HP will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730, option 3, option 3	1 (866) 874-0633	1 (866) 269-5251 (phone) 1 (866) 455-6558 (fax)

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APPENDIX D
NON-EMERGENCY TRANSPORTATION BROKER SYSTEM

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950**.

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett

Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

Rev.
04/01/14

APPENDIX E
Limitations on Billing of Case Management

Definition

Case Management Services means services which will assist Medicaid eligible individuals to gain access to needed medical, social, educational and other services. Such services include but are not limited to, the following:

- Assessment of eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical educational, social or other services.
- Development of a specific care plan based on the information collected through assessment; that specifies the goals and actions to address the medical, social, educational and other services needed by eligible individuals.
- Referral and related activities to help and individual obtain needed services.
- Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual.

Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for case management services to more than one agency or Medicaid provider that renders case management services to an individual. This policy is set forth according the federal Requirements and Limits Applicable to Specific Services defined in the State Medicaid Manual, section 4302.

It is the responsibility of the case manager to ensure that the member is not receiving case management services from any other agency. The case manager must obtain from the member information regarding any and all other services that he/she may be receiving prior to enrolling the member in a case management program. If the case manager should learn that the member is enrolled in another case management program, the case manager is advised not to render any case management services until it is verified that his/her case management services are primary. This may require termination of the member from another case management provider before case management from the new provider can be billed. It is the case manager's responsibility to advise the member of the various case management choices available to the member and to allow the member to make an affirmative choice among them.

Basis for Reimbursement

DCH will reimburse only one provider agency for case management services. The Department has established the case management hierarchy below to define which case management is primary and will be reimbursed. The Department's billing system has been modified to include edits to ensure the hierarchy is followed in the case of billing from more than one case management provider. The case management provider highest on the hierarchy will be reimbursed if 2 case managers should submit claims for the same month of service.

1) COS 830 - (Case Management Organization – CMO)
2) COS 851 - (SOURCE Case Management)
   COS 930 - (SOURCE Case Management)
3) COS 660 - (Independent Care Waiver)
   COS 680/681 (New Options Waiver/Comprehensive Supports Waiver)
4) COS 442 - (C-Bay)
5) COS 764 - (Child Protective Services Targeted Case Management)
6) COS 800 - (Early Intervention Case Management)
7) COS 765 - (Adult Protective Services Targeted Case Management)
8) COS 763 - (At Risk of Incarceration Targeted Case Management)
9) COS 762 - (Adults with AIDS Targeted Case Management)
10 COS 790 - (Rehab Services/DSPS)
11) COS 960 - (Children Intervention School Service)

NOTES: Persons enrolled in hospice have case managers who manage all of their care and may not receive case management from any other program while enrolled in hospice. The Department's hospice lock-in system will automatically cause any other claims for case management to be denied.

APPENDIX F
Georgia Families 360^{0} SM,

Information for Providers Serving Medicaid Members
in the Georgia Families 360^{0} SM Program

Georgia Families 360^{0} SM, the state's new managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360^{0}SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360^{0} SM members will also have a medical and dental home to promote consistency and continuity of care. Providers, foster parents, adoptive parents and other caregivers will be involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management will focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

Individual Quality Outcome Measures Review

Individual's Name:			CID#:		
Physical Address:	(pulls from member page physical address not agency address)				
Location of visit:	Choose an item.				
Date of visit:		Start Time:		End Time:	
Note Code:	Choose an item.				
Contact Type:	Choose an item.	Contact	Choose an item.	Billable Event:	Choose an item.
ADA Population	Choose an item.	Funding	Choose an item.	Exceptional	Choose an item.
Service Monitoring:	Choose an item.				
HRST Score:	(pulls from members HRST score)		Date of Last HRST:		

Individual Support Plan Focus Areas

Directions: For each section, check if the services/supports are being provided in an adequate manner or if there are concerns or deficits. In the *Comment/Actions Needed* box, list identified *Concerns, Barriers and Successes* for each section. Additionally, describe any steps being taken to address any concerns/issues observed.

	Focus Area	Select:	Comments/Actions Needed:
Environment			**Concerns, Barriers, Successes**
1	Is the home/site accessible to the individual?	Select	
2	Does the individual have access to privacy; including, but not limited to, personal care, visitors, discussions, mail, and/or other communications?	Select	
3	The home setting allows the individual the option to have a private bedroom.	Select	
4	Are all assistive technologies being utilized as planned and in good working order?	Select	
5	Does the individual have adequate clothing, food, and supplies available to accommodate the individual's needs and/or preferences/choices?	Select	
6	Is the Residential/Day setting clean, safe and appropriate for the individual's needs and preferences?	Select	
Appearance/Health			
7	Does the individual appear healthy and safe? Describe appearance and any changes since the last visit.	Select	
8	Have there been any changes observed or reported in health since the last visit? If yes, describe the change(s) and indicate if the HRST is aligned with the current health and safety needs of the individual.	Select	
9	Are the ISP, healthcare plans, nursing plans, medical crisis plans current and available to staff? Are they being implemented? Are nursing hours being provided as indicated on the ISP?	Select	

10	Are all medical/ therapeutic appointments and follow-up appointments, recommendations/orders and required assessments/ evaluations, being attended, followed, and/or completed, as ordered?	Select	
11	Has the individual had any hospital admissions and/or emergency room visits since the last visit? If so, have discharge plan instructions been followed?	Select	
Supports and Services			
12	Do the individual's paid staff and/or natural supports treat them with respect and dignity?	Select	
13	Are supports and services being delivered to the individual, as identified in the current ISP? Are staff ratios in place, as indicated in the ISP?	Select	
14	Is the individual being supported to make progress in achieving their goals (both ISP goals and informally expressed goals)? Indicate the status of the individual's progress toward achieving established goals.	Select	
15	Are there any additional service/support needs not being met at this time? Describe.	Select	
Behavioral and Emotional			
16	Since the last visit, are there any emerging or continuing behavioral/ emotional responses for the individual? If yes, are current supports adequate to prevent engaging external interventions?	Select	
17	Does the individual currently have an implemented Behavioral Support Plan, Crisis Plan, and/or Safety Plan? Is/Are the plan(s) available on site for staff review? (Evidence of implementation includes staff being knowledgeable about plan and ability to describe how they are implementing the plan.)	Select	
18	Since the last visit, has the individual accessed the DD crisis system, psychiatric hospital, crisis stabilization unit, ER, or had contact with law enforcement for behavioral issues? If yes, describe reason, frequency, duration of any admissions, and if discharge recommendations have been followed. As a result, has the BSP/Safety Plan/Crisis Plan been adapted to reflect any new recommendations or interventions needed?	Select	
Home/Community Opportunities			
19	Does the individual have people in his/her life other than paid staff and do they have community connections? Describe current natural supports and how/where the individual is connected to that person or group. Describe steps being taken to further develop natural supports.	Select	

20	Is the individual receiving services in a setting where he/she has the opportunity to interact with people who do not have disabilities (other than paid staff)? Is the individual being offered/provided documented opportunities to participate in activities of choice with non-paid community members?	Select	
21	Does the individual have the opportunity to participate in activities he/she enjoys in their home and community? Describe steps being taken to increase opportunities to meet this objective and allow choices to be offered while in services.	Select	
22	Is the individual actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities, if desired? Is yes, note how he/she is supported to do so. If no, how is the issue being addressed?	Select	
23	Does the individual have the necessary access to transportation for employment and community activities of his/her choice?	Select	
Financial			
24	Are there barriers in place that limit the individual's access to spend his/her money, as desired?	Select	
Satisfaction			
25	How did the individual communicate their overall satisfaction with their life activities during the visit (include providers, services, family, etc.)? Does the individual express/indicate satisfaction with current supports and services? Describe any dissatisfaction with current supports and services.	Select	

Observations/Comments:

SC Signature Date

Directions: For each focus area item, follow the steps below.

Be mindful that this review is a snapshot of what has occurred with the waiver participant from the time of the previous review until the time of this review (ex. within the past month, within the past quarter).

GATHER INFORMATION

- ✓ Observe and interact with the individual as it relates to the focus area item reviewed
- ✓ Observe the environment for evidence pertaining to the item reviewed
- ✓ Review any pertinent documentation relating to the item reviewed
- ✓ Engage in discussion with staff members or natural supports who may have information on the item reviewed. Observe staff/natural supports' interaction with the individual as it relates to the item reviewed.

OUTCOME EVALUATION: RECOGNIZE, REFER and ACT

- ✓ If all *essential elements* of the item have been met without concern and services/supports are being provided in an adequate manner, select ***Acceptable***. Describe in the ***Comments*** section how your review led you to assess the item as ***Acceptable***.
- ✓ If there are Successes or Positive Outcomes identified in any area of the review, enter details within the ***Comments*** box.
- ✓ If a concern/issue/deficit presents and it appears that the same finding can be captured in multiple items, capture the information in the item where it is most evident. Do not open ***Coaching/Referrals*** for multiple items for the same finding. In the ***Comments*** for the additional item(s), indicate "See coaching/referral for #__.
- ✓ For every concern/issue/deficit identified on any item, ask the provider/natural support if there is a plan in place to correct the issue identified (either at the time of the visit or after the visit, as a follow-up call to the appropriate party). If there is a plan in place to correct the identified issue and the plan includes a reasonable time frame (based on the SC's judgment), the SC should work together with the provider/natural support to decide on a target closure date. The time frame must align with the severity of the issue identified.
- ✓ If there are concerns/issues/deficits relating to the item reviewed, describe them in detail in the ***Comments*** box. Additionally, describe any steps being taken by the provider or natural support to address any concerns/issues/deficits observed and any barriers they have encountered in resolving the issue.
- ✓ Suggestions for ***Coaching/Referrals*** and ***Target Closure Dates*** are suggestions only. Please use your professional judgment to determine if the risk associated with the concern/issue/deficit warrants an earlier closure date or a more immediate action needed. Consult with your SC Supervisor, if there are ***ANY*** questions relating to risk tolerance.
- ✓ It is implicit in the ***Recognize, Refer and Act*** process that all SC's will provide ***Coaching*** in conjunction with any ***Referral*** opened. SC's should discuss with a provider why a referral is being made and coach them on developing a plan to resolve the issue.
- ✓ For every open ***Coaching*** or ***Referral***, the SC is responsible for adding a note in CIS about the progress toward resolving the concern/issue/deficit at a minimum of ***every month*** until it is closed.
- ✓ If a reportable critical incident is identified, the SC is required to follow the steps outlined in ***DBHDD Policy 04-106 - Reporting and Investigating Deaths and Critical Incidents in Community Services*** (https://gadbhdd.policystat.com)

Environment	Concerns Identified *(Essential Elements)*	Coaching/Referral Suggestions	Suggested Target Date for Closure

1	**Is the home/site accessible to the individual?**	Barriers preventing safe exit from the home (fire hazard)	**Non-Clinical Referral- Unaccepatable with critical deficiencies**	**Refer to FO** **60 days**
		Isolation as the result of internal barriers	**Non-Clinical Referral- Unaccepatable with critical deficiencies**	**Refer to FO** **60 days**
		Internal barriers that present safety hazards (ex. 2nd floor bedroom)	**Coaching-Acceptable with non-critial deficiencies**	**90 days** (Then Non-Clinical Referral)
		Barriers to internal access limiting independence and full use of the residence/site	**Coaching-Acceptable with non-critial deficiencies**	**90 days** (Then Non-Clinical Referral)
		Restrictions limiting free access to parts of the home (locks, signs or staff limiting presence in certain areas)	**Non-Clinical Referral- Unaccepatable with critical deficiencies**	**30 days** (Then Refer to FO)
		Bathroom modifications needed for safety	**Coaching-Acceptable with non-critial deficiencies**	**90 days** (Then Non-Clinical Referral)
		Smaller modifications needed for safety and independence (grab bars, non-slip mats)	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
		Modifications needed relating to hearing/visual impairments.	**Non-Clinical Referral- Unaccepatable with critical deficiencies**	**Refer to FO** **30 days**
2	**Does the individual have access to privacy; including, but not limited to, personal care, visitors, discussions, mail, and/or other communications?**	Another resident is consistently intruding on the individual's private bedroom without permission (Is staff redirecting the other resident to prevent their access?)	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
		Individual indicates that staff person is consistently entering their bedroom without receiving permission	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
		Individual is prevented from having private conversations without eavesdropping	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
		Individual is provided personal care supports in a manner that does not allow for dignity and privacy	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
		Individual is not allowed privacy to meet with visitors	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)

		Individual has cognitive capacity to receive/review their own mail, but staff are not allowing access	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Then Non-Clinical Referral)
3	**The home setting allows the individual the option to have a private bedroom.**	Individual wants to have a private bedroom and does not have a private bedroom	**Coaching-Acceptable with non-critial deficiencies**	**90 days** (then Non-Clinical Referral)
		If it is the individual's choice to share a bedroom with someone (free of coercion), no action is needed.		
4	**Are all assistive technologies being utilized as planned and in good working order?**	Individual has assistive technology, but they are not being supported to use it as indicated	**Coaching-Acceptable with non-critial deficiencies**	**60 days** (then Clinical Referral)
		Individual has assistive technology, but it is broken or not in good working order	**Coaching-Acceptable with non-critial deficiencies**	**60 days** (then Clinical Referral)
		Individual does not have needed assistive technology or the AT they have is not appropriate for their needs	**Clinical Referral-Unaccepatable with critical deficiencies**	**60 days** (Assessment Needed)
5	**Does the individual have adequate clothing, food, and supplies available to accommodate the individual's needs and/or preferences/choices?**	Food is not in adequate supply	**Coaching-Acceptable with non-critial deficiencies**	**24 hours** (then Non-Clinical Referral)
		Individual's access to food is restricted without a doctor's order related to diet or indication in ISP	**Coaching-Acceptable with non-critial deficiencies**	Resolution needed in **24 hours.** If doctor order or ISP addendum needed, need plan to correct within **72 hours**
		Individual is unsatisfied with availability of food options/choice	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Coach provider to increase reasonable choice. If ongoing, Nonclinical referral after 30 days)
		Limited access to clothing or limited supply of options of needed clothing	**Coaching-Acceptable with non-critial deficiencies**	**7 days** (If not resolved, Non-clinical referral)
		Household toiletry items, clean linens or other supplies not available, as needed	**Coaching-Acceptable with non-critial deficiencies**	**7 days** (If not resolved, Non-clinical referral)
6	**Is the Residential/Day setting clean, safe and appropriate for the individual's needs and preferences?**	Cleanliness concerns observed	**Coaching-Acceptable with non-critial deficiencies**	**72 hours** to resolve or develop plan to correct (Non-Clinical referral if not resolved)

6	**Is the Residential/Day setting clean, safe and appropriate for the individual's needs and preferences?**	Safety concerns observed	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**72 hours** to resolve or develop plan to correct (Referral sent to FO, if not resolved)
		Furnace is not working and the temperature consistently falls below 65 F or the air conditioner is not working and the temperature consistently rises above 85 F (or if it does not meet the individual health needs of the residents)	**Non-Clinical Referral - Unacceptable with immediate interventions**	Provider must have a plan to resolve immediately or it must be referred to FO for an alternate placement to be identified
		The residence does not have working plumbing or electricity	**Non-Clinical Referral - Unacceptable with immediate interventions**	Provider must have a plan to resolve immediately or it must be referred to FO for an alternate placement to be identified.
		A fire, flood or natural disaster has occurred, making the home uninhabitable, and there is no immediate plan for temporary or permanent relocation	**Non-Clinical Referral - Unacceptable with immediate interventions**	Refer to FO for an alternate placement to be identified.
		Setting is not appropriate for the individual – opportunities offered are no consistent with their interests and/or level of cognitive/intellectual functioning	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**Referral to SC** ("not associated with any provider") to seek additional providers or other services that are more appropriate. Enter note on progress every **30 days** at minimum.
Appearance/Health		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
7	**Does the individual appear healthy and safe? Describe appearance and any changes since the last visit.**	It is evident during observation that the participant has visible signs of emerging medical needs or vocally complains of a health issue, pain, etc. Provider must immediately attend to the participant's health needs.	**Clinical Referral-Unaccepatable with critical deficiencies**	SC must use clinical judgment – If this was your child/family member, what would be the time frame with which response is needed?
		It is evident during observation that the participant is unsafe or vocally complains of feeling unsafe. Provider must immediately attend to the participant's safety needs.	**Clinical Referral-Unaccepatable with critical deficiencies**	SC must use clinical judgment – If this was your child/family member, what would be the time frame with which response is needed?
		If provider is already taking reasonable steps to intervene – Coaching is appropriate. If not, Clinical Referral is appropriate.		

8	**Have there been any changes observed or reported in health since the last visit? If yes, describe the change(s) and indicate if the HRST is aligned with the current health and safety needs of the individual.**	There have been changes in health, but records (including HRST) are not reflecting those changes.	**Coaching-Acceptable with non-critial deficiencies**	Allow **14 days** to update all records to meet standard. After, make **Clinical Referral – No Action Necessary**
		Individual is not receiving timely, appropriate care in response to changes in health and there is only minor health risk (ex. hygiene impact on health)	**Coaching-Acceptable with non-critial deficiencies**	**30 days**
		Individual is not receiving timely, appropriate care in response to changes in health and there is major health risk	**Clinical Referral-Unacceptable with immediate interventions**	**48 hours**
9	**Are the ISP, healthcare plans, nursing plans, medical crisis plans current and available to staff? Are they being implemented? Are nursing hours being provided as indicated on the ISP?**	Nursing hours are not being delivered as ordered in ISP	**Clinical Referral-Unacceptable with immediate interventions**	**Report to FO**
		Needed plans are expired	**Clinical Referral-Unaccepatable with critical deficiencies**	**48 hours** (Report to FO after 72 hours)
		Needed plans are not available for review by staff in the home	**Coaching-Acceptable with non-critial deficiencies**	**48 hours** (Referral after 72 hours)
		Plans are available, but not implemented	**Coaching-Acceptable with non-critial deficiencies**	**48 hours** (Referral after 72 hours)
10	**Are all medical/ therapeutic appointments and follow-up appointments, recommendations/ orders and required assessments/ evaluations, being attended, followed, and/or completed, as ordered?**	An appt is needed or was previously recommended and the provider failed to make the appointment	**Coaching-Acceptable with non-critial deficiencies**	**48 hours** (Referral after 72 hours) **Option to extend Coaching if provider is making progress toward arranging the appt.)*
		Medical appt is an immediate need and provider is non-responsive	**Clinical Referral-Unacceptable with immediate interventions**	**Report to FO**
		Recommendations were made as the result of a medical appt and the provider is non-responsive in following through with needed actions	**Clinical Referral-Unacceptable with immediate interventions**	**Report to FO**

11	**Has the individual had any hospital admissions and/or emergency room visits since the last visit? If so, have discharge plan instructions been followed?**	Provider has not followed discharge instructions and have no explanation as to why they did not abide.	**Clinical Referral-Unaccepatable with critical deficiencies**	**7 days**
		Discharge instructions were not followed due to provider's lack of understanding of their responsibilities in the instructions. *(If SC is unable to assist through Coaching, then Clinical Referral needed)*	**Coaching-Acceptable with non-critial deficiencies**	**48 hours** (Referral after 72 hours) **Must show progress for extension of coaching*
Supports and Services		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
12	**Do the individual's paid staff and/or natural supports treat them with respect and dignity?** **Purely observation*	Staff/Family are observed to be communicating with the individual in a manner that is demeaning, intimidating or unreasonably harsh.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** *If ongoing, may be a reportable incident due to verbal/emotional abuse.* ***Policy 04-106***. Non-Clinical Referral to FO for disposition
13	**Are supports and services being delivered to the individual, as identified in the current ISP? Are staff ratios in place, as indicated in the ISP?**	Per ISP, individual is supposed to have enhanced staffing or 1:1 staffing due to exceptional medical or behavioral support needs and the observed staff ratio is deficient.	**Clinical Referral-Unacceptable with immediate interventions**	**Refer to FO**
		Services ordered in the ISP are not being delivered (ex. Van at CAG is broken, so they have not been attending; lapse in staff for CAI or CLS)	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**60 days** *******Inquire about the plan to re-initiate service delivery. If plan includes shorter timeframe, adjust.*
		Per CAG policy, individuals are being supported in excess of the approved ratio	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**60 days**
		Staff are not providing supports as identified in the ISP; Staff are performing duties not intended for the service	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (If not resolved, Non-Clinical Referral)
		Deficits in staff performance of necessary duties relating to the needed supports/services; Inadequate staff training on individual's support needs.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (If not resolved, Non-Clinical Referral)
		****Coaching is on a continuum of steps**** *1) Are staff knowledgeable about the individual's ISP?* *2) Is there clarity on staff responsibilities? (If not, staff's manager to provide direction)* *3) Are there training needs to support those responsibilities?*		

14	**Is the individual being supported to make progress in achieving their goals (both ISP goals and informally expressed goals)? Indicate the status of the individual's progress toward achieving established goals.**	Staff do not know what the individuals goals are or they do not understand the intent of the goal(s)	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Non-Clinical Referral after 60 days)
		Staff do not know how to implement supports to assist the individual in achieving the goal(s)	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Non-Clinical Referral after 60 days)
		Staff do not understand the individual's preferences, hopes and dreams.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Non-Clinical Referral after 60 days)
		Staff are observed to be uninterested in assisting the individual in goal achievement.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Non-Clinical Referral after 60 days)
15	**Are there any additional service/support needs not being met at this time? Describe.**	A change in service is needed (CAG to PV/SE, CAG to CAI, CLS to CAG, etc)	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**Referral to SC to addend ISP**
		There are unmet needs and non-clinical services need to be added	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**Referral to FO for Assessment Update**
		There are unmet needs and non-clinical services need to be added	**Clinical Referral-Unaccepatable with critical deficiencies**	**Referral to FO for Assessment Update**
Behavioral and Emotional		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
16	**Since the last visit, are there any emerging or continuing behavioral/ emotional responses for the individual? If yes, are current supports adequate to prevent engaging external interventions?** **Inquire about any significant life changes that may have led to these responses*	If yes, and supports are not adequate, *AND* the individual is currently in jail or a hospital	**Clinical Referral-Unacceptable with immediate interventions**	**Refer to FO**
		If yes, and supports are not adequate, *AND* individual is currently at home, make a referral and then coach on use of *GA Crisis Response System*	**Clinical Referral-Unaccepatable with critical deficiencies**	**30 days** (Contact weekly)
		****Target closure date is flexible – based on capacity to find BSC to develop a BSP***		
17	**Does the individual currently have an implemented Behavioral**	The individual has a plan, but the plan is not on site or available for review by SC/staff.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Non-Clinical Referral after 60 days)

	Support Plan, Crisis Plan, and/or Safety Plan? Is/Are the plan(s) available on site for staff review? (Evidence of implementation includes staff being knowledgeable about plan and ability to describe how they are implementing the plan.)	Staff are not knowledgeable about the plan(s) and it is evident that more training is needed.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Clinical Referral to FO to work with provider on responding to training needs)
		Staff are knowledgeable about the plans and are attempting to implement interventions, but the interventions are not effective.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (Coaching to provider BSC to do a plan review to determine more appropriate interventions. Clinical Referral to FO if provider BSC is not responsive within 30 days)
18	**Since the last visit, has the individual accessed the DD crisis system, psychiatric hospital, crisis stabilization unit, ER, or had contact with law enforcement for behavioral issues? If yes, describe reason, frequency, duration of any admissions, and if discharge recommendations have been followed. As a result, has the BSP/Safety Plan/Crisis Plan been adapted to reflect any new recommendations or interventions needed?**	Discharge recommendations have not been followed.	**Coaching-Acceptable with non-critial deficiencies**	**7 days** *Determine if training is needed. If yes, Clinical Referral.
		BSP/Safety Plan/Crisis Plan needs to be adapted based on recent incident(s), but it has not been updated.	**Coaching-Acceptable with non-critial deficiencies**	**14 days** (If not resolved, Clinical Referral)
Home/Community Opportunities		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
19	**Does the individual have people in his/her life other than paid staff and do they have community connections? Describe current natural supports and**	The individual has no/few natural supports or community connections and there are no steps being taken to assist them with developing these connections.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)

	how/where the individual is connected to that person or group. Describe steps being taken to further develop natural supports.	The individual has natural supports or community connections, but the provider is not supporting the individual to maintain them (or actively preventing them from maintaining them).	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)
20	**Is the individual receiving services in a setting where he/she has the opportunity to interact with people who do not have disabilities (other than paid staff)? Is the individual being offered/provided documented opportunities to participate in activities of choice with non-paid community members?**	The service setting does not allow the individual to interact with people who do not have disabilities (other than paid staff)	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)
		The individual is not being offered opportunities to participate in activities of choice with non-paid community members.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)
		***Inquire what the provider is doing to address the concern and identify next steps.**		
21	**Does the individual have the opportunity to participate in activities he/she enjoys in their home and community? Describe steps being taken to increase opportunities to meet this objective and allow choices to be offered while in services.**	The individual is not being offered opportunities to participate in activities he/she enjoys in the home and/or community.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)
22	**Is the individual actively supported to seek and/or maintain employment in competitive and integrated settings and/or offered customized opportunities, if desired? Is yes, note how he/she is supported to do so. If no, how is the issue being addressed?**	The individual desires employment and is not being actively assisted in seeking prevocational, supported employment or competitive employment opportunities.	**Coaching-Acceptable with non-critial deficiencies**	**30 days** (After 60 days, Non-Clinical Referral)

23	**Does the individual have the necessary access to transportation for employment and community activities of his/her choice?**	The individual does not have access to needed transportation. *Inquire about providers plans to resolve the barrier.	**Coaching-Acceptable with non-critial deficiencies**	14 days (Review natural supports for transportation options in interim)
		Work with the provider in the short-term to problem-solve and assist with researching options. If there is no reasonable plan in place to resolve, Non-Clinical Referral to FO for I&E SW Assessment update.		
Financial		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
24	**Are there barriers in place that limit the individual's access to spend his/her money, as desired?**	There is evidence of financial exploitation or intentional theft of monies in the individual's name.	**Non-Clinical Referral-Unaccepatable with critical deficiencies**	**Refer to FO**
		Individual is being charged room and board expenses that are higher than what is appropriate for the setting. Or personal funds for multiple residents are being co-mingled. ***See Policy 02-702**	**Coaching-Acceptable with non-critial deficiencies**	Allow **30 days** for provider to comply and return funds to their proper place. If not, Non-Clinical Referral directly to DBHDD DAC
		Individual is being limited from spending their personal funds as they desire.	**Coaching-Acceptable with non-critial deficiencies**	**30 days**
Satisfaction		**Concerns Identified *(Essential Elements)***	**Coaching/Referral Suggestions**	**Suggested Target Date for Closure**
25	**How did the individual communicate their overall satisfaction with their life activities during the visit (include providers, services, family, etc.)? Does the individual express/indicate satisfaction with current supports and services? Describe any dissatisfaction with current supports and services.**	Individual expresses dissatisfaction.	**Coaching-Acceptable with non-critial deficiencies**	A plan to resolve dissatisfaction must be in place within **30 days** ***Closure date will vary based on many factors***
		ACTIONS: **1) Identify the component with which the individual is dissatisfied.** **2) Identify the level of dissatisfaction to determine urgency of the request for change.** **3) Identify is the provider is actively engaged in improving the individual's satisfaction** **4) Identify is something can be done to resolve the dissatisfaction or if a change in services or provider is needed.** **5) SC to assist the provider in making a plan to change the manner in which services/supports are delivered or who is delivering the service/support.**		

New Support Coordination Method of Quality Outcome Evaluation

- As of July 1, 2016, support coordinators will be using a new form to evaluate outcomes and service delivery for waiver participants. This review is called the ***Individual Quality Outcome Measures Review***.

- The ***Outcome Review*** uses a new model for evaluating holistic outcomes for waiver participants. Focus Areas include: *environment, appearance and health, supports and services, behavioral and emotional state, home and community opportunities, financial condition,* and *overall satisfaction*. Support coordinators will continue to evaluate service delivery based on individualized service plans, but the new review method will a focus quality outcomes.

- The ***Recognize, Refer, and Act*** model is taking the place of the previously used Monitoring Tool Rating system. Rather than rating providers on a 1-to-4 scale, support coordinators will be evaluating service delivery and individual outcomes bases on the principles outlined below.

  Recognize Refer and Act involves recognizing concerns, unmet needs, and impending risks, and responding by either providing coaching, making referrals to an appropriate party, or directly linking—or advocating on behalf of—the individual to the most appropriate resources.
  Each focus area on the ***Individual Quality Outcome Measures Review*** will be evaluated based on the following criteria:

  1. *Acceptable:* *All elements of the focus area have been met satisfactorily, and services/supports are being provided in an adequate manner; no concerns to report.*
  2. *Coaching:* *An opportunity for the support coordinator and the provider/natural support system to collaborate on a resolution to a concern prior to informing the DBHDD field office. Based on the risk to the individual, the support coordinator will work with the provider to determine an appropriate timeframe for a resolution <u>before</u> referral is needed.*
  3. *Non-Clinical Referral—Critical:* *Coaching efforts have not been successful in resolving the issue, and assistance from the field office is needed.*
  4. *Clinical Referral—Critical:* *Coaching efforts have not been successful in resolving the issue, and assistance from field office clinicians or the integrated clinical support team is needed.*
  5. *Clinical or Non-Clinical Referral—Immediate Interventions Needed:* *The person is at imminent health and/or safety risk, and the field office must be informed immediately to assist with resolution.*

- Unlike the previous rating model, the results of any one ***Outcome Review*** do not necessarily result in any corrective action.

- A primary goal is to encourage a collaborative relationship between the support coordinator, provider agency staff, natural supports, and DBHDD staff. This collaboration serves as a pathway to identify an individual's unmet needs, work together to reduce or eliminate any associated risks, and ultimately achieve the best outcomes for the individual.