

Erie County Board of Mental retardation and Developmental Disabilities

Programs and Services

April 2005

Service and Support Administration Policy

I. PURPOSE

The purpose of this policy is to define the responsibilities and expectations of the Erie County Board of MR/DD (ECBMRDD) for service and support administration (SSA).

II. ELIGIBILITY

- A. The ECBMRDD will provide SSA to the following:
 - 1. Each individual who is applying for or enrolled in a Home and Community Based Waiver (HCBS) waiver
 - 2. Each individual three years of age or older who is eligible for county board services, and requests, or a person on the individual's behalf requests service and support administration.

III. EMPLOYMENT

- A. The ECBMRDD provide SSA by directly employing SSA's or by contracting for SSA services.
- B. SSA's providing services for the ECBMRDD may not be assigned responsibilities for implementing other services for individuals and shall not be employed by or serve in a decision making or policy-making capacity for any other entity that provides programs or services to individuals.

IV. RESPONSIBILITIES

SSA's employed or contracted by the ECBMRDD will act as the single point of accountability and perform the duties listed below:

- A. Eligibility. Establish an individual's eligibility for the services provided and/or administered by the county board.
- B. Enrollment. Explain to the individual, in conjunction with the process of eligibility determination:
 - 1. alternative services available to the individual;
 - 2. due process and appeal rights;
 - 3. right to choose any qualified and willing provider.
- C. Initial Waiver Enrollment. At the time the individual is being considered for enrollment in an HCBS waiver do the following:
 - 1. explain to the individual choice of waiver enrollment as an alternative to ICFMR placement by completing the Freedom of Choice form;
 - 2. explain to the individual feasible alternatives available once enrolled in an HCBS waiver; and,
 - 3. make a recommendation to the waiver eligibility specialist regarding whether the individual meets the criteria for an ICF/MR level of care.

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- D. Assessment. The assessment process is ongoing and functions to provide information that forms the basis of any individual plan development. After the initial request for services and at least annually the SSA will complete or coordinate and ensure the completion of assessments. Below are the minimum assessment process requirements.
1. The initial assessment must begin within sixty calendar days from the date that county board eligibility is established.
 2. The initial assessment begins with a review of available information to determine if other formal or informal evaluations should occur.
 3. A written assessment plan will be developed with the individual requesting services, the legal guardian, and if desired, the advocate of the applicant's choice.
 4. A medical exam current within six months from the date that eligibility was established will be available or be completed.
 5. A functional assessment, which may include a vocational assessment, is required for each individual requesting service. The functional assessment will be performed initially and at least every third year to determine supports/goals for the upcoming year for individuals receiving residential services. In the between years (2) the assessment can be reviewed by the SSA and noted as such. It is important to note the dates of review.
 6. An interview with the individual to determine their likes, dislikes, priorities, and desired outcomes, as well as, what is important to and for the individual, including skill development, health, safety, and welfare needs, as applicable.
 7. Individuals enrolling on a waiver will have additional assessment requirements. A waiver functional assessment appropriate to age and a protective level of care assessment are required annually. These assessments are also part of the annual redetermination for an ICF/MR level of care.
 8. The annual assessment process is to begin 90 days prior to the ISP effective date. Results of assessment should be requested and gathered within 30 days.
 9. The following informal assessments will be performed yearly for everyone with an ISP.
 - a. A review of the most current QA report (residential only).
 - b. Interview/input from current service providers.
 - c. Interview/input from family/advocate.
 - d. Any other informal assessments determined necessary to provide the most comprehensive and person-driven services.
- E. Individual Service Plan (ISP) Completion. An ISP is the written description of the services, supports, and activities to be provided to an individual. The SSA will:

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1. actively involve the individual to be served and their guardian/parent, if applicable, other person(s) selected by the individual, and, when applicable, the provider(s) selected by the individual in the development of the ISP.
 2. ensure the ISP focuses on the individual's strengths, interests, and talents.
 3. ensure the ISP assists the individual to have a meaningful, productive life and develop community connections.
 4. include in the ISP the results of the assessments performed
 5. ensure the ISP identifies all sources of supports, including alternative services and natural supports, available to meet the needs and desired outcomes of the individual.
 6. indicate completion and approval dates on the ISP.
 7. certify by signature and date that an ISP or ISP revision meets approval by, at a minimum, the individual/guardian, providers of service, and the SSA.
 8. indicate in the ISP the type of provider (i.e. job coach, direct care staff, neighbor, parent), the provider entity (Natural Support), frequency, duration (residential and adult services only), and funding source for each service and activity.
 9. identify on the plan the county board SSA.
 10. provide a complete copy of the ISP to the individual/guardian and a copy of relevant sections of the ISP to the individual's providers.
- F. ISP Revisions. The ISP is an evolving document that is based on the changing needs of individuals. The SSA will:
1. convene an ISP meeting within 10 days of a request to review the ISP;
 2. review and revise the ISP under any of the following circumstances: at the request of the individual or a team member, whenever the individual's assessed needs or circumstances change, or as a result of ongoing monitoring, quality assurance reviews, and/or identified trends and patterns of unusual incidents or major unusual incidents;
 3. provide copies of the revised plan to the individual, guardian, and providers.
- G. Due Process. The SSA will do the following:
1. provide the individual with written notification and explanation of the individual's rights to a Medicaid fair hearing if the ISP process results in a recommendation for the approval, reduction, denial, or termination of an HCBS waiver service or Medicaid case management service.
 2. provide an individual with written notification and explanation of the individual's right to use the administrative resolution of complaint process if the ISP process results in the reduction, denial, or termination of a service other than a Medicaid service. Such written notice and explanation shall also be provided to an individual if the ISP process

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results in an approved service that the individual doesn't want to receive, but is necessary to ensure the individual's health, safety, and welfare.

3. review and provide a copy of the ECBMRDD's civil rights policy annually

H. Budgets. The SSA will establish and obtain approval of budgets annually for services based on the ISP for the individual and the individual's assessed needs and preferred ways of meeting those needs. Budgets for Medicaid Waiver services will be based on the Ohio Developmental Disabilities Profile (ODDP). The ECBMRDD may set limits on budgets for Board funded services.

I. Provider selection. The SSA will through objective facilitation assist individuals in choosing vocational, habilitation, and residential providers. The Clearwater Council of Governments (COG) maintains a provider pool that includes all providers's interested in providing residential and supported employment services in Erie County. The COG recruits, provides training to, and monitors compliance of contracted waiver providers. The SSA will do the following:

1. complete a Request For Information (RFI) and submit it to the COG when an individual wants to use the Clearwater COG provider pool to find a certified supported living provider or a certified Medicaid waiver provider.
2. provide the individual information on all providers available to provide a given service when requested by the individual.
3. provide assistance to arrange and conduct interviews with providers of the individuals choosing
4. find someone that can help them choose a qualified provider should they be unable to do so independently
5. assist the individual to contact chosen providers.

J. Coordinating Services. The SSA will ensure that services are effectively coordinated and provided by providers, as identified in the ISP, by facilitating communication with the individual and among providers across settings and systems. The SSA will directly communicate with employees and supervisors of adult day habilitation services, supported living, residential services, vocational services, and transportation services. Relevant sections of the ISP will be shared with providers. Examples of communication include:

1. ISP revisions
2. relocation plans of the individual, including information necessary to determine health, safety, and welfare factors of the proposed living situation
3. hospitalizations or other changes in status that result in suspension or disenrollment from services
4. activities to ensure that services are provided to individuals in accordance with their ISP's and desired outcomes

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5. results of continuous monitoring.
- K. **Continuous Monitoring:** The SSA will provide monitoring in excess of formal QA reviews and formal ISP reviews. Continuous Monitoring includes:
1. maintaining an open line of communication with all providers of service.
 2. maintaining an open line of communication with individuals receiving services.
 3. performing assessments and reviews on a regular basis to insure the needed services are being provided.
 4. performing reviews on a regular basis to ensure that services provided are necessary and included in the ISP.
 5. monitoring behavior support plans and communicating with the behavior support committee to ensure behavior support methods are appropriate, least restrictive, and successful.
 6. providing 24 hour crisis intervention.
 7. identifying trends and patterns of unusual incidents and MUI's. Addressing those trends and patterns through a team process.
 8. participating in formal quality assurance reviews. Reviewing QA reports and addressing recommendations made in the reports with the team.
- L. **Formal Quality Assurance Reviews.** The Clearwater Council of Government (COG) is contracted to formally evaluate all residential services provided through the Board. The Clearwater Council of Governments will conduct a comprehensive quality assurance review of all HCBS Waiver and Supported Living services received by individuals. The reviews shall be conducted as a continuous process and occur no less frequently than at least every three years in conjunction with the individual's ISP update and contract renewal with the provider in accordance with procedures established by the COG. If the report indicates the need to address service issues, the Board shall resolve these issues with input from the affected parties including, but not limited to, the Board, SSA, residential provider, the individual, custodian, parent(s) or guardian, and any other person(s) as desired by the individual.
- M. **Advocacy.** The SSA shall ensure that each individual receiving services has a designated person to provide advocacy who is responsible on a continuing basis for providing the individual with representation, advice, and assistance related to the day-to-day coordination of services in accordance with the ISP. Neither the SSA for the individual or any other person providing SSA shall be the person designated. The SSA shall:
1. give the individual an opportunity, at least annually, to designate such person;
 2. make the designation if the individual declines to do so. If the individual has no such person involved in his/her life, actions shall be

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- specified in the ISP that will lead to the development of a circle of support for the individual;
 3. include the designated person's name in the ISP and describe the level of advocacy requested by the individual;
 4. permit an individual to change at any time the person designated to provide advocacy;
 5. work with the ARC's volunteer advocacy program in Erie County to identify possible candidates to provide this service when individuals do not have another person in their life to fulfill this role.
- N. Crisis Intervention. The county board shall, in coordination with SSA, make an on-call emergency response system available twenty-four hours per day, seven days per week. Persons who are available for the on-call emergency response system shall:
1. provide crisis/emergency intervention directly or through immediate linkage with the SSA.
 2. be trained and have the skills to identify the problem, determine response, ensure health and safety, and identify and contact the person(s) to take the needed action.
 3. notify the SSA to ensure adequate follow-up. The Investigative Agent shall also be notified as determined necessary by the nature of the emergency.
 4. document the emergency in accordance with county board procedures.
- O. Records. Records are maintained by the SSA Department according to the ECBMRDD policy on confidentiality.
- P. Targeted Case Management (TCM) Notes. Each individual receiving case management services from an SSA will have identified in the case note documentation or on a separate service plan the specific needs of the individual to be addressed by the SSA. These needs should be reviewed and assessed at least annually with the individual and their team. TCM notes will include:
1. the date, including year and time of service;
 2. the name of the person for who service is provided;
 3. a narrative description of the service
 4. the TCM form required elements including codes for: contact, service type, service need, location, and identifying whether the service is billable or non-billable
 5. service provider's name, title, signature and initials to correspond with each entry's identifying signature or initials. Initials may be used after narratives if there are multiple entries on a page.

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