My Life,
My Community

Support Coordination

A HANDBOOK FOR DEVELOPMENTAL DISABILITIES WAIVER SUPPORT COORDINATION

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DBHDS
Virginia Department of Behavioral Health
and Developmental Services

VCU
School of Education
Partnership for People
with Disabilities

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Introduction

Introduction

Target Audience

Support coordination/case management is the core service that Virginians with developmental disabilities use to help navigate and make the best use of Virginia's publicly funded system of services. This service is of critical importance in all dimensions of the services system. Strengthening the support coordinator's/case manager's role is essential to ensuring effective and accountable services within the Medicaid Home and Community-Based Services Development Disability (DD) Waivers. The purpose of this handbook is to guide support coordinators in all aspects of their work with people who have a Developmental Disabilities Waiver.

Terms Used in Handbook

Although the terms "support coordinator" (SC), "case manager" (CM), and even "services coordinator" may be used interchangeably, support coordinator is the term most frequently used in regulations and in most of the material and guidance related to developmental disability support coordination/case management services developed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Therefore, support coordinator (SC) and support coordination will be used throughout this handbook. There is a glossary of terms and their acronyms used in this handbook.

Use of this Handbook

This handbook is divided into chapters and sub-chapters. If you wish to go to a particular chapter or sub-chapter listed, you can click on that topic in the Table of Contents and it will take you to the appropriate page.

Virginia's Public Behavioral Health and Developmental Disability System

DBHDS supports individuals needing or receiving services by promoting recovery, self-determination, and wellness in all aspects of life. DBHDS' vision statement is, "A life of possibilities for all Virginians."

DBHDS oversees supports and services for Virginians with developmental disabilities (DD), mental illness (MI)s, and substance use disorders (SUD), and manages day to day operations for the DD Waivers.

The state agency that administers the DD Waivers in Virginia is the Department of Medical Assistance Services (DMAS). Locally, DD Waiver services are coordinated by SCs employed by or contracted through 40 agencies that are referred to as either community services boards (CSBs) or behavioral health authorities (BHAs). The actual services are delivered by CSBs/BHAs and private providers across the Commonwealth.

The following are entities that guide, inform, and support the role of the Support Coordinator:

- State Structure chart: The Big Picture
- Department of Behavioral Health & Developmental Services
- Departments and people to know from the DBHDS
    - Community Resource Consultants (CRC): The CRCs help guide SCs with problem solving and offer training and consultation.
    - Regional Support Specialists (RSS): The regional support unit (RSU) oversees management and implementation of the DD Waivers Waitlist by CSBs, as well as all aspects of waiver slot assignments through the Waiver Slot Assignment Committee (WSAC) process.
    - Service Authorization Consultants (SAC): The SACs authorize requested waiver services.
    - REACH (Regional Education Assessment Crisis Services Habilitation): REACH provides crisis stabilization, intervention, and prevention services.
    - Regional Support Teams (RSTs): RSTs provide recommendations in resolving barriers to the most integrated community settings consistent with a person's needs and informed choice.
    - Office of Integrated Health (OIH): OIH ensures quality supports and community integrated health services by building and improving new, innovative ways to effect change, and decrease
    - inter- and intra-departmental barriers across agencies.
    - Regional Housing Specialists: Housing specialists are responsible for developing local, regional, and statewide relationships and for identifying potential resources necessary to increase the availability of and access to affordable and accessible housing for individuals with a developmental disability who are Medicaid Waiver recipients or those who are eligible for a Medicaid Waiver and possibly on the Waiver waiting lists ("target population").
    - Office of Licensing (OL): OL licenses providers that provide treatment, training, support, and habilitation to those with mental illness, developmental disabilities, or substance use disorders; to people using services under the Medicaid DD Waivers; or those with brain injuries who use services in residential facilities.
    - Office of Human Rights (OHR): OHR works to ensure and protect the human rights of individuals who use services in DBHDS state facilities or programs operated, licensed, or funded by DBHDS.

A Brief History of Department of Justice Settlement Agreement in Virginia

In August 2008, the Department of Justice (DOJ) initiated an investigation of Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling. The Olmstead decision requires that people be served in the most integrated settings appropriate to meet their needs consistent with their choice.

In February 2011, DOJ submitted a findings letter to Virginia, concluding that the Commonwealth failed to provide services to those with intellectual and developmental disabilities in the most integrated setting appropriate to their needs.

In March 2011, upon advice and counsel from the Office of the Attorney General (OAG), Virginia entered into negotiations with the DOJ in an effort to reach a settlement without subjecting the Commonwealth to an extremely costly and lengthy court battle with the federal government.

On January 26, 2012, DOJ reached a settlement agreement with Virginia. Compliance with the Agreement resolves DOJ's investigation of Virginia's training centers and community programs and the Commonwealth's compliance with the ADA and Olmstead with respect to individuals with intellectual and developmental disabilities. See the DOJ Settlement Agreement.

CHAPTER 1:
Person-Centered Practices

Definition

"Person-centered practices" is a term that embodies values and skills used to support and interact with people. Although the term is often used in conjunction with the developmental disability field, person-centered practices are in fact about people and are used in many different settings and areas of support need. This chapter describes the values that underlie all person-centered practices. Specific tools and skills are abundant and varied. The Person-Centered Practices At-a-Glance resource page found at the end of this chapter provides links to training and websites to learn specific person-centered skills and obtain person-centered tools.

Person-centered practices encourage interaction with people with disabilities in much the same way as with people who do not have disabilities. People with disabilities have the same wants and needs as anyone else. Their needs are not 'special.' Like most of us, people with disabilities want to feel a sense of belonging, they want to make contributions, feel useful and productive, love and be loved, and govern their own lives, including where and with whom they work, live, and play. People with disabilities are valuable members of the community. Those persons who provide supports, including support coordinators, focus on promoting rich and fulfilling lives in the community.

Principles & Virginia's Vision

Virginia's vision includes all people, not just those who use the service system. The vision centers on a Virginia where individuals of all ages and abilities have the supports needed to enjoy the rights of life, liberty, the pursuit of happiness, and the opportunity to have a good life.

> This vision includes the idea that all people have the opportunities and supports needed to live a good life in their own homes and communities and that a good life is best led by the voice of the individual and byfollowing these Person-Centered principles:
>
> **Principles of Practice**
>
> **Principle 1: Listening** - People are listened to and their choices are respected.
> **Principle 2: Community** - Relationships with families and friends and involvement in the community are supported.
> **Principle 3: Self-Direction** - People have informed choice and control over decisions that affect them.
> **Principle 4: Talents and Gifts** - People have opportunities to use and share their gifts and talents.
> **Principle 5: Responsibility** - There is shared responsibility for supports and choices.

This broader vision includes having a system of supports and services through which people with disabilities have opportunities for freedom, equality, and the opportunity to participate fully in their communities. How a person participates in the community is defined by the person, based on what is important to that person.

In this system, people with disabilities…

- Set their schedules, make decisions about how and where they live, and have opportunities for recreation that reflects their personal desires and interests;
- Access their communities with the same opportunity as people without disabilities;
- Are employed, which increases integration and enables the pursuit of interests through increased income;
- Have access to benefits counseling and financial planning services;
- Routinely spend time with friends, family, and others not paid to support or provide services to them;
- Have access to home ownership or tenancy rights in affordable, integrated settings where they live with whom they choose;
- Have knowledgeable, Person-Centered supports to explore and identify services and resources that lead to integration;
- Have dependable transportation for community access when needed and desired; and
- Choose their healthcare providers and have access to supports and activities that promote health, wellness, and safety.

Important to and Important for

At the core of all Person-Centered practices is the ability to discover what is **important to** a person while balancing this with what is **important for** them. This is true about all people, not just those with a disability. All of us have things in our lives that are **important to** us and **important for** us. We all struggle to strike a balance between doing things that are good for our health/safety and having things in our lives that we cherish or that just comfort us. Having what is **important to** us helps all of us handle stressors and issues that weigh on us. We all benefit from a sense of belonging, a sense of worth, and a sense of competence.

Important To

Those things in life which help us to be satisfied, content, comforted, fulfilled, and happy. They include:

- People to be with/relationships
- Status and control
- Things to do
- Places to go
- Rituals or routines
- Rhythm or pace of life
- Things to have

Important For

Those things that keep a person healthy and safe. They include:

- Prevention of illness

- Treatment of illness/medical conditions
- Promotion of wellness (e.g. diet, exercise)
- Issues of safety: in the environment, physical and emotional well-being, including freedom from fear

Important For also includes what others see as necessary for a person to:

- Be valued.
- Be a contributing member of their community.

Promises of Person-Centered Practices

According to the International Learning Community for Person-Centered Practices, there are inherent promises made to each person when supporting them using Person-Centered practices.

A Promise to listen

- To listen to what is being said and to what is meant by what is being said.
- To keep listening.

A Promise to act on what we hear

- To find something that we can do today or tomorrow.
- To keep acting on what we hear.

A Promise to be honest

- To let people know when what they are telling us will take time.
- When we do not know how to help them get what they are asking for.
- When what the person is telling us is in conflict with staying healthy or safe and we can't find a good balance between what is **important to** and **important for** the person.

Values & Practices

Respect

The term "respect" has many types of meanings. It includes a positive feeling towards another person or the person's skills, opinions, or other characteristics, and the honoring of a person's beliefs, ideas, or culture. Respect requires seeing a person as a whole not as a disability. As a SC, respect may be demonstrated by:

- Listening;
- Developing an understanding of a person's background and their hopes and dreams;
- Presuming competence when meeting with and interacting with a person with a disability maintaining high expectations;
- Practicing cultural agility and humility;

- Using everyday language;
- Supporting a person’s dreams;
- Recognizing a person’s talents and gifts; and
- Facilitating the ways a person can contribute to their community.

Being Culturally Aware

We are all multi-faceted human beings. For the people an SC supports, disability is just one part of who they are. SCs should remember to acknowledge and consider every person’s varied and unique rituals, routines, values, morals, and culture. Being culturally aware is about giving careful consideration to one’s own assumptions and beliefs that are embedded in one’s goals for a person.

The most important thing SCs can do to become more culturally aware is to understand their own cultures and assess their natural biases (the lens through which they view their world). Discuss with your supervisor if there are any agency resources that might help support cultural awareness.

Communication

A SC will meet people who may communicate in different ways. It may sometimes be assumed a person is not communicating because they do not use words to talk. The truth is that everyone communicates in some way. All people have the need to communicate to express choice, feelings, needs, likes and dislikes. Just because someone does not speak with words it doesn’t mean they don’t have something to say!

Communication is an exchange of ideas between people through a system of words, signs, or behaviors like gestures, body language, and actions. Some people use words to communicate, however, we do not use words alone to get our ideas across. We also employ behaviors to communicate, such as facial expressions (smiles, frowns, eye blinking), pointing or other physical gestures, vocal sounds, eye contact, and body movements. A number of studies have been conducted to understand what percent of human communication is non-verbal. While the studies disagree on an exact percentage, all agree that most communication is nonverbal. In fact, nonverbal behavior is the most crucial aspect of communication. Although some people may not use words to communicate, it does not mean that they cannot understand what others are saying.

Communication Considerations

The SC and the CSB/BHA should communicate effectively and convey information in a manner that is easily understood by diverse audiences including:

- Persons who have limited English proficiency;
- Those who have low or no literacy skills; and
- Those whose disabilities limit their ability to communicate in typical ways.

Remember that SCs have a responsibility to support individuals no matter what language they speak. If needed, ask a supervisor how to access interpreters or other supports.

Use of Everyday Language

How support coordinators talk with and about people with disabilities will influence the attitudes and interactions others have with people with disabilities. Choice of words in speaking and attitudes conveyed through tone of voice are very important. Language can create a barrier when a SC uses “special” language or professional jargon when talking to or about people with disabilities. Special language says people with disabilities are different and sets up an “us” versus “them” dynamic. Using words like “client” or “consumer” depersonalizes people. Instead, use everyday language, words, and phrases you would use when talking about co-workers, friends, and family members. Some examples:

Instead of this ….	Say this….
Client, consumer	Person, the person’s name
My caseload, my clients, my guys	The people I support
John was placed in a job	John found a new job
Jane transitioned from high school	Jane graduated
I did an ISP on someone	I did an ISP with someone
Ed needs support with toileting	Ed needs support using the restroom
I transported Amy	I drove Amy
Non-verbal	Does not speak with words
He is a Level 2/Tier 2	He is assigned to Level 2
Refused	Chose not to
Waiver individual	Someone who has a waiver slot

“Person First” language emphasizes the person and not the disability. The first choice is always to call someone by name. If the situation dictates that the disability must be mentioned, always put the person first. The phrase, “a disabled person” can be disrespectful and emphasizes the disability rather than the person. A SC should say, “a person with a disability.” Instead of saying “someone with Down’s,” say, “a person who has Down syndrome.” Referring to the person first lets others know that he or she is, first and foremost, a person who deserves respect.

SCs need to also be aware of a person’s individual preferences as well. There are some people with disabilities who do not prefer person first language. For example, some people who are on the autism spectrum may prefer to be referred to as ‘autistic’ rather than ‘a person with autism’. They assert that autism is part of them, and they cannot be separated from their autism as it might be with a person being cured of a disease. Therefore, they prefer to be called “autistics” to identify that this diagnosis and way of being is an important part of their identity. In instances such as these, it is important to respect and use the language an individual person prefers. To read more, visit Autism Mythbusters.

According to the International Learning Community for Person-Centered Practices, “How you say what you say matters as much as the actual words you say.” Some other things to keep in mind regarding language are:

- **Tone** - The inflection or emotion in your voice. It should be age appropriate (no baby talk for adults), mild, and respectful.

- **Volume** - Loudness of your voice. It should be appropriate for the situation. If you are in a noisy location, you may have to speak louder (not yell) to be heard. It can also be effective to lower the volume of your voice to draw someone's attention.
- **Context** - Where are you? Is it a comfortable, familiar location? Who else is around? Privacy is important. What is the intensity of emotion being expressed? Are you or others upset, frustrated, sad, happy, etc.?
- **Body Language** - Gestures and movements that accompany the words. Some experts say that 75% to 90% of perceived language is body language. Body language such as crossing your arms can show disinterest. Shaking your finger at a person can show anger. Rolling your eyes can show disbelief. You want your body language to match with what you are saying, your intent, and how you are saying it.

Always remember that language reflects values – using respectful and person-centered language shows that a person truly is respectful of the people they support.

Personal Choice and Decision Making

Personal choice means making decisions about all the details of our lives. Each day, as soon as we wake up, we are engaged in making choices. We ask ourselves: "Should I hit the snooze button or get up?," "Should I call in sick or go to work?," or "What should I wear?" We also make major decisions about who to live with and what sort of work we want to do. We are in control and it feels good to be empowered and able to make our own decisions. Everyone is entitled to make decisions about their lives. However, it is rare that anyone makes major decisions in their lives in isolation from others. Most of us talk with those we are close to when making major decisions. SCs play a significant role in promoting choice when planning with a person and when evaluating whether a plan is working for them. Efforts should be made to also include others in decision-making, if the person chooses to do so. Individual choice drives the formulation of outcomes on the Individual Support Plans, the way provider agencies operate, the staffing patterns (what staff do and when they do it), and the daily actions of the direct support professionals. Choice should occur naturally and should be expected without unnecessary restrictions. Many people entered supportive services with little to no choice. It is the SCs responsibility to promote personal choice by noticing likes, dislikes, and opinions as forms of choice.

"Informed choice" refers to one's ability to make a decision based on a clear understanding of the facts, results of the choice, and possible future consequences. Some people do not show the capacity for informed consent and need supports from family members, an authorized representative, or a legal guardian. This is typically reserved for decisions or choices that might have an effect on a person's health and safety. This does not mean that the day-to-day choices or expression of hopes and dreams should be restricted. Additionally, capacity can be increased through the use of Supported Decision-Making. Supported Decision-Making should be explored first before more restrictive forms of support, such as a legal guardians.

Dignity of Risk

The concept of "dignity of risk" is the right of a person to engage in experiences meaningful to them and that are necessary for personal growth and development. Life includes risks for everyone. Choice inherently involves risk, sometimes in a menial way; in other instances, in life threatening ways. Overprotecting people with disabilities keeps them from many life situations that they have the right to experience, and it may prevent meaningful connections and fulfillment of their hopes and dreams. Rather than protecting people with disabilities from disappointments and sorrows, which are natural parts of life, it is important to support them to make informed decisions. This enables them to experience the possibility of success and the natural risk of possible failure. Occasionally, a SC may believe they know the outcome for those who "dream too big." Dignity of risk demands we try to help people explore and try and reach for their dreams.

Individual Rights

All people have basic human rights. All people, including people with disabilities, are entitled to enjoy rights and freedoms to privacy, to have personal possessions, to marry, to exercise free speech, to live in neighborhoods, to complain, to vote, etc. It is also every person's right to be free from abuse, neglect, and exploitation, and not to have restrictions on those rights and freedoms. Some people the SC supports may have had their legal rights limited through the appointment of a guardian, conservator, or another legal process. This does not mean they cannot make day-to-day choices and decisions or should have their dreams or plans go unheard. It is the SC's responsibility to seek guidance and help with decision-making when appropriate or needed to preserve the health and safety of the person. As an employee of a community agency providing supports to people with developmental disabilities, it is the SC's responsibility to be knowledgeable of the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by DBHDS (the "Human Rights Regulations") [12VAC35-115].

Confidentiality

Confidentiality is a right to privacy and respect of information given to and shared among professionals about people. People generally expect that their medical records, financial records, psychological records, criminal records, driving records, and other personal records are going to be kept in a confidential manner. SCs must remember to have this same respect for the private information about those they support. This includes health information that is covered by the Health Insurance Portability and Accountability Act (HIPAA) and substance use information that is more stringently covered under 42 CFR, Part 2. Each agency should provide additional information about confidentiality and requirements related to sharing information.

Person-Centered Practices Resources

Life Course Tools

Person-Centered Thinking Training in Virginia

Support Development Associates

Helen Sanderson Associates

The International Learning Community for Person Centered Practices

Cornell University Person-Centered Planning Education Site

A Checklist for Person Centered Information Gathering and ISP Development Mary Lou Bourne 2008.

A Guide for Developing Preliminary Essential Lifestyle Plans: Conversation with the Person with WhomYou are Planning Smull & ASA 2001 link at.

A Guide for Developing Preliminary Essential Lifestyle Plans: Conversations with Family and Support Services Smull & ASA 2001.

Read about Myths and Misconceptions about Person-Centered Planning pages 69 through 73.

CHAPTER 2:
Support Coordination Overview

Support Coordination

Support coordination is the core service that many Virginians with DD depend upon to help navigate and make the best use of our publicly funded system of services. In some ways SCs are the most important staff members in our entire system! They make sure individuals have access to services and ensure that those services are effective. When a need has been identified, SCs take the lead in problem solving and advocating for the people they support. SCs either work directly for a CSB/BHA or contract with one. Although support coordination is not a DD Waiver service, it is required for all DD Waiver recipients and paid for by Medicaid.

There are two kinds of support coordination, one for people with ID and one for all others who have DD but not an ID diagnosis. They have different qualifications but have the same general expectations.

Support Coordination for people with ID

DMAS regulations define “support coordination” for people with ID as:

12VAC30-50-440. Support coordination/Case management (support coordination) for individuals with an intellectual disability (ID). The target group is Medicaid-eligible individuals with an intellectual disability as defined in state law (§ 37.2-100 of the Code of Virginia).

Targeted support coordination services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

1. An individual receiving ID support coordination shall mean an individual for whom there is an individual support plan (ISP) in effect that requires direct or individual-related contacts or communication or activity with the individual, the individual’s family or caregiver, service providers, and significant others. Billing can be submitted for an individual only for months in which direct or individual-related contacts, activity or communications occur consistent with the ISP.

2. There shall be no maximum service limits for support coordination/case management services except as related to individuals residing in institutions or medical facilities. For these individuals, reimbursement for support coordination/case management shall be limited to 30 days immediately preceding discharge. Support Coordination/case management for individuals who reside in an institution may be billed for no more than two pre-discharge periods within twelve months.

The term intellectual disability, as defined by the American Association of Intellectual and Developmental Disabilities (AAIDD) and utilized by the state of Virginia, means a person has significant limitations in **intellectual functioning** (reasoning, learning, problem solving) and in **adaptive behavior**, which covers a range of everyday social and practical skills. The disability originates before the age of 18.

> **Intellectual Functioning** refers to general mental capacity, such as learning, reasoning, problem solving, and so on. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning.
>
> **Adaptive Behavior** is the collection of conceptual, social, and practical skills that are learned and performed by people in their everyday lives.

- **Conceptual skills** include language and literacy; money, time, and number concepts; and self-direction.
- **Social skills** include interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.
- **Practical skills** include activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

Additional Considerations

The AAIDD emphasizes that when determining whether a person has an intellectual disability, many things need to be taken into account including, but not limited to, the person’s linguistic diversity, cultural differences, and their community environment.

Support Coordination for people with DD

12VAC30-50-490 Support coordination/case management (support coordination) for individuals with developmental disabilities.

The target group is Medicaid-eligible individuals with DD (other than ID) or related conditions as defined in state law (§ 37.2-100 of the Code of Virginia) who are on the waiting list or are receiving services under one of the DD Waivers. This target group shall be eligible for support coordination.

1. An individual receiving DD Support Coordination shall mean an individual for whom there is a Person-Centered Individual Support Plan (PC ISP) in effect which requires monthly direct or in-person contact, communication or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the Support Coordinator/Case Manager every 90-days. Billing shall be submitted for an individual only for months in which direct or in-person contact, activity or communications occur and the Support Coordinator's/Case Manager's (SC) records document the billed activity. Service providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

2. Individuals who have developmental disabilities as defined in state law but who are on the DD waitlist for waiver services may receive Support Coordination/Case Management services only if there is a special service need identified, in which case an ISP shall be developed to address the special service need. In this case, the Support Coordinator/Case Managers shall make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, and medical needs or provide assistance related to an acute need that coincides with the allowable activities noted in subsection D of this section. If an activity related to the special service need is provided in a given month, then the support coordinator/case manager would be eligible for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service shall not continue until a special service need presents again.

Virginia uses the definition set forth by the federal Developmental Disabilities Act (42 USC Ch. 144).

§ 37.2-100 of the Code of Virginia :

”Developmental disability” means a severe, chronic disability of an individual that:

1. Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness;
2. Is manifested before the individual reaches 22 years of age;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
5. Reflects a need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

A child from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

There are many conditions that qualify as a DD including autism, brain injury (before age 22), cerebral palsy, other mental or neurological conditions (seizures), and intellectual disabilities which include Down syndrome, fetal alcohol spectrum disorder (FASD) and Fragile X syndrome. Other developmental disabilities may be strictly physical, such as blindness or deafness that began from birth or childhood.

Targeted Case Management (State Plan Option)

Targeted case management services are services furnished to assist individuals, eligible under the Medicaid State Plan. This can include:

- A person who is a recipient of the DD Waiver
- A person with an ID on the waiting list for the DD Waiver who is eligible for Medicaid (in this instance the person may or may not be a recipient of one of the other Waivers)
- A person with a DD on the waiting list for the DD Waiver who is eligible for Medicaid AND has a short-term special need (in this instance the person may or may not be a recipient of one of the other Waivers)
- A person with an ID not on the waiting list for the DD Waiver, who is eligible for Medicaid and targeted case management, but not DD Waiver (in this instance the person may or may not be a recipient of one of the other Waivers)

Monitoring/Follow Along

Many CSBs or support coordination providers have protocols for how to provide support to people who do not receiving targeted case management. There may be different documentation and direct contact protocols for monitoring and follow-along.

Post Move Monitoring

When a person residing in a training center is seeking to move to a more integrated home in the community, the SC plays an important role in ensuring a successful transition. The assessment and plan development process for a person discharging from a training center is similar to the process for someone already residing in the community. Additionally, there is supplemental funding available to ensure all identified essential supports are available and in place at the time of discharge. Virginia has approved limited funding as a part of the plan to support individuals transitioning from a training center or other state facility, according to the “community move process,” to a community home of their choice. Transitional Funding, formerly known as “bridge funding,” can be used in a variety of ways to support these individuals as they move to their own homes or to a home licensed by DBHDS. The application is available on the DBHDS website. Please ask your supervisor for assistance with any additional funding resources available in your locality.

Choice of Support Coordinator

Anyone seeking support coordination services must be offered a choice of SC. Choice of providers is **always an option and can be exercised at any time** by a person using SC services and documented on the Virginia Informed Choice Form at a minimum on an annual basis. Each provider of support coordination shall implement a written policy describing how people are assigned SCs and how they can request a change of their assigned SC or SC provider.

Role of family and friends, the use of a Supported Decision-Making Agreement, Powers of Attorney, Authorized Representatives, Legal Guardians

When working with someone, it should be presumed that they can tell everything about themselves, handle their own affairs, and make informed decisions about their goals and support needs to the same degree as someone who does not have a disability. In many instances, however, a person may want/need the input from others who know them well.

This can come from family or friends, who may choose to use a Supported Decision-Making Agreement, on an informal basis and/or from a conservator, authorized representative or legal guardian on a formal basis. No matter who is included in the process of getting to know someone, it is important to always remember that the person who uses services is at the center of all information gathering and planning. Each of these roles is discussed below.

> "Person-centered planning celebrates, relies on, and finds its sober hope in people's interdependence. At its core, it is a vehicle for people to make worthwhile, and sometimes life changing, promises to one another."
>
> - John O'Brien

Family & Friends

A SC will encounter a wide variety of family. It is important to gain an understanding of what "family" means to the person being supported and who they consider a part of their family. A SC should ask for loved ones' names and what they are called by the person. With permission, SCs should treat family members and friends as partners in getting to know the person and planning with them. Including and getting to know family members will go a long way to build trust.

Tips for including families:

- Start with the assumption that families want to make a positive contribution and have the best interests of their family member at heart.
- Resist characterizing families as "overprotective," "not interested," or "barriers to. . ."
- Engage families by asking for their side of the story. It may end up providing important information about history and ways to support their loved one.
- Recognize that often family members know the person best. They care about the person in a way that is different from everyone else and they will probably be involved in supporting their loved one for the rest of their lives.
- Appreciate the huge commitment, energy, and knowledge a family brings to the table.
- Make it a priority, as long as a person agrees, to sustain, value, and strengthen connections with family and friends.

Supported Decision-Making & Supported Decision-Making Agreements (SDMA)

Everyone has the right to meaningfully participate in decisions regarding all aspects of life and everyone receives help with making decisions, not just people with disabilities. Many individuals with disabilities are able to live independent lives and make important decisions through the use of supported decision-making. Supported decision-making allows individuals with disabilities to maximize their self-determination by making the ultimate decision regarding their own lives, including supports and services, while receiving assistance of those they trust to ensure they receive all of the information needed to make an informed decision. It is important to practice supported decision-making starting at a young age, not just as an adult, for individuals to build their confidence with making decisions on their own.

"Principal" means an adult with an intellectual or developmental disability who seeks to enter or has entered into a supported decision-making agreement with a supporter.

"Supported decision-making agreement" means an agreement between a principal and a supporter that sets out the specific terms of support to be provided by the supporter, including (i) helping the principal monitor and manage his medical, financial, and other affairs; (ii) assisting the principal in accessing, obtaining, and understanding information relevant to decisions regarding his affairs; (iii) assisting the principal in understanding information, options, responsibilities, and consequences of decisions; and (iv) ascertaining the wishes and decisions of the principal regarding his affairs, assisting in communicating such wishes and decisions to other persons, and advocating to ensure the wishes and decisions of the principal are implemented.

"Supporter" means a person who has entered into a supported decision-making agreement with a principal. (§ 37.2-314.3)

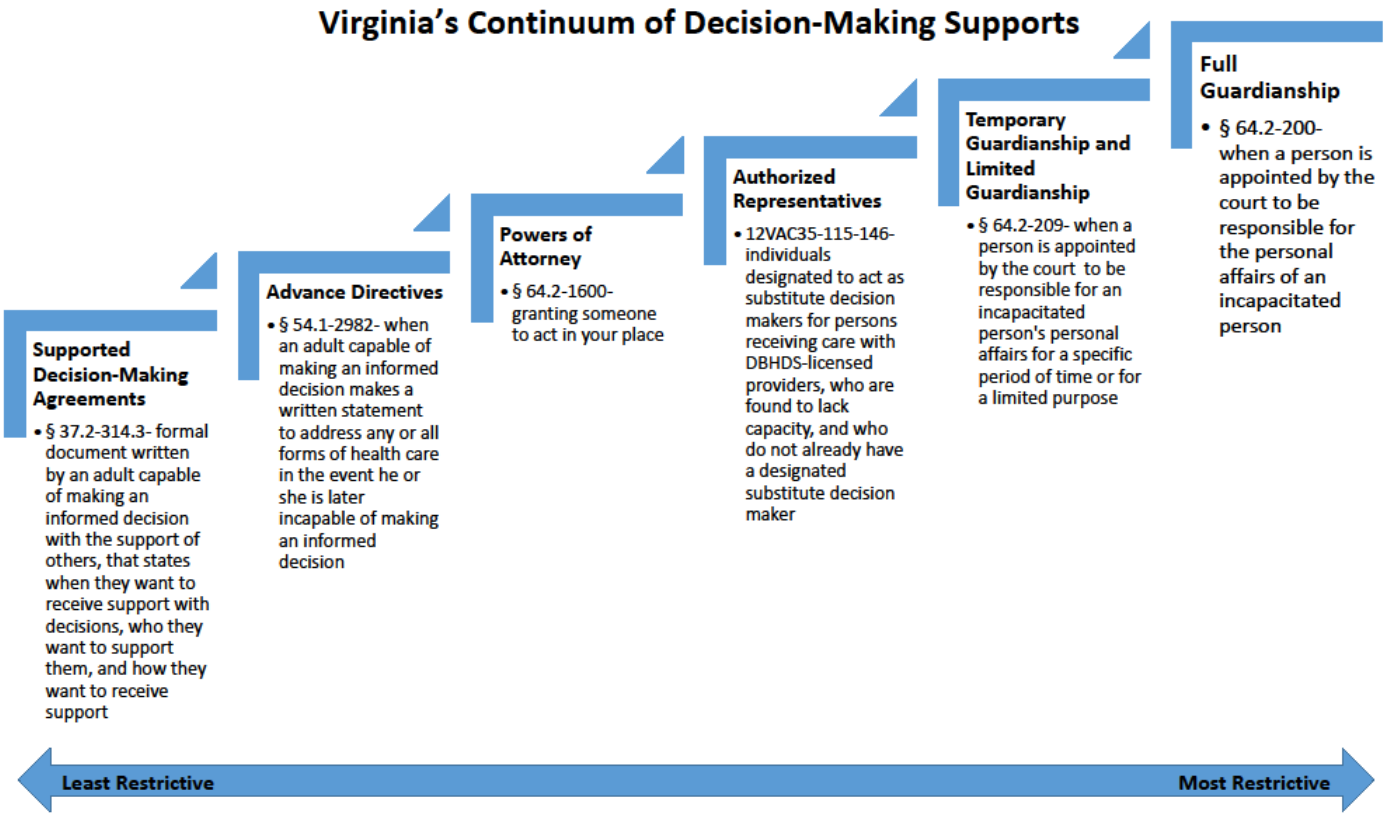
Supported decision-making agreements (SDMAs) are the formal process of documenting who an individual wants to support them, in what areas of life, and how they want to be supported. Both the individual and the supporters consent to entering into this agreement. SDMAs can be updated and amended at any time. SDMAs are formally recognized in Virginia, as noted in §37.2-314.3. A SDMA is not a legal document a judge would order in court, but people should follow any choices the decision-maker makes, as the decision-maker has the right to make all final decisions.

A 2020 Supported Decision-Making Workgroup identified four principles for supported decision-making in Virginia.

1. That all individuals should be presumed capable of making their own decisions.
2. When an individual requires assistance in making decisions, the least restrictive option that meets the individual's needs should be pursued, and every effort should be made to maximize an individual's autonomy and independence.
3. Supporters, guardians, substitute decision-makers, and other agents should always take into consideration an individual's expressed personal preferences to the extent appropriate.
4. Making good decisions takes practice and individual growth. Everyone should have the opportunity to learn and grow from making poor decisions, sometimes called "dignity of risk."

5. Poor decision-making should not be motivation for restricting an individual's rights through guardianship or substitute decision-making.

It is important for SCs know an individual communicates their preference or to ensure that someone who does is present when decisions are being made. If an individual has a SDMA, then SCs should request a copy of it and invite the Supporters to meetings as outlined in the SDMA. In instances when an individual has a substitute decision-maker, such as a legal guardian or authorized representative, efforts should be made to determine what the individual's preferences or choice are and to follow them to the greatest extent possible.



Virginia's Continuum of Decision-Making Supports

Supported Decision-Making Agreements
- § 37.2-314.3- formal document written by an adult capable of making an informed decision with the support of others, that states when they want to receive support with decisions, who they want to support them, and how they want to receive support

Advance Directives
- § 54.1-2982- when an adult capable of making an informed decision makes a written statement to address any or all forms of health care in the event he or she is later incapable of making an informed decision

Powers of Attorney
- § 64.2-1600- granting someone to act in your place

Authorized Representatives
- 12VAC35-115-146- individuals designated to act as substitute decision makers for persons receiving care with DBHDS-licensed providers, who are found to lack capacity, and who do not already have a designated substitute decision maker

Temporary Guardianship and Limited Guardianship
- § 64.2-209- when a person is appointed by the court to be responsible for an incapacitated person's personal affairs for a specific period of time or for a limited purpose

Full Guardianship
- § 64.2-200- when a person is appointed by the court to be responsible for the personal affairs of an incapacitated person

Least Restrictive **Most Restrictive**

Power of Attorney (POA)

"Power of Attorney" is defined as a writing or other record that grants authority to an agent to act in the place of the principal, whether or not the term power of attorney is used.

"Principal" means an individual who grants authority to an agent in a power of attorney. (§ 64.2-1600)

There are three types of power of attorney (POA): general POA, limited POA, and durable POA.

Authorized Representative (AR)

> *"Authorized representative"* means a person permitted by law or the human rights regulations to authorize the disclosure of information or to consent to treatment and services or participation in human research. The decision-making authority of an authorized representative recognized or designated under this chapter is limited to decisions pertaining to the designating provider. Legal guardians, attorneys-in-fact, or health care agents appointed pursuant to § 54.1-2983 of the Code of Virginia may have decision-making authority beyond such provider.

It is important to note that an authorized representative (AR) acts on behalf of someone who lacks the capacity to make decisions about informed consent and participation in research. Lack of capacity is not something that can be decided by a SC, a family member, or even the person using support coordination services.

Legal Guardianship (LG) and Conservatorship

> *"Guardian"* means a person appointed by the court who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of involuntary admission, residence. (22VAC30-70-10)
>
> *"Conservator"* means a person appointed by the court who is responsible for managing the estate and financial affairs of an incapacitated person. (22VAC30-70-10)
>
> *"Incapacitated person"* means an adult who has been found by a court to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator. (22VAC30-70-10)

In Virginia, one's parent is considered to be a child's legal guardian (LG) until the child reaches the age of 18. Once a child reaches 18, a parent may petition the circuit court to become a LG for the child with DD if the parent feels the loved one is incapable of making life decisions. A person's LG may also be someone unrelated to them. No matter whom the court appointed LG is, it is important as the SC to remember that:

- A legal guardian has to be appointed by the court.
- The LG ultimately makes all decisions that are made regarding the care of the "incapacitated person." (This is a legal term and is only used here because it is such. It is not recommended that anyone should be referred by this term in everyday language.) This does not mean that the voice of the person themselves should not be heard. In fact, it is incumbent on the LG to encourage participation in all decision making *and to listen to the individual and support them in their choices.*

- It is also the legal guardian's responsibility to file annual reports with the local Department of Social Services (LDSS).

A conservator, also appointed by the circuit court, handles the financial affairs for someone. The LG and conservator may or may not be the same person.

The responsibilities of the conservator are to take care of and preserve the assets and income of the "incapacitated person" and to file annual reports with the commissioner of accounts regarding money and property received and disbursed.

Waiver Management System (WaMS)

The Waiver Management System (WaMS) is a web-hosted data management system used to manage the DD Waivers. WaMS interfaces with the Medicaid Enterprise System (MES), establishes the assessment levels of care based on a person's needs, and automates the service authorization process. WaMS is customized to allow a single process for service authorizations for all three Waivers (Community Living, Family and Individual Supports, and Building Independence) supporting people with ID/DD. WaMS interfaces with various Electronic Health Record (EHR) systems to transfer data into WaMS.

SCs use WaMS for a variety of documentation requirements including the PC ISP, VIDES survey, authorizations for Waiver services, regional support team, and Waiver waiting list management Virginia Waiver Management System (WaMS) Portal. SCs should speak to their supervisors about getting their account set up. Once in WaMS, there are extensive user manuals, training videos, and tips.

Appeal Rights

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code (12VAC30-110-10 through 12VAC30-110-370), require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the person's receipt of services. This includes actions to deny a request for medical services or an action to reduce or terminate coverage after eligibility has been determined.

A SC may need to assist a person to request an eligibility appeal in writing within 30 days of receipt of the notice about the action. The person may write a letter or complete an Appeal Request Form that would include:

- Name
- Medicaid ID number
- Phone number with area code, and
- a copy of the notice about the action

Appeals are then mailed to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 452-5454

For reduction or termination of coverage, if the request is made before the effective date of the action and the action is subject to appeal, the coverage may continue pending the outcome of the appeal. However, the person may have to repay any services received during the continued coverage period if the agency's action is upheld.

After the person files an appeal, they will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone. The hearing officer's decision is the final administrative decision rendered by DMAS. However, if the person disagrees with the hearing officer's decision, an appeal may be filed at the local circuit court.

DMAS Appeal Rights page

DMAS Appeals Form

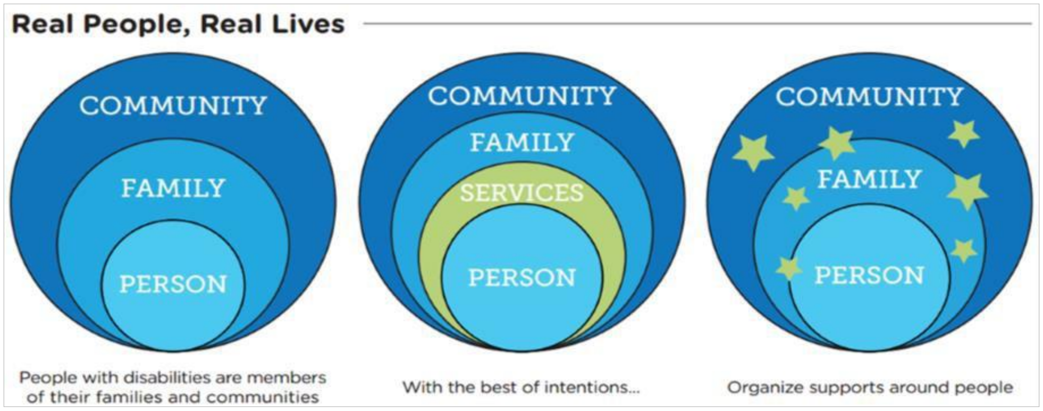
CHAPTER 3: Qualifications

Centers for Medicare & Medicaid Services (CMS) Setting Regulations

The Home and Community-Based Services (HCBS) settings regulations (previously known as the "final rule") published in the Federal Register, became effective March 17, 2014. They were designed to enhance the quality of HCBS, provide additional protections, and ensure full access to the benefits of community living. Settings regulations establish requirements for the qualities of settings for those who use Medicaid-reimbursable HCBS services.

HCBS Requirements for Residential/Non-residential Settings

- *Supports full access to the greater community*
    - *Provide opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources, and*
    - *Ensure that people use services in the community, to the same degree of access as those not using HCBS*
- *Selected by the person served from among setting options including non-disability specific settings and options for a private unit in a residential setting*
    - *Person-centered service plans document the options based on the person's needs, preferences, and, for residential settings, resources available for room and board*
- *Ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint*
- *Optimizes one's initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact*
- *Facilitates one's choice regarding services and supports and who provides them*



Resource: Michelle 'Shelli' Reynolds, PhD UMKC Institute for Human Development

For many of people, typical lives mean being surrounded by family and community and being an active member of the community (first circle in the diagram above). Sometimes, even with the best of intentions, services are put in place that create a barrier between people using those services and their family and community (middle circle). The goal should always be to organize services and supports around a person that reinforce the integration of services in a person's life, family, and community (third circle above).

A residential setting that is provider-owned or controlled is subject to additional requirements. These settings include group homes, sponsored placements, and supported living situations.

HCBS Requirements for Residential Settings

- *Have a lease, or other signed legally enforceable agreement providing similar protections*
- *Have access to privacy in their sleeping units*
- *Have entrances lockable by the individual, with keys provided to appropriate staff as needed*
- *Have a choice in selecting their roommate(s) if they share a room*
- *Have the freedom to decorate and furnish their sleeping and/or dwelling unit*
- *Have the ability to control their daily schedules and activities and have access to food at any time*
- *Be able to have visitors at any time*
- *Be able to physically maneuver within the setting (e.g., setting is physically accessible)*

Though it is not the responsibility of the SC to ensure that providers adhere to the additional requirements, it is important that SCs familiarize themselves with these requirements as they may need to discuss the settings regulations with providers.

To learn more about the HCBS settings rule go to: https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

Providers may ask about where to find the HCBS Toolkit. Information can be found at this link: https://www.dmas.virginia.gov/for-providers/long-term-care/waivers/home-and-community-based-services-toolkit/

As a SC, there are three additional regulations to be aware of. They are:

DD Waiver Regulations – The three DD Waivers – Building Independence (BI), Family and Individual Supports (FIS), and Community Living (CL) share the same set of regulations. Service authorization and operations related to the Waivers fall under DBHDS. Link:

https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/

DD Waiver Manual – The Virginia Medicaid DD Waivers Provider Manual is a policy manual that includes the DD Waiver regulations and expectations. To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members. Link:

https://vamedicaid.dmas.virginia.gov/

Office of Human Rights Regulations – The Office of Human Rights monitors compliance with the Human Rights Regulations by promoting the basic precepts of human dignity, managing the DBHDS Human Rights complaint resolution program, and advocating for the rights of persons with disabilities in our service delivery systems. Link:

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

Office of Licensing Regulations – The Office of Licensing provides a license and oversight to providers who offer services to individuals who have a DD (and other categories). Services include case management and a multitude of other services. Link:

https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/

Support Coordinator Qualifications

SCs who provide DD SC and were hired after September 1, 2016 must possess a minimum of a bachelor's degree in a human services field or be a registered nurse (RN). SCs hired before September 1, 2016 who do not possess a minimum of a bachelor's degree in a human services field or are not a RN may continue to provide support coordination if they are employed by or contracting with an entity that had a Medicaid provider participation agreement to provide DD support coordination prior to February 1, 2005, and the SC has maintained employment with the provider without interruption, which must be documented in the personnel record.

SCs who provide ID targeted case management (ID TCM) may be hired:

(i) Without a bachelor’s degree in a human services field but with one year of direct DD experience; or

(ii) Without the five-year equivalency requirements recognized by the Office of Licensing, until one of these standards is met if a qualified supervisor has signed all assessments, individual support plans, and quarterlies completed by the SC. The names of any SC providing ID TCM under this return to the standard as written in the current regulation (now and as hired) should be emailed to CMSC@dbhds.virginia.gov so that DBHDS may maintain a record of CSB staff hired to only the level of the ID TCM standard.

Support Coordinator Required Training

New SCs are required to complete 14 modules built on the principles of recovery, self- determination, person-centeredness, and community inclusion. The first 10 modules include a narrated and interactive PowerPoint, a PowerPoint test document, and links to information which may be downloaded and printed. DD SCs hired on or after April 1, 2019, are required to complete all modules and must demonstrate their knowledge and understanding of the content by passing a competency-based test for each module within 30 days of employment. The link for the first 10 modules is:

Support Coordination/Case Management - Virginia Commonwealth University (vcu.edu).

Module 11 on Employment and 3 housing modules are in the Commonwealth of Virginia Learning Center. You must have an account to access these trainings. Login (virginia.gov).

The CSB performance contract requires all direct and contract staff that provide case management services to complete the case management curriculum developed by DBHDS and that all new staff complete it within 30 days of employment. DD case managers and SCs must complete the ISP training modules within 60 days or within 30 days of employment for new staff. You can access this training on the Commonwealth of Virginia's Learning Center (COVLC): https://covlc.virginia.gov/Default.aspx

- PC ISP Training Development, Module 1 (Parts I and II)
- PC ISP Training Development, Module 2 (Parts III and IV)
- PC ISP Training Development, Module 3 (Part V)

Background and List of Excluded Individuals and Entities (LEIE) Checks

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties. All providers are required to take the following three steps to ensure federal and state program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) database monthly by name for employees, contractors, and/or entities to validate their eligibility for federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to: DMAS Attn: Program Integrity/Exclusions 600 E. Broad St, Ste 1300 Richmond, VA 23219 or E-mailed to: providerexclusions@dmas.virginia.gov.

CHAPTER 4:
Support Coordination: Assessment and Intake

How to screen, assess and conduct an intake

The community services board (CSB)/behavioral health authority (BHA) is the single point of entry for a person seeking services. The CSB/BHA will schedule an intake appointment with the individual. The individual should be asked to bring required documentation for the intake appointment. SCs should ask their supervisors for more information regarding the agency's intake process.

The CSB/BHA shall provide anyone interested in accessing DD Waiver Services with a DBHDS provided resource guide that contains information including but not limited to case management eligibility and services, family supports- including the IFSP Funding Program, family and peer supports, and information on the My Life, My Community Website, information on how to access REACH services, and information on where to access general information.

Information gathered at intake (check with a supervisor for agency-specific requirements)

- Documentation to support diagnosis of DD (to include ID if applicable)
- Consent to exchange information
- Risk Awareness Tool (RAT)
- Human rights notification
- Documentation of choice between institution and community-based services
- Waitlist

Documentation to support diagnosis of developmental disability (to include ID if applicable)

Eligibility for Developmental Disability (DD) Waivers

To be eligible for the DD Waiver a person must meet three criteria: diagnostic eligibility, functional eligibility, and financial eligibility.

Diagnostic Eligibility

Diagnostic eligibility means that an individual must have a disability that affects the individual's ability to live and work independently. The Diagnostic Eligibility Review Form can be used to ensure that collected documentation substantiates a diagnosis that confirms eligibility for SC services. A psychological or other evaluation of the individual may affirm that the individual meets the diagnostic criteria for developmental disability. SCs may want to use the optional Diagnostic Eligibility Review Form.

Financial Eligibility

Financial eligibility means that the person seeking services meets the financial criteria to receive Medicaid. This is determined by the LDSS, following the Medicaid eligibility rules used for people who need long-term care.

Functional Eligibility-Virginia Individual Developmental Disability Eligibility Survey (VIDES)

To meet functional eligibility requirements, an individual must need the same support as someone who is living in an intermediate care facility (ICF) for people with an ID/DD. This is determined by the Virginia Individual DD Eligibility Survey (VIDES). There are different versions of this assessment depending on the age of the person seeking services.

- Infant VIDES - under the age of 3
- Children VIDES - between the ages of 3 through 17
- Adult VIDES - 18 and older

Functional eligibility is established when someone meets the following established dependency level for the age-appropriate VIDES.

- Infant VIDES - must meet 2 out of the 5 categories
- Children VIDES - must meet 2 out of 8 categories
- Adult VIDES - must meet 3 out of 8 categories

The VIDES should be completed in WaMS or in an electronic health record. Only an SC who has been trained may administer the VIDES. SCs should ask their supervisor for training.

Eligibility Summary

An SC might determine that a person only meets one or two of the three eligibility criteria to receive a DD Waiver. For example, a person with an ID diagnosis may not meet the minimum functional criteria on the VIDES, rendering them ineligible to be placed on the DD Waiver waitlist. In this instance, the SC would provide that person with appeal rights and work with them to determine alternative options and resources that are available in the community.

Note: A person can be on the waitlist and not meet financial eligibility criteria.

Consent to Exchange Information

The SC is responsible for ensuring there is documentation of consent to exchange information. During the initial assessment, as needed, and annually thereafter, the SC should ensure there are current consent forms for any collateral contacts or organizations to which the SC must communicate and/or release information pertaining to the person who uses SC services.

Risk Awareness Tool

The Risk Awareness Tool (RAT) was designed to increase awareness of the potential for a harmful event (i.e., bowel obstruction, fall with injury, etc.) to occur and to facilitate the process of taking action to reduce and prevent the risk. It assesses for potential risk in 11 key health and safety areas. The RAT is completed annually.

Human Rights Notification

During the initial assessment and annually thereafter, the SC must ensure that the individual is aware of and has reviewed the human rights as described in the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services ("Human Rights Regulations"). [12VAC35-115]. SC organizations are required to notify each individual and authorized representative about these rights and how to file a complaint. The notice shall be in writing and in any other form most easily understood by the person using services. The notice shall provide the name and phone number of the human rights advocate and give a short description of the human rights advocate's role. The provider shall give this notice to and discuss it with the individual at the time services begin and every year thereafter. This notice shall be signed and filed in the individual's services record. More information regarding the Human Rights Regulations is located at https://dbhds.virginia.gov/quality-management/human-rights.

Determining Capacity

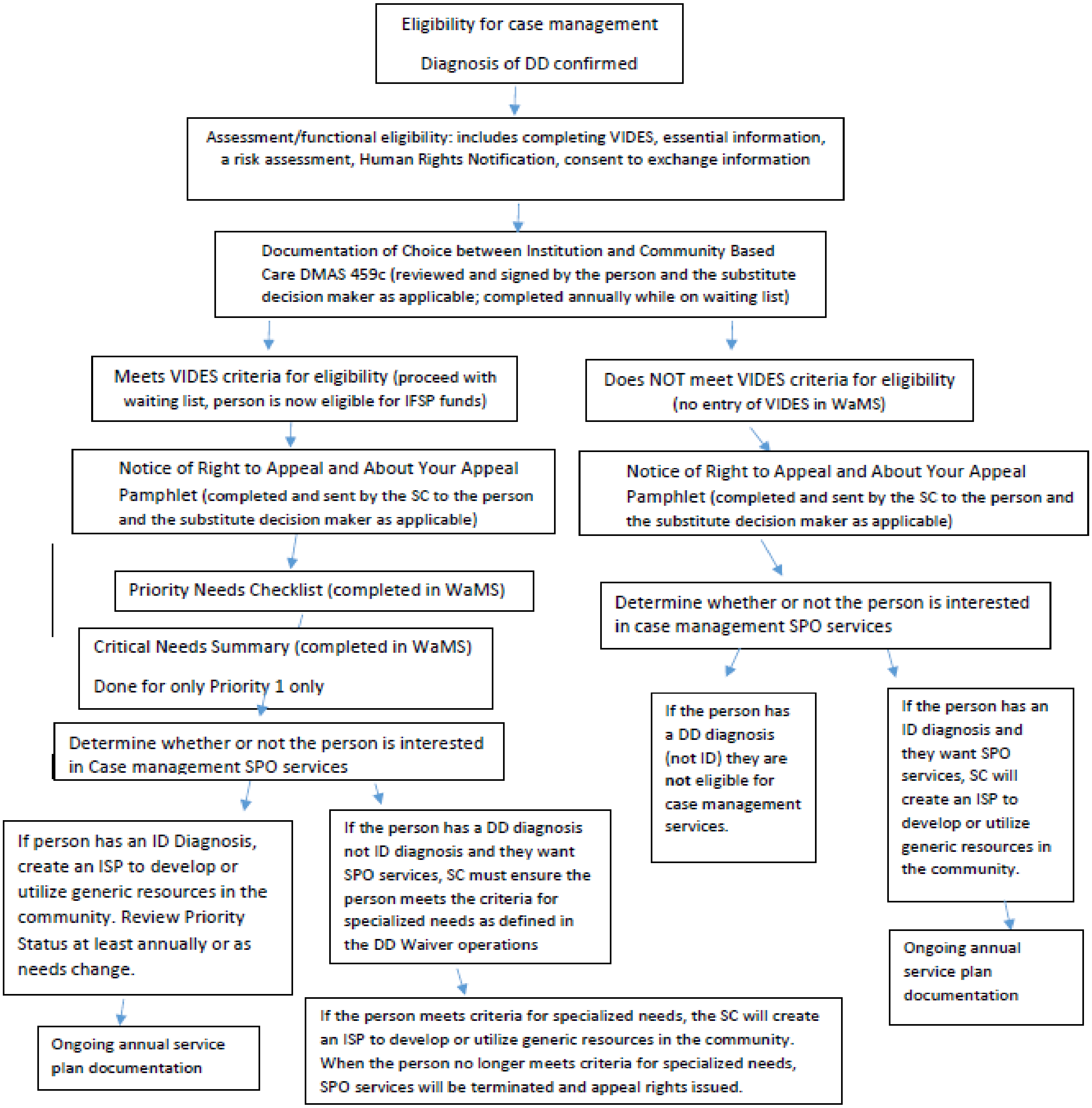
According to the Human Rights Regulations (12VAC35-115-145. Determination of Capacity to Give Consent or Authorization), if the person receiving services is suspected of lacking the capacity to consent to treatment, services, or research, or to authorize the disclosure of information, the SC must obtain an evaluation conducted by or under the supervision of a licensed professional who is not directly involved with the individual to determine whether the individual has capacity to consent or to authorize the disclosure of information. See the specific requirements in 12VAC35-115-145.

Therefore, before an AR or LG is selected, a determination must be made by the above means that the person served is not capable of making informed decisions about care or consent to participate in research. This is true even if the person requests an AR or LG to be designated.

Choice of Waiver/Intermediate Care Facility

During the initial assessment and while screening for the DD Waiver wait list, the SC is responsible for ensuring documentation that indicates the person's desire for DD community-based care. This documentation ensures that the individual understands the choice between community-based care over institutional services. The required documentation is known as the Documentation of Recipient Choice Between Institutional Care or Home and Community-Based Services Form DMAS 459C. It is completed during the initial screening for the DD Waiver program and annually thereafter until the individual receives a DD Waiver. It should be maintained in the person's record. Please see the next page for the Case Management and Wait List Eligibility Flowchart.

Case Management and Wait List Eligibility Flowchart



Eligibility for case management

Diagnosis of DD confirmed

Assessment/functional eligibility: includes completing VIDES, essential information, a risk assessment, Human Rights Notification, consent to exchange information

Documentation of Choice between Institution and Community Based Care DMAS 459c (reviewed and signed by the person and the substitute decision maker as applicable; completed annually while on waiting list)

Meets VIDES criteria for eligibility (proceed with waiting list, person is now eligible for IFSP funds)

Notice of Right to Appeal and About Your Appeal Pamphlet (completed and sent by the SC to the person and the substitute decision maker as applicable)

Priority Needs Checklist (completed in WaMS)

Critical Needs Summary (completed in WaMS)

Done for only Priority 1 only

Determine whether or not the person is interested in Case management SPO services

If person has an ID Diagnosis, create an ISP to develop or utilize generic resources in the community. Review Priority Status at least annually or as needs change.

Ongoing annual service plan documentation

If the person has a DD diagnosis not ID diagnosis and they want SPO services, SC must ensure the person meets the criteria for specialized needs as defined in the DD Waiver operations

If the person meets criteria for specialized needs, the SC will create an ISP to develop or utilize generic resources in the community. When the person no longer meets criteria for specialized needs, SPO services will be terminated and appeal rights issued.

Does NOT meet VIDES criteria for eligibility (no entry of VIDES in WaMS)

Notice of Right to Appeal and About Your Appeal Pamphlet (completed and sent by the SC to the person and the substitute decision maker as applicable)

Determine whether or not the person is interested in case management SPO services

If the person has a DD diagnosis (not ID) they are **not** eligible for case management services.

If the person has an ID diagnosis and they want SPO services, SC will create an ISP to develop or utilize generic resources in the community.

Ongoing annual service plan documentation

Supports Intensity Scale (SIS®)

Supports Intensity Scale (SIS®) is an assessment tool that identifies the practical supports required by individuals to live successfully in their communities. DBHDS shall use the SIS Children's Version® (SIS-C®) for individuals five years through 15 years of age. DBHDS shall use the SIS Adult Version® (SIS-A®) for individuals 16 years of age and older.

SIS assessment requirements:

a. At least every four years for those individuals who are 22 years of age and older.
b. At least every three years for those individuals who are 16 years of age through 21 years of age.
c. Every two years for individuals five years through 15 years of age when the individual is using a tiered service, such as group home residential, sponsored residential, supported living residential, group day, or community engagement. Another developmentally appropriate standardized living skills assessment approved by DBHDS, such as the Brigance Inventory, Vineland, or Choosing Outcomes and Accommodations for Children, shall be completed every two years for service planning purposes for those in this age grouping who do not receive a SIS assessment.

Once awarded a DD Waiver slot, the SIS process begins. DBHDS routinely communicates to SIS vendors the order for SIS assessment completion. To move forward with scheduling, the SIS vendors rely on SCs for needed information. The SC is responsible for identifying qualified respondents and dates the SC is available to participate in the SIS assessment.

For individuals who desire additional information about the SIS, The AAIDD, the copyright holder and sole owner of the Supports Intensity Scale AAIDD, has developed information for respondents who have questions. The aim is to explain what to expect during the interview, the SIS Family Friendly Report, and provide a SIS Respondent Handbook.

SIS-A Respondent Resources: https://www.aaidd.org/sis/sis-a/sis-a-resources
SIS-C Respondent Resources: https://www.aaidd.org/sis/sis-c/sis-c-resources

A completed SIS Family Friendly Report is made available to the board's SIS point person via SIS Online. The SC is responsible for sharing a copy of the SIS report with all providers and family members. Team members should use the SIS in conjunction with Virginia Supplemental Questions, the person-centered planning process, and other assessment information to develop an individual's ISP.

A mathematical algorithm uses the SIS scores to assign one of seven levels of need and one of four reimbursement tiers to each SIS assessment. The reimbursement tier sets the reimbursement rate for tiered DD waiver services (group home, sponsored residential, supported living, independent living supports, group day, community engagement, and group supported employment). This process provides greater reimbursement for smaller settings and for supporting those with more intensive needs. For more information on the SIS and the SC's role in the assessment, review the forms at the end of this handbook.

Physical Exam

When a person receives a DD Waiver slot, the SC should request documentation of a recent physical examination and document the date in WaMS. It is expected that people will make a good faith effort to obtain a physical on a regular basis and as needed. The physical exam must have been completed no more than 12 months prior to the initiation of DD Waiver services. For children through 21 years of age, physicals must be completed according to the EPSDT frequency.

DMAS 460 Virginia Informed Choice Form (DMAS 460)

When working with an individual to determine choice of providers, it is crucial for the SC to ensure the person is aware of all options. The person should be given information on all available DD Waiver services and SCs. Many CSBs keep an up-to-date list of local DD Waiver providers. Additionally, the SC could direct the individual and family to the DMAS provider search tool. A signed copy must be retained in the person's electronic medical record. The Virginia Informed Choice Form (DMAS 460) should be reviewed and completed with the person and/or substitute decision-maker at enrollment into the DD Waiver, updated annually (and include choice and name of SC), when there is a request for a change in waiver providers, when new services are requested, or when the person wants to move to a new location or is dissatisfied with the current provider.

DMAS 225 Medicaid Long Term Care (LTC) Communication Form

The DMAS 225 is a form that serves as a method of communication between the SC and the LDSS. The DMAS 225 is required in the following circumstances:

- Home and community-based waiver services are implemented
- An individual dies, with a description of the cause of death along with documentation
- An individual is discharged or terminated from ALL waiver services
- Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 calendar days
- A selection by the individual or his family/caregiver, as appropriate, of a different support coordination/case management provider

Prompt submission of this form is necessary to ensure that LDSS has correct and current information in order to determine patient pay responsibilities and ensure ongoing eligibility for Medicaid. For more detailed information about the SC's role as it pertains to patient pay, see the link below. More information about patient pay can be found in Chapter 6 patient pay.

CHAPTER 5:
Wait List and Slot Assignment

Wait List

In Virginia, the need for DD Waiver services is greater than the number of slots Virginia has available to distribute. Therefore, everyone who meets eligibility criteria and requests DD Waiver services is added to a waitlist. Because DD waiver slots are distributed based on urgency of need and the number of waiver slots are made available based on Virginia's budget, there is no way to tell how long a person will remain on the waitlist.

Key point to remember: When placing someone on the waitlist, the Support Coordinator should ensure the family knows what services they would utilize if offered a waiver slot. The SC should regularly monitor the needs of people and discuss the services that are available under the DD Waiver. Remember that a person must be willing to use services within 30 days of being awarded a slot. There is, however, a method for determining the urgency of need among those waiting for services.

Support Coordination while on the Waitlist

If the individual is Medicaid eligible, and is determined to meet either DD or ID active support coordination/ case management service criteria, and the individual is requesting support coordination/case management services, the SC may open the individual to Medicaid targeted case management services according to the following parameters:

- When an individual with ID meets Medicaid targeted case management criteria, an ISP, in compliance with DBHDS regulations, is developed to address the service need(s). SCs may engage in a monthly allowable activities/contacts and face-to-face contacts at least every 90 calendar days (plus a 10-day grace period) to address the service need(s) identified in the ISP.
- Individuals with DD, other than ID, may not receive routine, ongoing support coordination/case management services unless there is a documented "special service need". CSBs cannot bill for individuals on the DD waiver waitlist receiving DD (non-ID) support coordination/case management services unless a special service need is identified.

If a special service need is identified for an individual on the DD waiver waiting list, an ISP must be developed to address that need. A special service need is one that requires linkage to and temporary monitoring of those supports and services identified in the ISP to address an individual's mental health, behavioral, and medical needs or provides assistance related to an acute need that coincides with support coordination allowable activities (see below). SCs must make face-to-face contact with the individual at least every 90 calendar days to monitor the special service need, and documentation is required to support such contact. If an activity related to the special service need is provided in a given month, then the SC would be eligible for reimbursement. Once the special service need is addressed related to the specific activity identified, billing for the service may not continue until a special service need presents again.

Examples of special service needs for people with DD who are waiting for waiver services could include:

- A child with autism on the waiting list needs to access behavioral services;
- An adult experiences the loss of a family caregiver and needs to look for alternate housing;
- Following a stroke an adult needs to locate specialized medical services to transition back home;
- A family member reports a child on the waiting list has experienced changes in his health status and needs to explore options to avoid placement in an institutional setting;
- A young person is transitioning out of school and needs to access vocational rehabilitation or employment services;
- A young woman who has limited contact with family begins experiencing seizures and needs to support to locate a neurologist;
- New neighbors move into a person's neighborhood resulting in escalating conflict between the person with DD and the neighbors.

Individuals with no identified funding source are provided with emergency services and, subject to the availability of funds appropriated for them, case management services. The SC assists individuals who are not admitted to support coordination/case management services to identify other appropriate and available services. Individuals on the DD Waiver waitlist are provided with information about the Individual and Family Support Program (IFSP) and other services for which they may be eligible.

Depending on the availability of state and local resources, individuals may be offered other CSB-funded services. In collaboration with DBHDS, the CSB monitors all individuals on the DD Waiver waitlist and provides CSB contact information should the individual’s status change and a reassessment of needs is indicated.

Priority Needs Checklist

The Priority Needs Checklist must be completed and submitted in order to add a person to the waitlist. The checklist identifies the reason a person falls into priority category (one, two, or three) and is completed after the VIDES has been conducted. The Priority Needs Checklist is located and completed in WaMS under the screening and assessments section. Priority status is based on how much and how urgently someone is in need of help.

Key Points to Remember:

- The priority screening should be reviewed anytime there is a change in circumstance to assure it accurately reflects the support needs of the person seeking services.
- Only those who meet Priority One status can be assigned an available DD Waiver slot.
- Those assigned with a Priority two or Priority three status cannot be awarded a CL Waiver or FIS waiver unless every person in the state who is assigned a Priority One status, already has a slot.
- For assignment of the BI waiver, a person assigned to Priority Two or Three may receive a BI slot if no one in a higher priority category is requesting and qualifies for assignment of the BI waiver.

Critical Needs Summary

The SC must also complete a Critical Needs Summary (CNS) in WaMS for those designated as having a Priority One status. The purpose of the CNS is to determine a person’s level of urgency. This is a required step in placing a person on the waitlist. In WaMS, the CNS option will appear under the screening and assessments section after the Priority Needs Checklist has been completed and submitted.

Right to Appeal

Once a person has been placed on the DD Waiver waitlist, the SC must send a letter notifying them of appeal rights. Additionally, if a person on the waitlist has a change in priority status, they must also be issued appeal rights if moving to a lower priority.

Annual Waitlist Contact

Additionally, once a year DBHDS will send a letter to everyone on the DD Waiver waitlist. Included in the letter will be instructions to review and sign the Documentation of Individual Choice Between Institutional Care or Home and Community-Based Services Form and the Needed Services Form.

DD Waiver Slot Allocation General Information

DD Waiver slots become vacant when someone who was previously using DD Waiver services moves out of state, passes away, moves into a nursing facility or institution, no longer meets eligibility criteria, or chooses to no longer utilize the supports provided under the DD Waiver. Currently the number of slots is limited by the availability of funding for DD Waiver services. Funds are managed at the state level and the appropriation of additional funds to increase the number of slots is dependent upon Virginia General Assembly action. Each CSB is allotted a designated number of slots. If an assigned slot becomes vacant, the CSB must use it in a timely manner to provide DD Waiver services to another eligible individual. Slots are reassigned to people on the DD Waiver waitlist by the waiver slot assignment committee (WSAC).

When the General Assembly allocates more than 40 slots for a given waiver, allocations will be made by providing one slot per board then a standard calculation (considering priority numbers per board) will be used to disseminate the remaining slots.

When the General Assembly allocates less than 40 slots for a given waiver, allocations will be made by combining all WSACs within a region. Each WSAC will be represented by the assigned facilitator and two additional representatives per committee.

Waiver Slot Assignment Committee

WSACs were developed to establish a means for determining the assignment of DD Waiver slots. The DD Waiver separates the eligibility determining entity (CSB SCs) from the entity who determines slot assignment. There is a WSAC in each locality/region of Virginia. The committee is comprised of people with diverse personal and professional backgrounds, as well as varied knowledge and expertise and no identified conflict of interest. For more information on qualifications for committee members and the responsibilities of the WSAC members, please refer to the WSAC forms at the end of this handbook. SCs play an important role in the assignment of a vacant DD Waiver slot. They must ensure that information in WaMS accurately reflects an individual’s current needs. When a slot is available for assignment, the CSB contacts the regional support specialist (RSS) and a WSAC meeting is convened. For more information SC’s role in the operations of WSAC, please refer to the WSAC forms at the end of this handbook.

Slot Assignment

Once a person is offered a DD Waiver slot, the SC is responsible for ensuring that the transition to Waiver services includes a thorough review of the assessment information and service options under the DD waiver. Those responsibilities are listed below.

Waiver Slot Management

In addition to updating the assessments and obtaining documentation of informed choice, the SC is also responsible for enrolling the person into the newly assigned slot. When a slot has been assigned, the enrollment status of the person in WaMS is listed as projected enrollment status. In order to initiate services, the person’s status must be moved to active status. This process is completed in WaMS. See the WaMS CSB user guide section 9 for more detailed instructions of how to move a person from projected to active status.

Retain a Slot

At times, the services for a person are delayed in starting or may be interrupted for some reason such as a hospitalization or difficulty in locating a service provider. In this instance, if services are interrupted or delayed for 30 days, the CSB must request that the DD Waiver slot be held for that person. The SC will then complete the retain slot form located in WaMS. More detailed instructions on how to complete a retain slot form can be found in section 10 of the WaMS CSB user guide.

Emergency Slot

At times, an SC may provide support to someone who needs immediate access to DD waiver services. There is a specific criterion that the person must meet in order for a SC to request access to an dmergency DD Waiver slot. After exploring all possible alternative options, a CSB can request access to an emergency Waiver slot by submitting an emergency slot request form.

Reserve Slot Request Form

At times, a SC may be providing support to someone who has experienced a change in assessed needs, requiring services available in a different waiver. The reserve slots enable a safety net with which someone can return to the original waiver, if needed. The SC must ensure that the person meets the criteria in order to request a reserve DD Waiver slot. There is a chronological waitlist that DBHDS keeps for reserve slots funded by the General Assembly action.

Update WaMS Data

In order for DD Waiver services to be initiated, the SC should ensure that any information in WaMS is accurate and up to date, including but not limited to:

- Individual’s profile (demographics, contact information, diagnosis etc.)
- Current/updated VIDES

CHAPTER 6:
Developmental Disability Waiver & Services

Introduction

Virginia's Medicaid Waivers, which are referred to as Home and Community-Based Services (HCBS), can cover supports a person needs to live independently at home and in the community by combining federal and state money to provide long-term community-based supports for people who are elderly or have disabilities.

Waivers enable Virginia to offer a variety of standard medical and non-medical services without the requirement that someone live in an institution in order to use those same services. This handbook focuses on the DD Waivers. Medicaid Waivers expand Medicaid eligibility to those who may not otherwise qualify for services based on Medicaid financial requirements. Medicaid Waivers provide an opportunity for people to transition from institutions and large settings to community-based settings. As a result, Waivers allow people to be active in and live in their own community, connect with people without disabilities, and have greater independence and flexibility in their lives.

The state agency that administers the DD Waivers in Virginia is DMAS. DBHDS manages day-to-day DD Waiver operations. Locally, DD Waiver services are coordinated by CSBs/BHAs. Support coordination services are provided by SCs employed by CSBs/BHAs and private providers under contract with the CSBs/BHAs across the state.

Brief History of Developmental Disability Waivers

HCBS Waivers were established by the U.S. Congress in 1981 to slow the growth of Medicaid spending for nursing facility care and to address criticism of Medicaid's institutional bias. Congress was responding to the growth in institutional costs and to people with disabilities who preferred to live in their own homes with services such as personal care and community living supports. States were given the option to develop waiver programs as alternative services for people who are eligible for placement in an institution.

Virginia first applied for a waiver for those with an intellectual disability in 1990, with the federal Medicaid agency, the Center for Medicare and Medicaid Services (CMS). In early 1991, Virginia's waiver application was accepted by CMS, and Virginia was able to begin offering services through what was then called the Mental Retardation Waiver. This waiver, which was renamed the ID Waiver, was amended several times over the next 20 years, increasing the scope of community support services.

In 2000, the individual and family DD support Waiver was established to serve people with DD not meeting the diagnostic criteria for the ID Waiver. In 2005, Virginia began the day support Waiver, which focused on day support and employment activities, allowing for additional people to be supported while waiting to use more comprehensive services offered through the ID Waiver.

Description of Developmental Disability Waivers

The DD Waivers provide supports and service options for successful living, learning, physical and behavioral health, employment, recreation, and community inclusion.

The DD Waivers are designed to serve individuals of any age with a DD and children (birth through age 9) with a substantial developmental delay or specific congenital or acquired condition. There are three DD Waivers, the building independence waiver, the family and individual supports waiver and the community living waiver.

- **The building independence waiver** (BI) is for adults (18+) who are able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports are complemented by non-waiver-funded rent subsidies. BI Services at a glance
- **The family and individual supports waiver** (FIS) is for individuals living with their families or friends, in their own homes, or in supported living (for those over 18) including supports for those with some medical or behavioral needs. This is available to both children and adults. FIS Services at a glance
- **The community living waiver** (CL) includes residential supports and a full array of medical, behavioral, and non-medical supports. This is available to adults and children and may include 24/7 supports for individuals with complex medical and/or behavioral support needs through licensed services. CL Services at a glance

Services in Waivers

The services available under the DD Waivers are listed below in alphabetical order. This listing provides the most current information available. DMAS also has a DD Waiver policy manual located here. The Compatible/Incompatible Combinations of services in the DD Waivers chart can be accessed in Chapter 15 under Waiver.

Assistive Technology

Service Description: Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.

In order to qualify for these services, the individual shall have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. Assistive technology shall be covered in the least expensive, most cost-effective manner. Equipment or supplies already covered by the State Plan may not be purchased under the waiver. The SC is required to ascertain whether an item is covered through the State Plan before requesting it through the waiver.

Service Units and Service Limitations: Maximum $5000 per calendar year.

Benefits Planning Services

Service Description: Benefits planning is an individualized analysis and consultation service. This service assists recipients of a DD waiver and social security (supplemental security income, social security disability insurance) to understand their personal benefits and explore their options regarding working, how to begin employment, and the impact employment will have on their state and federal benefits. This service includes education and analysis about current benefits' status and implementation and management of state and federal work incentives as appropriate. Benefits planning involves the development of written resource materials, which aid individuals and their families/legal representatives in understanding current and future rewards that come from working, thereby reducing uncertainties associated with losing necessary supports and benefits if they choose to work or stay on the job. This service facilitates individuals in making informed choices concerning the initiation of work. Furthermore, it provides information and education to individuals currently employed in making successful transition to financial independence.

Allowable activities include but are not limited to:

Pre-employment benefits review which may include:

a. Benefits planning query (BPQY from Social Security Administration (SSA)
b. Pre-employment benefits summary and analysis (BS&A)
c. Employment change benefits summary and analysis

Work incentives development or revisions (PASS, IRWE, BWE, IDA):

a. Plan to achieve self-support (PASS)
b. Impairment-related work expenses (IRWE)
c. Blind work expenses (BWE)
d. Individual development accounts (IDA)
e. Student earned income exclusion (SEIE)
f. Medicaid while working
g. Medicaid Works (Virginia's Medicaid Buy-In Program)
h. Work incentive revisions

Resolution of SSA benefits issues:

a. Overpayments
b. Subsidies
c. Work activity reports

Other Services:

a. ABLE now
b. Financial health assessment

Service units and service limitations: The annual year limit for benefits planning services is $3,000. No unspent funds from one plan year may be accumulated and carried over to subsequent plan years. Providers may not bill for waiver benefits planning services while the eligible individual has an open employment services case with the Department for Aging and Rehabilitative Services (DARS) and is eligible for the same service through DARS.

Center-Based Crisis Supports

Service description: Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (crisis therapeutic home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting.

Allowable activities include but are not limited to:

1. Psychiatric, neuropsychiatry, and psychological assessment, and other assessments and stabilization techniques
2. Medication management and monitoring
3. Behavior assessment and positive behavior support
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community and
6. Assistance with skill-building as related to the behavior creating the crisis in areas such as self-care/ ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance.

Service units and service limitations: 1 day unit up to 6 months in 30 day increments.

Community-Based Crisis Supports

Service description: Community-based crisis supports are ongoing supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual’s home and community setting. Crisis staff work directly with and assist the individual and their current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. These services provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement.

Allowable activities include but are not limited to:

1. Psychiatric, neuropsychiatric, and psychological assessment, and other assessments and stabilization techniques
2. Medication management and monitoring
3. Behavior assessment and positive behavior support
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual
5. Training of family members and other caregivers and service providers in positive behavioral supportsto maintain the individual in the community
6. Assisting with skill building as related to the behavior creating the crisis in areas such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, and medication compliance

Service units and service limitations: 1 day unit up to 6 months in monthly increments.

Community Coaching

Service Description: Community coaching is a service designed to assist people in acquiring a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of community engagement.

Allowable activities include but not limited to: (determined with age sensitivity in mind and reflective of the person’s interests): Skill building through participation in community activities and opportunities such as outlined in Community Engagement and encompassing:

- Activities and events in the community, volunteering, etc.
- Community, educational or cultural activities and events
- Skill-building and support in building positive relationships
- Routine needs while in the community
- Supports with self-management, eating, and personal needs of the individual while in the community
- Assuring safety

Community coaching requires 1:1 support and must take place solely in community settings.

Service units and service limitations 1 hour unit, up to 66 hours/week alone or in combination with other day options

Community Engagement

Service description: Community engagement supports and fosters the ability of a person to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities.

Community engagement provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). The activities enhance involvement with the community and facilitate the development of natural supports.

Allowable Activities:

Skill building, education, support and monitoring that assists with the acquisition and retention of skills in the following areas:

- Activities and public events in the community
- Community educational activities and events
- Interests and activities that encourage meaningful use of leisure time (e.g., through participating in sports/exercise, a club or other social group, a class to learn a new hobby)
- Unpaid work experiences (i.e., volunteer opportunities)
- Maintaining contact with family and friends

Skill-building and education in self-direction designed to enable achievement in one or more of the following outcomes particularly through community collaborations and social connections developed by the program (e.g., partnerships with community entities such as senior centers, arts councils, etc.).

Community engagement must be provided in the least restrictive and most integrated settings according to the individual's person-entered plan and individual choice.

Service units and service limitations: 1 hour unit, up to 66 hours alone or in combination with other day options; no more than a ratio of 1:3 and must take place solely in the community.

Community Guide

Service description: Community guide services include direct assistance to promote individuals' self-determination through brokering community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation. This means that community guides investigate and coordinate as necessary the available naturally occurring community resources to facilitate the individual's participation in those resources of interest to the individual.

Allowable Activities:

This service may be provided by persons with one of two emphases:

- General community guide involves using existing assessment information regarding the individual's general interests to determine specific preferred activities and venues that are available in the individual's community to which the individual desires to be connected to promote inclusion and independent participation in the life of the individual's community.
    - Use assessment and other information provided by the SC along with an in-depth discussion and with the individual and people who know the individual
    - Assist the individual in connecting to the identified community resources
    - Provide advocacy and informational counseling
    - Escort to or demonstrate means of accessing identified integrated community activities, supports, services, or resources
    - Follow up with individual to determine and document the individual's participation

- Community housing guide involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining activities.
    - Complete tenant screening
    - Develop a plan using the community housing guide roadmap form
    - Assist with the housing search and application process
    - Help identify and request resources to cover expenses
    - Assist in arranging for and supporting details of the move
    - Provide education and training on the role, rights, and responsibilities of the tenant and landlord
    - Provide training in being a good tenant and lease compliance
    - Assist in resolving disputes with landlords or neighbors
    - Assist with the housing recertification process

Community guide is expected to be a short, periodically intermittent, intense service associated with a specific outcome. An individual may receive one or more of the two types of community guide services in a plan year.

Community guide activities conducted not in the presence of the individual shall not comprise more than 25 percent of the authorized plan for support hours. The community guide shall not supplant, replace, or duplicate activities that are required to be provided by the SC. Prior to accessing funding for community guide, all other available and appropriate funding sources shall be explored and exhausted.

Service units and service limitations: Each type of community guide service may be authorized for up to six consecutive months, and the cumulative total across both may be more no more than 120 hours in a plan year.

Companion Services

Service description: Companion services provide nonmedical care, socialization, or support to adults ages 18 and older. This service is provided in an individual's home or at various locations in the community.

Allowable activities include, but are not limited to:

1. assistance or support with tasks such as meal preparation, laundry, and shopping;
2. assistance with light housekeeping tasks;
3. assistance with self-administration of medication;
4. assistance or support with community access and recreational activities; and
5. support to assure the safety of the individual.

Unlike personal assistance and residential support, companion services do not permit routine support with activities of daily living (such as using the bathroom, bathing, dressing, or grooming). The allowable activities center on “instrumental activities of daily living” (meal prep, shopping, community integration, etc.).

Companion services may be self-directed or agency-directed.

Service units and service limitations: 1 hour unit consumer-directed or agency-directed up to 8 hours a day, 18 and older.

Consumer Directed Services Facilitation

Service description: Consumer-directed services facilitation uses the support of a services facilitator who is a Medicaid-enrolled provider. A services facilitator can be enrolled as an independent Medicaid provider or as an employee of a Medicaid-enrolled services facilitation agency provider. The services facilitator supports eligible individuals, and sometimes their families, in properly using consumer-directed services (CD services). CD services empower the person with a disability to have greater control over the services they use. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services they use. CD services may be used in differing degrees and may span different types of services.They range from independently making all decisions and managing services directly, to using a representative to manage needed services. The underlying principle of CD services is that people with disabilities have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services.

Service units and service limitations: Per visit, initial and 6-month re-assessments. The online training is found on the Partnership for People with Disabilities website.

Service description: Crisis support services are intensive supports provided by appropriately trained staff in the areas of crisis prevention, crisis intervention, and crisis stabilization to a person who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize his current community living situation. This service shall be designed to stabilize a person and strengthen his current living situation so they can be supported in the community during and beyond the crisis period.

This service includes: crisis prevention, crisis intervention, and crisis stabilization

- **Crisis prevention services** provide ongoing assessment of medical, cognitive, and behavioral status as well as predictors of self-injurious, disruptive, or destructive behaviors, with the initiation of positive behavior supports to prevent occurrence of crisis situations. Crisis prevention also encompasses providing support to the family and the individual through facilitating team meetings, revising the behavior plan, etc. as they implement changes to the plan for support and address any residual concerns from the crisis situation. Staff will arrange to train and mentor staff or family members who will support the individual long term once the crisis has stabilized in order to minimize or prevent recurrence of the crisis. Crisis support staff will deliver such support in a way that maintains the individual's typical routine to the maximum extent possible.

- **Crisis intervention services** are used in the midst of the crisis to prevent the further escalation of the situation and to maintain the immediate personal safety of those involved. Crisis intervention is a relatively short-term service that provides a highly structured intervention that may include temporary changes to the person’s residence, removal of certain items from the setting, changes to the person’s daily routine and emergency referrals to other care providers. Those providing crisis intervention services must also be well-versed and fluent in verbal de-escalation techniques, including active listening, reflective listening, validation, and suggestions for immediate changes to the situation.

- **Crisis stabilization services** begin once the acuity of the situation has resolved and there is no longer an immediate threat to the health and safety of those involved. Crisis stabilization services are geared toward gaining a full understanding of all the factors that precipitated the crisis and may have maintained it until trained staff from outside the immediate situation arrived. Crisis stabilization plans are developed by staff trained in basic behavioral treatment and crisis management. These plans may include modifications to the environment, interventions to enhance communication skills, or changes to the individual’s daily routine or structure. Staff developing these plans must be able to train support staff, family, and other significant persons in the individual’s life.

Service units and service limitations: 1 day unit; limits vary by component.

Electronic Home-Based Services

Service description: Electronic home-based services are goods and services based on Smart Home© technology. This includes purchases of electronic devices, software, services, and supplies not otherwise provided through the waiver or through the State Plan that would allow access to technology that can be used in a person's residence to support greater independence and self-determination.

The items and services must:

- Decrease the need for other Medicaid services (e.g., reliance on staff supports); and/or
- promote inclusion in the community; and/or
- increase the individual's safety in the home environment.

Allowable activities include:

- Assessment for determining appropriate equipment/devices
- Acquisition, training, and use of goods and services
- Ongoing maintenance and monitoring services to address an identified need in the individual's person-centered service plan (including improving and maintaining the individual's opportunities for full participation in the community).

Service units and service limitations: Up to $5,000 annually. Not available to individuals using residential supports that are reimbursed on a daily basis (e.g., group home, sponsored or supported living residential services).

Employment and Community Transportation

Service description: Employment and community transportation is offered in order to enable individuals to gain access to waiver and other community services or events, activities, and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan.

Environmental Modifications

Service description: Environmental modifications are physical adaptations to the individual's primary home or primary vehicle that are necessary to ensure the health and welfare of the individual or that enable the individual to function with greater independence. Such adaptations may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the individual. Modifications may be made to a primary automotive vehicle in which the individual is transported if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a nonrelative who provides primary long-term support to the individual and is not a paid provider of services.

Service units and service limitations: Up to $5,000 calendar year.

Waiver will not pay for durable medical equipment.

Group Day Services

Service description: Group day services include skill-building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, and enhancement of social networks. Supports may be provided to ensure an individual's health and safety.

Skill-building is a required component of this service unless the individual has a documented degenerative condition, in which case day support may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills.

Group day services should be coordinated with any physical, occupational, or speech/language therapies listed in the person-centered plan.

Allowable activities include but are not limited to skill development and support in order to:

- Develop self, social, and environmental awareness skills
- Develop positive behavior, using community resources
- Volunteer and connect with others in the community
- Engage in career planning to include establishing a career goal
- Develop skills required for paid employment in a community setting

Service units and service limitations: 1 hour unit up to 66 hours/week alone or in combination with other day options; Maximum 1:7 ratio.

Group Home Residential

Service description: Group home residential consists of skill-building, routine supports, general supports, and safety supports, provided primarily in a licensed or approved residence that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Group home residential services may be in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home or (ii) in the home of an adult foster care provider.

This service includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports, as needed.

Group home residential services shall be authorized for Medicaid reimbursement in the Person-Centered Plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Supports may be provided individually or simultaneously to more than one person living in the home, depending on the required support.

Service Units and Service Limitations: 1 day

Independent Living Support

Service description: Independent living support is provided to adults (18 and older) and offers skill-building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.

Individuals typically live alone or with roommates in their own homes or apartments.
These services are not provided in licensed homes. The supports are provided in a person's residence or in community settings. There must be a backup plan for times when independent living supports cannot be provided as regularly scheduled.

Allowable activities include but are not limited to:

- Skill-building and support to promote community inclusion
- Increasing social abilities and maintaining relationships
- Increasing or maintaining health, safety and fitness
- Improving decision-making and self-determination
- Promoting meaningful community involvement
- Developing and supporting with daily needs

Service units and service limitations: 1 month unit up to 21 hours a week.

Individual and Family/Caregiver Training

Service description: Family/caregiver training provides training and counseling services to families or caregivers of those who use waiver services. For purposes of this service, "family" is defined as the unpaid people who live with or provide care to an individual served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include people who are employed to care for the individual. All family/caregiver training must be included in the individual's written plan of care.

Allowable activities include:

- Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support
- Participation in educational opportunities designed to enable individuals to gain a better understanding of their disabilities or increase their self-determination/self-advocacy abilities

The need for the training and the content of the training in order to assist family or caregivers with maintaining the individual at home must be documented in the plan of care. The training must be necessary in order to improve the family or caregiver's ability to give care and support.

Service units and service limitations: 80 hours per plan of care year, billed hourly.

In-Home Support Services

Service description: In-home support services are residential services that take place in someone's home, family home, or community setting and typically supplement the care provided by the individual, family, or other unpaid caregiver. In-home support services are designed to ensure the health, safety, and welfare of the individual.

Allowable services include:

- Skill-building
- Routine supports
- Safety supports, any of which enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings

It is permissible to bill this service for up to three people at a time (e.g., siblings); however, the per person reimbursement rate decreases with each additional individual. A backup plan for times when in-home supports cannot be provided as regularly scheduled must be in place.

Service units and service limitations: 1 hour; up to 3 people during a single time period.

Peer Mentor Supports

Service description: This service is delivered to waiver recipients by other individuals with DD who are or have been service recipients, have shared experiences with the individual, and provide support and guidance. The service is designed to foster connections and relationships which build individual resilience. Peer mentor supports encourage individuals with DD to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the Waiver with Waiver participants so that the Waiver participant is better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe, as well as to overcome personal barriers which are inhibiting the individual from being more independent. Peer mentoring is intended to assist with empowering the individual receiving the service. This service is delivered based on the support needs of the individual as outlined in the person-centered plan. This service is designed to be short-term and periodic in nature.

Allowable activities include:

- The administering agency facilitates peer to peer "matches" and follows up to assure the matched relationship meets the individual's expectations
- The peer mentor has face-to-face contact with the individual to discuss specific interests/desired outcomes related to realizing greater independence and the barriers to achieving them
- The peer mentor explains community services and programs and suggests strategies to the individual to achieve desired outcomes, particularly related to living more independently, engaging in paid employment, and expanding social opportunities in order to reduce the need for supports from family members or paid staff
- The peer mentor provides information from experience to help the individual with problem-solving, decision-making, developing supportive community relationships, and exploring specific community resources that promote increased independence and community integration;
- The peer mentor assists the individual in developing a personal plan for accessing the identified integrated community activities, supports, services, and/or resources

Service Units and Service Limitations:

1. Peer mentor supports is expected to be a short, periodically intermittent, intense service associated with a specific outcome. Peer mentor supports may be authorized for up to 6 consecutive months, and the cumulative total across that timeframe may be no more than 60 hours in a plan year.
2. The peer mentor shall not supplant, replace, or duplicate activities that are required to be provided by the SC. Prior to accessing funding for this waiver service, all other available and appropriate funding sources shall be explored and exhausted.
3. Peer mentors cannot mentor their own family members.
4. Peer mentors shall be at least 21 years of age and may provide these supports only to individuals 16 years of age and older.
5. Individuals who receive supports through DD or other Waivers may be peer mentors.

Personal Assistance

Service description: Personal assistance services provide direct support with activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. These services may be provided in home and community settings to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal assistance services may be consumer/self-directed (CD) or agency-directed. If self-directed, a services facilitator is needed.

Each individual and family/caregiver, family, or caregiver shall have a back-up plan for needed supports in case the personal assistant does not report for work as expected or terminates employment without prior notice.

Allowable activities include:

1. Support with activities of daily living (ADLs), such as bathing or showering, using the toilet, routine personal hygiene skills, dressing, transferring, etc.
2. Support with monitoring health status and physical condition
3. Support with medication and other medical needs
4. Supporting the individual with preparation and eating of meals
5. Support with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc.
6. Support to assure the safety of the individual
7. Support needed by the individual to participate in social, recreational and community activities
8. Assistance with bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care when properly trained and supervised by an RN
9. Accompanying the individual to appointments or meetings

Personal Assistance is not available to those who:

- Use group home residential services
- Use sponsored residential services
- Use supported living residential services
- Live in assisted living facilities
- Receive comparable services through another program

Service units and service limitations: Ratio 1:1; 1 hour unit; not compatible with congregate services.

Personal Emergency Response System

Service Description: Personal emergency response system (PERS) is an electronic device and monitoring service that enable certain individuals to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS services may be authorized when there is no one else in the home with the individual who is competent or continuously available to call for help in an emergency. Medication monitoring units must be physician-ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring services simultaneously.

Service units and service limitations: One month unit.

Private Duty Nursing

Service description: Private duty nursing is individual and continuous care (in contrast to part-time or intermittent care) for individuals with a serious medical condition and/or complex health care need, certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or ICF-IID. Care is provided by a RN or a licensed practical nurse (LPN) under the direct supervision of a RN.

These services are provided at a person's place of residence or other community settings.

Allowable activities include, but are not limited to:

- Monitoring of an individual's medical status and
- Administering medications and other medical treatment

Service units and service limitations: 15 minutes

Respite

Service description: Respite services are specifically designed to provide temporary, substitute care for care that is normally provided by the family or other unpaid, primary caregiver. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver.

Such services may be provided in home and community settings to maintain health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs).

Respite services may be consumer/self-directed or agency-directed. If self-directed, a services facilitator must be used.

Service units and service limitations: 1 hour unit up to 480 hours per fiscal year, for unpaid primary caregivers only

Shared Living

Service description: Shared living means an arrangement in which a roommate resides in the same household as the person who uses Waiver services and provides an agreed-upon, limited amount of supports in exchange for Medicaid funding the portion of the total cost of rent, food, and utilities that can be reasonably attributed to the live-in roommate. For those 18+.

Shared Living supports include:

- Fellowship such as conversation, games, crafts, accompanying the person on walks, errands, appointments and social and recreational activities
- Enhanced feelings of security which means necessary social and emotional support inside or outside of the residence
- Personal care and routine daily living tasks that do not exceed 20% of companionship time such as meal preparation, light housework, assistance with and the physical taking of medications

Service units and service limitations: 1 month

Skilled Nursing

Service description: Skilled nursing is defined as part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These services shall be provided for individuals enrolled in the Waiver having serious medical conditions and complex health care needs who do not meet home health criteria but who require specific skilled nursing services which cannot be provided by non-nursing personnel. Skilled nursing services may be provided in the individual's home or other community setting on a regularly scheduled or intermittent basis. It may include consultation, nurse delegation as appropriate, oversight of direct support staff as appropriate, and training for other providers.

Allowable activities include, but are not limited to:

- Monitoring of an individual's medical status or
- Administering medications and other medical treatment.

Training, consultation, nurse delegation, or oversight of family members, staff, and other persons responsible for carrying out an individual's support plan for the purpose of monitoring the individual's medical status and administering medications and other medically-related procedures consistent with the Nurse Practice Act [18VAC90-20-10 et seq., by statutory authority of Chapter 30 of Title 54.1, Code of Virginia]

Service units and service limitations: 15 minutes

Sponsored Residential

Service description: Sponsored residential services take place in a licensed or DBHDS-authorized sponsored residential home. These services shall consist of skill-building, routine supports, general supports, and safety supports, provided in a licensed or approved residence that enable a person to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Sponsored residential services shall be authorized for Medicaid reimbursement in the person-centered plan only when the individual requires these services and when such needs exceed the services included in the individual's room and board arrangements with the service provider.

Sponsored residential services are provided to the individual in the form of continuous (up to 24 hours per day) services performed by the sponsor family. Sponsored residential support includes the expectation of the presence of a skills development (formerly called training) component, along with the provision of supports as needed.
These supports may be provided individually or simultaneously to up to two individuals living in that home, depending on the required support.

Service units and service limitations: 1 day; support to no more than 2 individuals

Supported Employment

Service description: Supported employment services are ongoing supports to those who need intensive ongoing support to obtain and maintain a job in competitive, customized employment, or self-employment (including home-based self-employment) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

- **Individual supported employment** is support usually provided one-on-one by a job coach in an integrated employment or self-employment situation. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals.
- **Group supported employment** is defined as continuous support provided by staff in a regular business, industry, and community setting to groups of two to eight people with disabilities and involves interactions with the public and with co-workers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces.

Allowable activities include but are not limited to:

- Job-related discovery or assessment
- Person-centered employment planning
- Negotiation with prospective employers
- On-the-job training, evaluation and support
- Developing work-related skills
- Coverage for transportation when necessary
- Both the individual and group model must be in an integrated setting

Service units and service limitations: Individual model is 1:1; group model in groups with 8 or less; 1 hour up to 40 hours per week.

Supported Living

Service description: Supported living takes place in an apartment setting operated by a DBHDS-licensed provider. These services shall consist of skill-building, routine supports, general supports, and safety supports, that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Supported living residential services are provided to the individual in the form of around-the-clock availability of staff services performed by paid staff who can respond in a timely manner. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support.

Allowable activities include, but are not limited to:

- Using community resources
- Personal care activities
- Developing friends and having positive relationships
- Building skills
- Daily activities in the home and community
- Supporting to be healthy and safe

Service units and service limitations: 1 day; may be provided individually or simultaneously to more than one individual living in that home, depending on the required support

Therapeutic Consultation

Service description: Therapeutic consultation is designed to assist the individual's staff and/or the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

The specialty areas are:

- Psychology
- Occupational therapy
- Speech and language pathology
- Physical therapy
- Behavioral consultation
- Rehabilitation engineering
- Therapeutic recreation

The need for any of these services shall be based on the PC ISP and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to advance individuals' desired outcomes as identified in their ISPs.

Service units and service limitations: 1 hour

Required training: DBHDS requires training that covers 2021 regulatory changes to therapeutic consultation behavioral services. TCBS Training is available on the COVLC. A CSB Staff Account registration guide is available to assist with setting up an account if needed. Search for behavioral service providers here.

Transition Services

Service description: Transition services are non-recurring setup expenses for those who are transitioning from an institution or licensed/certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for living expenses.

Transition services are furnished only to the extent that they are reasonable and necessary as determined and clearly identified in the service plan, and the person is unable to meet such expenses or when the services cannot be obtained from another source. Transition services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household items that are intended for purely diversional/ recreational purposes. This service does not include services or items that are covered under other waiver services such as environmental modifications or assistive technology.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens
- Setup fees or deposits for utility or services access, including telephone, electricity, heating, and water
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy
- Moving expenses
- Fees to obtain a copy of a birth certificate or an identification card or driver's license
- Activities to assess need, arrange for, and procure needed resources

Service units and service limitations: Up to $5,000 lifetime expended within 9 months of authorization

Workplace Assistance

Service description: Workplace assistance services are supports provided to people who have completed job development and completed or nearly completed job placement training but require more than typical job coach services to maintain stabilization in their employment. Workplace assistance services are supplementary to the services rendered by the job coach; the job coach still provides professional oversight and job coaching intervention.

The provider provides on-site rehabilitative supports related to behavior, health, time management, or other skills without which the individual’s continued employment could be endangered. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of workplace assistance services.

- The activity must not be related to training for work skills which would normally be provided by a job coach
- Services are delivered in their natural setting (where and when they are needed)
- Services must facilitate the maintenance of and inclusion in an employment situation

Service units and service limitations: Ratio is 1:1; 1 hour up to 40 hours per week.

Patient Pay

Some individuals who are approved for Medicaid under eligibility rules unique to Waiver recipients may have a patient pay responsibility. Patient pay refers to an individual’s obligation to pay towards the cost of long- term services and supports if the individual’s income exceeds certain thresholds. This means that Virginia reduces its payment for DD Waiver services by the amount of the individual’s income remaining after all allowable deductions are made for “personal maintenance needs.”

Patient pay is determined by the LDSS using the following methodology:

- The allowable income level used for waivers is 300% of the current supplemental security income (SSI) payment standard for one person.
- Under the DD Waivers, the coverage groups authorized under the Social Security Act are considered as if the individual were institutionalized for the purpose of applying institutional deeming rules. All individuals under the Waivers must meet the financial and nonfinancial Medicaid eligibility criteria and meet the level-of-care criteria for an ICF/IID. The deeming rules are applied to Waiver-eligible individuals as if the individuals were residing in an ICF/IID or would require that level of care.
- The Commonwealth will reduce its payment for DD Waiver services provided to an individual by that amount of the individual's total income, including amounts disregarded in determining eligibility, that remains after allowable deductions for personal maintenance needs, other dependents, and medical needs have been made according to federal guidelines. DMAS will reduce its payment for DD Waiver services by the amount that remains after the following deductions:
- For individuals to whom § 1924(d) of the Social Security Act applies and for whom the Commonwealth waives the requirement for comparability pursuant to § 1902(a)(10)(B), DMAS will deduct the following in the respective order:
    - The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four hours but less than 20 hours per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

    - For an individual with only a spouse at home, the community spousal income allowance determined in accordance with the Social Security Act.

    - For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with the Social Security Act.

    - Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third-party including Medicare and other health insurance premiums, deductibles, or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

- For individuals to whom § 1924(d) does not apply and for whom the Commonwealth waives the requirement for comparability pursuant to 1902(a)(10)(B), DMAS will deduct the following in the respective order:

- The basic maintenance needs for an individual under the DD Waivers, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual will have an additional income allowance. For an individual employed 20 hours or more per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least four but less than 20 hours per week, earned income will be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, will be added to the maintenance needs allowance. However, in no case will the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

- For an individual with a dependent child, an additional amount for the maintenance needs of the child, which is equal to the Title XIX medically needy income standard based on the number of dependent children.

- Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third-party including Medicare and other health insurance premiums, deductibles, or coinsurance charges, and necessary medical or remedial care recognized under state law but not covered under the State Plan for Medical Assistance.

DMAS will reimburse the providers only for services that are not covered by the patient pay.

The patient pay determination is initiated when an individual’s SC notifies the LDSS via the DMAS-225 that the individual has been approved for DD Waiver services or the individual receiving DD Waiver services experiences a change in circumstances, income, or assets.

The LDSS will determine an individual’s patient pay amount obligation into the Medicaid management information system (MMIS) or other Medicaid informational system adopted by the administering Medicaid agency at the time action is taken as a result of an application for Waiver services, redetermination of eligibility, or reported change in an individual’s situation. That amount is transmitted electronically to the Medicaid enrollment and claims system.

If an individual receiving DD Waiver services has a patient-pay amount, a provider is designated to collect the patient pay. Providers designated to collect patient pay are responsible for collecting the patient pay amount and reducing the claim for Medicaid payment of DD Waiver services by that amount.

Verification of an individual’s patient pay obligation will be available through the web-based automated response system (ARS) and telephone-based MediCall system. Responsible providers, as designated by the SC, must monitor the ARS/MediCall systems in order to determine the appropriate amount of patient pay to collect. These verification systems allow the provider to access information regarding Medicaid eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification.

The website to enroll for access to this system is https://rb.gy/76e7sn. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Information regarding how to access these systems is included in Chapter 1 of each provider manual.

The DMAS-generated notice of approval of pre-authorized services serves as the provider's individual eligibility and authorization to bill for Waiver services. Only the cost of medically necessary, individual-specific, customized, non-covered items or services may be deducted from the patient pay by the eligibility worker.

The assigned provider should include the patient pay on the claim. Providers must submit claims for all services, even if the provider does not expect reimbursement for a claim due to patient pay. MMIS is only able to track patient pay when a claim is submitted. Providers are responsible for collecting only the amount of patient pay that is deducted from their claim.

PATIENT PAY CONSUMER DIRECTED SERVICES

The only exception to application of patient pay rules stated above is for those choosing to self- direct their consumer-directed services.

Agency providers need to document how the actual patient pay amount was obtained. The fiscal agent is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

MEDICAID LTC COMMUNICATION DOCUMENT (DMAS-225)

It is the responsibility of the Support Coordinator to complete the DMAS-225 form. The form is sent to the LDSS for review by an eligibility worker and determination on patient pay responsibility. The DMAS-225 is then sent back to the Support Coordinator. The Support Coordinator will review the DMAS-225 and, for individuals who have a patient pay obligation, identify the provider with the highest potential billing amount and inform the provider in writing that they must collect the patient pay.

The DMAS-225 will be used to advise the LDSS staff which provider is responsible for collecting the individual's patient pay obligation. The Support Coordinator, should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the Support Coordinator of the individual's eligibility status.

Once a responsible provider is identified, the Support Coordinator forwards a computer-generated confirmation of level of care eligibility and the DMAS-225 (with the top portion completed) to the LDSS indicating that the individual has met the level of care requirements and providers have been selected.

Following verification that the individual has been screened and approved to receive DD Waiver services, the LDSS eligibility worker will determine the individual's Medicaid eligibility, complete the LDSS portion of the DMAS-225 and return it to the Support Coordinator with the bottom section completed, showing confirmation of the individual's Medicaid identification number and the date on which the individual's Medicaid eligibility was effective.

The SC must maintain a copy of the Department of Social Services (DSS)-completed DMAS-225 in the individual's support coordination file.

The SC may monitor the ARS/MediCall systems for financial eligibility and patient pay obligations. DSS is responsible for notifying the SC if the individual no longer meets eligibility requirements and for updating the SC of changes to an individual's eligibility.

The DMAS-225 is also used by the SC and the LDSS to exchange information that may affect the eligibility status of an individual. The SC must complete an updated DMAS-225 and forward it to the LDSS eligibility worker whenever an individual experiences any of the following:

- A change in address
- A change in provider of support coordination services
- An increase or decrease in monthly income
- A change in collector of patient pay
- Discharge from all DD Waiver services
- An interruption in all DD Waiver services for more than 30 consecutive days
- Death

The SC must update the DMAS-225 and submit it to the LDSS within 5 business days following any of these changes. The exact change in circumstances and reason for the change must be clearly noted on the DMAS-225.

Commonwealth Coordinated Care Plus Waiver

A Medicaid managed care program includes the CCC plus Waiver (CCC+). This Waiver combined what was formerly the elderly and/or disabled with consumer direction Waiver (EDCD) and the assisted technology (AT) Waiver. The CCC+ Waiver is administered by DMAS.

CCC+ is an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports (LTSS).

People eligible are those who:

- Meet the nursing facility (NF) level of care criteria that is determined using the uniform assessment instrument (UAI) or are dependent upon technological support and require substantial, ongoing skilled nursing care
- If under age 65, must also have a disability (Note: mental illness solely does not qualify as a disability for this waiver);
- Can have their health, safety, and welfare safely maintained in the home when the nurse or personal care aide is not present
- Are determined to be at imminent risk of NF placement

- Are determined that community- based care services under the waiver are the critical services that enable them remain at home rather than being placed in a NF

Review, Add, Change Service Providers

Once a person with a new DD Waiver slot has chosen service providers, the SC is responsible for adding the chosen providers into WaMS prior to the authorization of services. Service providers cannot access an individual in WaMS until the CSB has added the provider(s). Attachments related to the PC ISP are then loaded into WaMS in preparation for the authorization process. More detailed instructions on how to add, remove and change service providers can be found in the WaMS CSB user guide section 11.

Service Authorization (SA)

Service authorization (SA) of DD Waiver services is completed in WaMS. The overall process for requesting SA is as follows:

- SC creates the SA in WaMS
- Provider adds services to SA
- SC Reviews/adds/changes as needed
- DBHDS staff approves, rejects, denies, or pends SA
- MES processes the SA

Note: SCs complete SAs for environmental mods, PERS, and assistive technology as the provider if the CSB/ BHA is licensed to be a provider of these services and chooses to act as the provider. Please check with a supervisor for information on particular CSB/BHA policy and procedures.

Two approvals need to happen:

- A financial application for adult Medicaid and appendix D must be completed requesting long-term care and given to the local DSS
- The UAI needs to be completed by the Department of Health (DOH). A social worker from DSS or nurse from the local DOH contacts the applicant to schedule an appointment.

More information about the CCC+ Waiver.

More detailed instructions of how to create SAs can be located in section 12 of the WaMS user guide.

Access

Representatives from DOH and local DSS screen people to determine if they meet the qualifications to use this Waiver. The screening team includes a DOH nurse and a DSS representative. They use the UAI to determine if someone meets the required functional dependencies, medical/nursing needs, and are at risk of nursing home placement. Screenings may also take place when someone is hospitalized.

Working with MCO Care Coordinators

Virginia has six (6) Managed Care Organizations available for the CCC+ Waiver. CCC Plus: Health Plans are located on the DMAS website under the link entitled CCC Plus MCO member services contact information.

Each health care plan offered under the CCC+ Waiver will provide a care coordinator to work with the participant and doctors to create an individualized health care plan that includes among other things, individual outcomes and needed supports and services.

Chapter 7:
Support Coordination Process: Plan Development and Implementation

Introduction

Support coordination services aim to assist people with disabilities to utilize services while also becoming more independent and active in community life. SCs establish a positive and respectful relationship with people and their support networks. Support coordination starts with a person-centered planning process based on the preferences and needs of the people using services.

Person-centered planning is a set of approaches designed to assist people to plan their life and supports. It is a planning process that focuses on the needs and preferences of the person -- not the system -- and empowers and supports people in defining the direction for their own lives. Person-centered planning promotes self- determination, community inclusion, and independence.

The key areas for consideration in person-centered planning are:

- What are the things that are important to and for a person?
- Who are the important people in a person's life?
- What are the person's strengths or gifts?
- What is important to the person now and in the future (their dreams)?
- What kinds of support does the person need to achieve the life they want?
- What do we need to do to support the person?

Linking to Services

When people receive a DD Waiver slot, SCs need to have a conversation with them about the life they want to live and the supports they might need to access in order to achieve their vision of a good life. In order to link people with appropriate resources, SCs must be knowledgeable about community resources that are available and should maintain regular contact with these resources in order to facilitate access and stay informed. Many CSBs create and maintain shared information files internally about available resources and service providers, including medical, housing, residential, vocational and employment, community and civic, and spiritual resources. The SC should check with a supervisor to obtain access to resource guides. DBHDS and DMAS also maintain online lists of providers throughout the state of Virginia for persons seeking services outside their region. SCs can also access the My Life My Community Website, the DBHDS Licensed Provider Location Search , or the DMAS provider search to look for service providers in their region.

Touring/Visiting Providers

When a person expresses interest in exploring new services, they may be ready to begin touring and visiting potential service providers. The SC can play a key role by doing the following:

- Provide the person with information about all available services and qualified providers
- Provide contact information for reaching the organization
- Support the person in making the initial contact
- As necessary, contact the organization and accompany the person to the first meeting
- Make sure the person has the ability to access and utilize the service or resource
- Follow up as needed to address any barriers to access and ensure a successful connection

Virginia Informed Choice form (DMAS-460)

When a person who uses a DD Waiver is considering options for services, the SC must offer the person a choice of all services available to them, as well as a choice of all of the providers qualified and willing to provide the desired services, including SC services and individual SCs. After making sure that the person has been given the opportunity to make an informed choice, the SC must document this by reviewing and completing the Virginia informed choice form DMAS-460.

An SC can ensure informed choice by doing the following:

- Identify the needed resource and the person’s preferences
- Review existing services and providers and person’s satisfaction
- Discuss all available options and choices (especially more integrated options such as independent living, employment, and community engagement)
- When the person chooses a service, explain, in an understandable manner, the nature of the chosen services, any alternative services that might be advantageous for them, and any accompanying risks or benefits of the proposed and alternative services.

Referrals

A referral is the process by which a SC helps a person apply to use a service or other resource. Once a person has made a choice of service providers, the SC will work with the person and the service provider to share pertinent documentation, such as assessment information, service preference, and any other documentation the provider may request. The SC needs to ensure that a signed consent to exchange information has been completed for each new service provider before providing information about the individual.

Annual Eligibility Determination

The VIDES must be completed annually in order to document the individual’s continued eligibility and need for support coordination services and DD Waiver services. The annual VIDES must be completed prior to the ISP meeting, but no earlier than 11 months, nor later than 13 months after the previous year’s VIDES. For example, for a 10/1/18 and 10/1/19 ISP:

Previous VIDES	Annual VIDES	Compliant?
8/10/18	8/29/19	Yes – same month
8/10/18	9/7/19	Yes – crosses over a month, but still in 30 day window
8/10/18	9/12/19	No – more than 13 months
8/10/18	7/25/19	No – more than 30 days before annual ISP.

Additionally, if it is completed in the same month as the previous year's VIDES, it will be considered to meet compliance (e.g., 2018 VIDES was completed on August 10th and 2019 VIDES is completed on August 29th). Similarly, if the VIDES is completed no more than two weeks after last year's VIDES and the time frame crosses over from one month to the next (e.g., 2018 VIDES was completed on September 25th and 2019 VIDES is completed on October 7th), that will also be considered acceptable.

How to Utilize Assessment Information to Begin Plan Development

The assessment process includes the completion of the SIS®, the risk awareness tool, the crisis risk assessment tool, and parts I and II of the PC ISP (personal profile and essential information). Other assessments that should be reviewed may include medical reports, school reports, and psychological evaluations.

Effective assessments start with prioritizing the person's immediate concerns. It is important for a SC to pay attention to any immediate health and safety issues, risk, or risks of harm which can include:

- Medical conditions
- Risks and potential risks
- Restrictive protocols
- Special supervision requirements
- Other presenting needs, as expressed by the person and/or the team and as documented in the referral information
- The strengths and preferences of the person and resources that might be available

Conducting assessments is about eliciting personal stories. Since they are the expert on their life, most information gathered should be from the individuals and supporters who know the individual best, which may include their substitute decision maker, if applicable. When using the assessment to begin plan development, it is important to:

- Listen to concerns without interrupting
- Respect preferences, needs, and values
- Use the assessment interview to begin to engage the person served
- Help the person identify strengths, resources, interests, and preferences
- Include the family and other supporters with the person's permission
- Determine together the person's support needs
- Share the findings from the assessment with the person seeking services

Once the assessment is complete, it is time to move on to the development of the plan.

Person-Centered Planning and the Team Meeting

Once a person has chosen initial services and supports, and again on at least an annual basis, the SC should arrange for a team meeting. The team consists of the person, the SC, and the provider(s) at a minimum and should also include people who are chosen by the person and who know the person best. The person with whom a plan is being developed is always at the center of the planning process. The degree of his involvement depends on his desire to participate, along with the extent to which they are able to participate. When planning with someone, it is best to bring together a group of people that want to contribute their time and talents because they know and care about the person and want to help them identify and achieve their goals. The CMS Home and Community Based Settings (HCBS) regulations require that the person-centered planning process:

- Is driven by the individual
- Includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual

Given these requirements, it is not acceptable for the SC or any provider to schedule meetings and inform the person. Rather, SCs and providers should work with the person to support them to drive the scheduling process. This may require some flexibility on the part of the SCs and providers, but, remember, meetings and plans belong to the people using services.

Annual person-centered planning meetings should ideally be held at least six weeks prior to the due date of the PC ISP. This timeframe allows for last minute rescheduling as well as time for SCs and providers to write their parts of the plan, individuals (and substitute decision makers, as appropriate) to approve the written plans, and submission for service authorization approvals. Service authorization requests should be submitted 30 days prior to the requested start date but must be no later than 10 days prior.

SCs, providers, and people using services should draft part I personal profile and part II essential information prior to the meeting. All team members contribute to its completion during the annual meeting with a draft or notes or in writing before the meeting. The SC combines the information that is discussed and finalized at the annual meeting. The SC shares the final parts I-IV with the person and all team members following the meeting. The information included in the sections of the personal profile is intended to be gathered through conversations with the person and those that know the person best.

Person-centered planning meetings can often feel like an overwhelming amount of work, and it is tempting to conduct a meeting as if checking everything off a list. However, the only way to write a true person- centered plan is to have robust discussions and gather information about the person and what is important to to him as well as his needs and preferences.

Facilitating Conversation

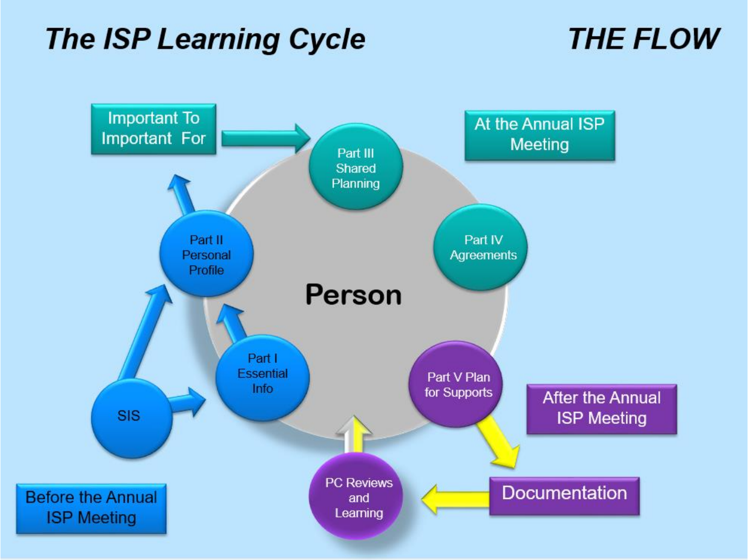
Having conversations is the primary mechanism used in planning, and often it is the SC who facilitates these conversations. It is important to know that gathering information from people who know a person well, professionally or personally, may be done outside of a meeting as long as it is done with informed consent.

As the facilitator, the SC must always keep the person as the focus of the discussion. Starting the meeting by asking team members what they like and admire about the person sets a positive tone for a meeting and allows everyone to be heard and recognized. It is also good to talk first about the good things that have happened in the person's life since the last meeting. Person-centered planning does not mean we ignore the things that are of concern, but it should not be the initial or primary topic of discussion. While facilitating the meeting, talk directly with the person, rather than talking around and about the person. Ask questions and gather information. When possible, empower the person to share his personal profile with the team and include information about things that are important, what is working and needs to stay the same, and what is not working and needs to change. Team members can offer ideas and suggestions, which can be added to the profile with agreement from the person. SCs should also facilitate a discussion about what the person's vision for a good life is. A person's dreams and goals should be a driving force in the plan.

The person and the team should also discuss things that are important to that person (issues of health and safety and being a valued member of one's community, for example), as well as any risks that have been identified. After ensuring that the person's needs and preferences have been identified and that the team is supporting the person to find a balance between what is important to and for them, the discussion can address specific, measurable outcomes to include in the shared plan.

Completing the Person-Centered Individual Support Plan (PC ISP) Trainings in the Commonwealth of Virginia Learning Center

Prior to completing PC ISP documentation, all SCs should complete the PC ISP training modules in the Commonwealth of Virginia learning center.



Parts of Virginia's PC ISP

Virginia's Person-Centered ISP has 5 distinct parts:

1. Personal Profile
2. Essential Information
3. Shared Planning
4. Agreements
5. Plan for Supports

Part I- Personal Profile

Facilitating a conversation with the person, with input from the rest of the team, is essential in order to gather the information necessary for part I of the plan. The personal profile first outlines the person's preferences for the meeting and how they prefer to be supported during the meeting, so it is essential that this conversation happens prior to planning the meeting.

The personal profile discusses the person's talents and contributions. When completing this section, the SC should have discussions with the person, those who know and love them, and providers about the things that people like and admire about the person, as well as the truly great things about them. SCs should consider how they talk about their own friends and family, and how they themselves would want to be introduced to others. Saying things like the person has a great sense of humor and loves sculpting clay is more genuine than listing "disability praise" such as "he ambulates independently."

The next section in the personal profile discusses those things that are important to and for a person. Remember that "important to" things make the person happy, content, and fulfilled, while "important for" are matters of health and safety and being a valued member of one's community. These questions should be answered with regard to the seven life areas indicated in the plan: employment, integrated community involvement, community living, safety and security, healthy living, social and spirituality, and citizenship and advocacy.

The next section in the personal profile asks about the life that the person wants. The team should have a discussion with the person about the things that are working well, what should remain the same or be enhanced, and what needs to be changed. The person should be empowered to share his dreams and visions of what he wants his good life to look like
The final section of the personal profile asks the opposite question – what are the things that the person does not want in his o life? The person should be supported to openly talk about things that are currently not working or making sense, or things that may not currently exist or be happening that they want to avoid having in their life.

All of the information in the personal profile should be used as a tool to determine what is important to a person and act as a bridge to developing the outcomes in part III of the PC ISP, shared planning.

Part II - Essential Information

Part II of the PC ISP, or essential Information, contains a wide variety of information necessary to provide supports to an individual. Part I provides information across the following areas:

- Representation
- Disability Determination
- Health Information
- Behavioral and Crisis Supports
- Medications
- Physical and Health Conditions
- Last Exam Dates
- Allergies
- Social, Developmental, Behavioral and Family History
- Communication, Assistive Technology, and Modifications
- Education
- Employment
- Future Plans
- Review of Most Integrated Settings

Part III- Shared Planning

Part III of the PC ISP, or shared planning, lists outcomes shared across providers, as necessary, in order to help the person on a path to the life they want. The Part III contains measurable outcomes listing an achievement the individual wants to pursue, the key steps to get there, when it will be accomplished, and who is responsible for helping the person reach that achievement. The shared plan is completed at the annual meeting and contains the outcomes that lead to the life the person wants.

In the development of outcomes, it is important not to lose sight of the purpose of planning, discovering, and setting in place plans to pursue the life the person wants. In shaping outcome statements, three considerations are recommended. Outcomes that are meaningful to the individual can support a person with achieving independence, integration, or an increased quality of life. As outcomes are developed, teams may benefit from asking if the outcome speaks to one of these three areas to determine if the outcome supports the person in a meaningful way.

It is important to remember that services themselves are not outcomes. “Mary goes to day support” is not an outcome. Think about the reasons people go to day support. Is it so they can develop their ability to communicate better, learn to use resources in their community, or develop the abilities they need in everyday life? The service is just what supports individuals to get what matters to them based on their own particular needs and interests.

While the SC is responsible for entering parts I-IV into WaMS, outcomes and key steps to get there are developed at the planning meeting with input from the entire team. SCs do not “assign” outcomes, rather, the person, the SC, the provider, and other planning partners discuss possible outcomes as they relate to the life that the person wants. Every team member is responsible for contributing to the discussion, and providers should be aware of the allowable activities and limitations of their service when agreeing to outcomes and key steps. **It is critical that outcomes and key steps are developed and agreed to by the team during the planning meeting.** It may be helpful to write the outcomes and key steps down during the meeting so that everyone knows and agrees who will be supporting the outcomes. Review the Life Areas Cheat Sheet and the Integrated Community Involvement Fact Sheet to learn more about developing outcomes in the shared planning team process.

Part IV- Agreements

Part IV, or the agreements section, is an evaluation of the annual planning meeting. It contains questions for the individual and team, as well as a signature page that is signed by all present at the meeting. Answer all questions and record any plans to address or resolve objections. This is also a place to record any inability to meet a request and the related team decision. All parties involved in planning will sign the part IV, and it will serve as the signature page for the plan. Signatures indicate agreement with the plan.

Waiver Management System (WaMS)

SCs are responsible for putting all of the information for parts I-IV that was agreed to during the meeting into WaMS. If, in the process of entering the ISP information into WaMS, the SC finds that something is wrong or that they disagree with something, the SC should not just make changes. Instead, the SC should reconvene the team to discuss the issue and obtain team agreement. Likewise, if a provider disagrees with something that the SC wrote in the plan in WaMS, the provider should also reconvene the team to discuss and come to an agreement. Once the SC has entered all parts I-IV into WaMS, it is necessary to ensure that the ISP is in the correct status (either Complete or Pending Provider Input). An ISP with a status of pending SC input is considered to be incomplete.

If changes need to be made to parts I and II after the ISP is complete, the SC may make those changes. If changes need to be made to part III, those changes need to be initiated by the provider. Please see the WaMS user guide for more information.

Part V- Plan for Support (PFS)

Part V, or the plan for supports (PFS) is the provider-completed part of the ISP. All service providers must have a PFS that details the activities and support instructions that are expected to lead toward the agreed-upon outcomes. The PFS includes: Support instructions and preferences that are constant in a person's life

- The individual's desired o from the shared planning (or a PFS revision)
- The support activities the provider has agreed to provide to support the person with each outcome
- What will be seen or obtained to resolve each activity
- Any additional support instructions needed to complete activities
- A general schedule of supports
- When applicable, documentation of consent for any safety restrictions

Avoid Jargon –

When writing plans, use ordinary language rather than professional jargon. SCs can use themselves as a yardstick. If they would not use the same words or descriptions for themselves, then they should not be used to describe someone else. Also remember, the language needs to be understood by the plan owner. Here are just a few examples:

- Instead of “interpersonal skills”, use “easy to get along with”.
- Instead of “ambulates independently”, use “walks on his own” or consider whether this needs to be said at all.
- Instead of “verbal cues or prompts”, use “remind her by saying…”
- Instead of “auditory monitoring distance”, use “within earshot”.
- Instead of “off-task behaviors”, use “distractions”.
- Instead of “on-task behaviors”, use “pays attention”.

How to Write Measurable Outcomes

An individual’s desired outcomes should be based on what is important to the person with regard to personal preferences; however, outcomes need to also be written in a way that is measurable. For example, having more spending money might be important to a person but does not establish what this means in measurable terms. In addition to being observable, a few additional considerations can increase measurability of outcomes – the frequency of the outcome, the target date, and the steps that lead to the outcome.

The statement “John has more money” can be improved by considering how this could describe an achievement that John would find meaningful such as: “John saves 50 dollars per month so that he can go on vacation next year,” or “John earns at or above minimum wage for 12 months so that he has more shopping money.”

Each outcome in the PC ISP will have a target date noted as “by when,” which indicates that the outcome is expected to be accomplished or will be reassessed by that date. When desired, a frequency should be included in the wording of the outcome statement.

The next step for planners and teams to increase measurability is to describe the basic steps that lead to the outcome. These steps are shared across the planning team to contribute to achieving the outcome. To make an outcome measurable, we would ask, “What are the steps to get there?” These steps lay out the plan to pursue the achievement which is in line with action planning, a foundational person-centered practice. These steps should be logical and, when considered together, be expected to result in the time-bound achievement that is defined in the outcome.

There is a suggested formula for writing meaningful outcomes. This formula has been slightly modified as follows for the examples provided. The asterisk* is a reminder to include a frequency when desired:

> **[Person’s name] [activity/event/important FOR]* so that/in order to [important TO achievement]**
>
> (From DBHDS person-centered ISP guidance document. For more detailed information and examples, see this document at the Virginia Regulatory Townhall website.

Support Coordination Part V

The SC outcome statements from the part III encompass the tasks associated with targeted case management to include linking, monitoring, assessing, coordinating, and planning with an individual. There are often other outcomes in a person's shared plan that require specific SC actions. These must be included in the SC part V plan for supports alongside any standard global outcome. The SC would then have support activities under each outcome. The support instructions would be specific to how the SC will support the individual.

PFS Approval and Submission

When providers complete their part V and submit it in WaMS to the SC, the SC must review the part V to assure that it fulfills all of the requirements for the particular service offered and addresses the identified outcomes and support needs. SCs should pay particular attention to the outcomes, key steps, and support instructions to ensure that the service being provided and the plan for supports are within the scope of the allowable activities for the service, and that the plan does not indicate anything that is indicated as not allowable or a service limitation. For example, skill-building is not allowable in companion services, so the SC should make sure that the companion part V does not include any skill-building activities. If the Part V does not meet the regulatory requirements and limitations for the service, the SC should inform the provider and ask that they make the changes necessary. Allowing time for plan revisions is one of the reasons why it is highly recommended that the planning process begin at least six weeks in advance.

Service Authorizations to Initiate Services

Once a person has made an informed decision about support options and chosen service providers, the SC can begin the process of authorizing services in WaMS. It is the responsibility of the SC to ensure that the information in WaMS is up-to-date, add all service providers into WaMS, review all requests, modify the amount or type of services as needed, and submit the service authorization for processing. More detailed information about the initiation of service authorizations can be found in section 12 of the WaMS user guide.

WaMS User Guide At-A-Glance
"When to Submit What" At-A-Glance
Service Authorization Guidance At-A-Glance

How to Evaluate and Document Implementation of a PC ISP

Once a PC ISP is complete, it is time to work towards completion of support activities in the SC's part V, complete documentation regarding progress towards completion of the outcomes, and review that documentation quarterly in a person-centered review.

Throughout the plan year, the SC will work to complete tasks related to supporting a person reach their outcomes as specified in the SC's plan for support.

Progress Notes

An SC is required to complete documentation regarding contacts with the person and significant others in regard to the individual, progress towards outcomes, and significant events including health and safety concerns such as falls, hospitalizations, etc. This documentation, called progress notes, should include specific details, such as full date of contact, who reported the information (name, title, and/or relationship to the individual), place of contact, type of contact, summary of contact (including what the SC did in regard to linking, coordinating, and advocating), and should always have a signature/electronic signature and title of the SC completing the note with the date. Notes are required to be completed on the day the described supports were provided. Documentation that occurs after the date supports were provided shall be dated for the date the entry is recorded, and the date of supports delivery shall be noted in the body of the note.

Person-Centered Review

Quarterly, the SC will complete a person-centered review (PCR) according to the schedule indicated in part IV. This includes not only progress on outcomes for which the SC is responsible but also a summary of the PCRs received from all service providers. Providers have a 10-day grace period after the end of a quarter to complete their PCRs and submit them to the SCs, then SCs have a 30-day grace period after the end of a quarter to complete their PCRs.

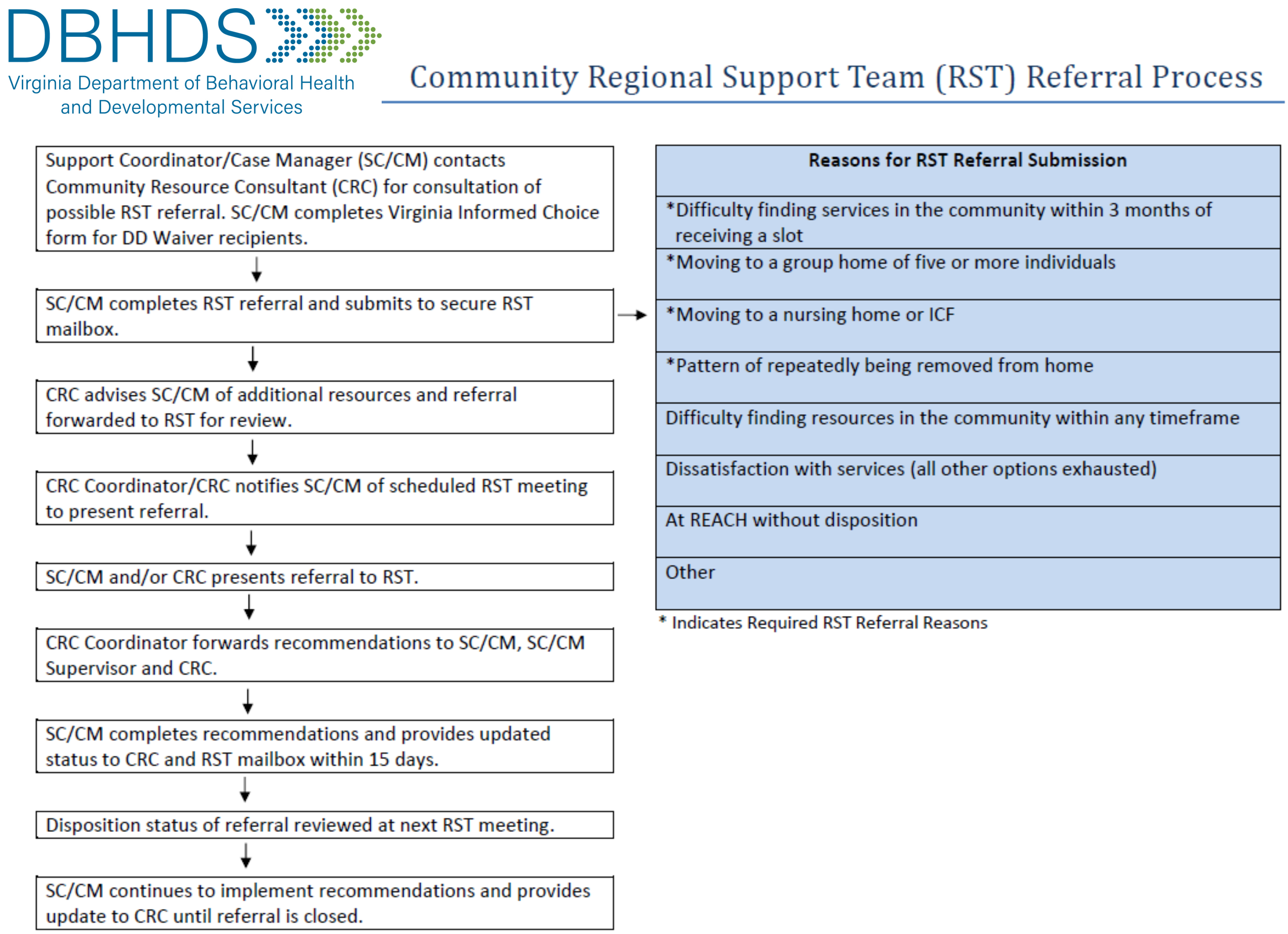
The PCR includes information regarding outcome status including a summary of significant events from the quarter in regard to each outcome. If a change to the plan is needed, this will be documented in the PCR. Additionally, the PCR will include information regarding safety risks identified over the quarter, changes desired or needed regarding supports and services, satisfaction with supports and services, as well as plans to address any dissatisfaction, whether or not all Medicaid services were implemented and how to address them if not, and, finally, any other significant events not included elsewhere in the PCR.

Information in progress notes and PCRs, as well as in continued conversations throughout the year with the individual and team members, will be helpful in preparation for the upcoming plan year.

Regional Support Teams

At times, an SC may encounter difficulties or barriers to community supports for someone. In this instance, the Regional Support Team (RST) may offer assistance. RSTs can provide recommendations and assistance in resolving barriers in the most integrated community setting consistent with someone's needs and informed choice. Submission of RST referrals are required to ensure informed choice and availability of services. Through referrals, the RST will monitor, track, and trend choice, integrated option availability, and challenges that require further system development. The SC shall notify the Community Resource Consultant (CRC) and RST in the following circumstances: a.) within five calendar days of an individual being presented with any of the following residential options: i. an intermediate care facility, ii. a nursing facility, iii. a training center, or iv. a group home with a licensed capacity of five beds or more; b.) if the CSB is having difficulty finding services within 30 calendar days after the individual's enrollment in the waiver; or c.) immediately when an individual is displaced from his or her residential placement for a second time.

Recommendations from the RST are explored by individuals receiving services and their authorized representatives/substitute decision-makers with assistance of the SC. The recommendations provide opportunities for the individual to choose more integrated options.



DBHDS
Virginia Department of Behavioral Health
and Developmental Services

Community Regional Support Team (RST) Referral Process

Support Coordinator/Case Manager (SC/CM) contacts Community Resource Consultant (CRC) for consultation of possible RST referral. SC/CM completes Virginia Informed Choice form for DD Waiver recipients.

↓

SC/CM completes RST referral and submits to secure RST mailbox. →

↓

CRC advises SC/CM of additional resources and referral forwarded to RST for review.

↓

CRC Coordinator/CRC notifies SC/CM of scheduled RST meeting to present referral.

↓

SC/CM and/or CRC presents referral to RST.

↓

CRC Coordinator forwards recommendations to SC/CM, SC/CM Supervisor and CRC.

↓

SC/CM completes recommendations and provides updated status to CRC and RST mailbox within 15 days.

↓

Disposition status of referral reviewed at next RST meeting.

↓

SC/CM continues to implement recommendations and provides update to CRC until referral is closed.

Reasons for RST Referral Submission
*Difficulty finding services in the community within 3 months of receiving a slot
*Moving to a group home of five or more individuals
*Moving to a nursing home or ICF
*Pattern of repeatedly being removed from home
Difficulty finding resources in the community within any timeframe
Dissatisfaction with services (all other options exhausted)
At REACH without disposition
Other

* Indicates Required RST Referral Reasons

PC ISP Training Modules

Self-Directed Training Modules are available on the Commonwealth of Virginia Learning Center (COVLC Log In) in the following areas:

- PC ISP Training Development, Module 1 (Parts I and II)
- PC ISP Training Development, Module 2 (Parts III and IV)
- PC ISP Training Development, Module 3 (Part V)

CHAPTER 8:
Support Coordination Process:
Monitoring Billable Activities and Evaluation

Support Coordination Timelines

Through monitoring and evaluations, the SC takes the lead in ensuring that the support team members follow through with the commitment(s) they made to support individuals to reach their desired outcomes. This is accomplished through a number of billable and non-billable activities. It is important to know the difference to assure that a review of progress, satisfaction, and risk not only has been completed, but also that an allowable activity has occurred so that the CSB/BHA can bill for the support provided. To accurately monitor and evaluate each person, there are tasks that will need to occur, depending on the person, every 30, 60, or 90 days. Each SC is responsible for keeping up with timelines and billable activities.

Monthly Contact

SCs must conduct a minimum of one contact or activity every month, defined as:

- Direct or individual-related contacts, communication or activity with the individual, their family/caregiver (as appropriate), service provider, or other organization on behalf of the individual

The assigned SC will provide support coordination services as frequently and timely as the person needs assistance. There must be at least one documented contact, activity, or communication as designated previously and relevant to the ISP during any calendar month for which support coordination services are billed. **SCs are responsible for proactively identifying risks, implementing plans to mitigate previously known and newly identified risks, and resolving them in a timely manner.**

Billing will be submitted for an individual only for months in which direct or individual-related contact, activity, or communication occurs and the SC's records document the billed activity. Service providers will be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

The allowable support activities can include but are not limited to:

- Coordinating initial assessment and annual reassessment of the individual and planning services and supports, to include history-taking, gathering information from other sources, and the development of a PC ISP. This does not include performing medical or psychiatric assessments, but may include referral for such assessment.

- Coordinating services and supports planning with other agencies and providers, including making appointments
- Linking the individual to services and supports specified in the PC ISP
- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources, including crisis supports
- Enhancing community integration by contacting other entities to arrange community access and involvement
- Making collateral contacts with the individual to promote implementation of the PC ISP and successful community adjustment
- Monitoring implementation of the PC ISP through regular contacts with service providers as well as periodic site visits and home visits
- Instruction and counseling which guides the individual in problem-solving and decision-making and develops a supportive relationship that promotes implementation of the PC ISP. Counseling in this context is defined as problem-solving activities designed to enhance an individual's ability to live in the community. Allowed instructional activities would include discussion about the benefits of the activities listed in the service plan.
- Monitoring the quality of services
- Assisting the individual to secure services in an ICF/IDD if the individual or family member requests institutional placement
- Monitoring the PC ISP to ensure it is implemented as written and making TIMELY referrals, service changes, and amendments to the PC ISP

The activity of writing the PC ISP, person-centered review, or progress note is not considered a billable case management activity. However, developing the PC ISP through a team meeting is a billable activity.

There will be no maximum service limits for support coordination services, except for individuals residing in institutions or medical facilities. For these individuals, reimbursement for support coordination will be limited to 90-days pre-discharge (immediately preceding discharge) from the institution into the community. While individuals may require re-entry to institutions or medical facilities for emergencies, discharge planning efforts should be significant to prevent readmission. For this reason, support coordination may be billed for only two 90-day pre-discharge periods in a 12-month period.

Ongoing Assessment/Monitoring

In Chapter 2, assessment was identified as the ongoing process of gathering and summarizing information that guides the work between the SC and the person using services. The assessment not only helps to determine initial eligibility for services but ongoing eligibility as well.

Is the PC ISP implemented appropriately?

Monitoring the PC ISP to determine if it is being implemented appropriately involves doing the following activities:

- Actively observe the person and service providers to make sure the plan is being properly implemented, including the completion of the On-site Visit Tool (OSVT)
- Make periodic site and home visits to assess the quality of care and satisfaction
- Make collateral contacts with people who support the individual (with whom there is a signed consent
- to exchange information) in various aspects (school, work, medical, friends, paid providers, family, etc.) to obtain a well-rounded picture of the person
- Consistently support the person in identifying concerns, and modify the plan to reflect concerns and how concerns are addressed as necessary
- Follow up with the individual and support partners to determine if instructions provided by qualified professionals are being followed

Regularly meeting with people in their natural environment -- for example their home, day program, or workplace will allow proper assessment of the plan implementation. Keep in mind that visiting someone at a worksite may be considered intrusive by the employer; therefore, the SC should identify alternative ways to monitor that service.

Status of Current Risks and Identifying New Risks

Ongoing assessment should include gathering information to make sure health and safety needs are met. Some risks, like pressure soresincluding decubitus ulcers, can be reduced by understanding who is at risk, recognizing early signs of skin breakdown, and implementing interventions early. While SCs may not see skin breakdown, they can promote risk mitigation by having knowledge of risk factors, who is at risk, and ensure that outcomes are added to the PC ISP to prevent skin breakdown for those at risk. SCs can inquire directly with support personnel and ask to see positioning logs, skin check logs, etc., to further monitor the risk. Prevention is the key! For more information, go to the Department of Behavioral Health and Developmental Services (DBHDS) Office of Integrated Health (OIH) website for the presentation on promoting skin integrity as well as other health and safety information.

The SC should assess the status of current risks and evaluate the person's current living situation to determine if there are new risks. Some examples of areas the SC may want to pay close attention to are:

- The person's dietary and nutritional needs;
- The current living situation;
- Activities of daily living (ADLs);
- Risk of suicide or self-harm;
- Social or environmental risk factors (family situation, lack of social support, or isolation); and
- Change in mood or behavior.

The use of the on-site visit tool (OSVT) details the assessment of current risks and new risks. The OSVT is to be completed at the face-to-face visit monthly for people with enhanced case management (ECM) and once per quarter for people with targeted case management (TCM). The OSVT helps ensure consistency for SCs across the state to confirm the ISP is implemented appropriately and the evaluation of a change in status is completed. The form helps guide the SC through a detailed checklist of focus-area questions based on observation and report. When completing the OSVT, SCs need to ensure that every question is answered in order for the assessment to be complete. The findings from the OSVT and any required follow-up actions should be documented in a corresponding case note. Information from this tool/notes should also be included in the quarterly PCR. Access the OSVT online at https://dbhds.virginia.gov/case-management.

Ways to Minimize Risks

An SC can help to minimize the risks by:

- Identifying strengths (competencies, accomplishments, resources, support network)
- Understanding the capability of service providers to meet the person's needs and preferences
- Reviewing assessments completing by qualified professionals
- Making referrals as appropriate to help mitigate newly identified risks or potential risks
- Following up with the individual and any support partners to assure plan to mitigate risk are being developed and followed
- Link with assistive technology and environmental modifications as appropriate
- Being knowledgeable of community opportunities and resources
- Helping people make informed decisions
- Ongoing collaboration with the person, family members, and service providers

Documenting Newly Identified Needs, Preferences, Supports, and Services

When the SC is conducting monthly contacts, face-to-face visits, and PCRs, all newly identified needs, preferences, supports, and services should be documented in the progress notes. The PC ISP is updated when changes occur or new information is discovered, and updates are communicated with others supporting the person. Having ongoing and regular contacts with the person, service providers, and family members, as appropriate, can help the SC assess and identify needed modifications to the PC ISP.

PC ISP Updates

When the SC identifies the need to update or modify a PC ISP, they must:

- Review current outcomes and make changes to the PC ISP to reflect any modifications, including updating the case management plan for supports
- Review modified provider service plans in WaMS (for DD Waiver only)
- Submit the modified provider service plan (part V plan for supports) for service authorization if there is a request for a change in hours or service providers
- For SC responsibilities related to modifications in service authorizations, use the WaMS CSB User guide section 12
- Update the PC ISP part I personal profile, part II essential information, and part III shared plan (remember the SC can only update the Part III if they are adding or removing a provider from the outcomes. Any other changes to the Part III come from the provider,) as needed
- Obtain consent to exchange information forms for any new service providers
- Update the informed choice DMAS 460.

Face-to-Face Visits

SCs are required to meet with each individual face-to-face at least every 90 days. A 10-day grace period is permitted; however, use of the grace period does not change the original 90-day due date and schedule.

Previous FTF Done	Next FTF Due	Next FTF Actually Done	Compliant?
8/10/21	11/8/21	11/4/21	Yes – within 90 days
11/4/21	1/2/22	1/7/22	Yes – within the 10 day grace period – but next due date reverts back
1/2/22	4/2/22	4/1/22	Yes – within 90 days
	6/30/22	7/18/22	No – beyond the 90 days plus 10 day grace period

At face-to-face meetings, the SC will:

- Observe and assess for any previously unidentified risks, injuries, needs, or other changes in status
- Assess the status of previously identified risks, injuries, or needs, or other change in status
- Assess whether the person's service plan is being implemented appropriately and remains appropriate for the person
- Assess whether supports and services are being implemented consistent with the person's strengths and preferences and in the most integrated setting appropriate to the person's needs

"Face-to-face visit" means an in-person meeting between the Support Coordinator and the individual and family/caregiver, as appropriate, for the purpose of assessing the person's status and determining satisfaction with services, including the need for additional services and supports.

Documentation must clearly state that:

- The SC was in the presence of the person, the date, and the location of the visit.
- Unmet needs were identified, and a plan was developed to address the unmet need, if applicable.
- Satisfaction with services was assessed.
- Status of services was evaluated and adjusted as needed.
- A face-to-face visit occurred, and there are observations or assessments of:
  - a newly identified need
  - change in status or preference
  - an inadequately addressed risk or need
  - any issues with implementation of the PC ISP
- Then the SC will:

  - review and update the PC ISP as needed
  - develop a mitigation plan
  - document the issue

If any issues are identified during the face-to-face assessment, the individual's status or preferences have changed, or the PC ISP is not being implemented as written or needs to change, document this in the face-to-face visit note and OSVT.

It may be appropriate to convene a team meeting to review and update the PC ISP. Determine if new services are needed, or if current services/support activities need to be modified. The SC should ensure that the PC ISP is amended when the reassessment indicates that revisions in the plan are needed to address and meet an individual's changed needs. The ISP should be updated as indicated and should include an implementation schedule for the changes needed to address the individual's needs.

Any identified issues should be addressed. Remember, the SC is responsible for coordination of services. The SC makes all team members aware of changes or newly identified risks that may affect their implementation of PC ISP outcomes.

Documenting and communicating information is very important. It also confirms and validates that support was provided and received. If an issue is identified, it must be documented along with its resolution and/or the attempts to address barriers.

The SC will conduct a face-to-face visit once every 90 days (with the allowance for a 10-day grace period) unless one of the following criteria are met.* If one of the below criteria are met, the individual meets criteria for enhanced case management.

- Receives services from providers having conditional or provisional licenses
- Has any items scored with a 2 under 1a or 1b on the SIS
- Has an interruption of service greater than 30 days
- Has an inability to access needed therapeutic services, assistive technology, environmental modifications, and/or behavioral consultation
- Encounters the crisis system, including risk triggers, criminal justice system, or APS involvement
- Has transitioned from a training center within the previous 12 months
- Resides in congregate settings of 5 or more individuals**

*Some exceptions apply

** exceptions are described in the 2023 Case Management Operational Guidelines available here: https://townhall.virginia.gov/l/GDocForum.cfm?GDocForumID=2099

Enhanced Case Management

Review the individual's need for ECM criteria at each face-to-face AND update as changes occur. ECM criteria will be applied to anyone:

- With a DD Waiver; or
- Receiving TCM and who are on the DD Waiver waitlist and have a CCC+ Waiver

For individuals that are receiving ECM, these visits must occur **at least one time per calendar month, with no more than 40 days between visits**. For example, if an ECM visit occurs on March 2, the next visit is due on or before April 11th. There are 40 days from March 2nd to April 11th and this timeframe enables one visit to occur in both calendar months. Please see below:

To assist with determining when to initiate and cease the provision of ECM, DBHDS developed, in collaboration with CSBs, an automated **ECM Worksheet** that is available for download on the DBHDS website at https://dbhds.virginia.gov/wp-content/uploads/2022/09/CM-Worksheet-FINAL-11.3.21-1.xlsx.

See the 2023 Case management Operational Guidelines to read more about the requirements for ECM and how to meet the requirements successfully. Searching for providers with either a conditional or provisional license can be completed on the DBHDS website.

Chapter 9:
Support Coordination Process: Transitions of Support

Transfers between Support Coordinators Within the Same CSB

The relationship between SCs and the individuals they support is very important. At times, the individual may feel the need to request a new SC. Licensing regulations dictate that all CSB/BHAs should implement a written policy describing how people are assigned SCs and how they can request a change of their assigned SC. To proactively promote choice, SCs will review choice of providers when service changes occur and include choice of current providers and specific SCs at least annually by completing the Virginia Informed Choice Form (DMAS 460) as required by Medicaid. When a person requests a change in SC, the SC should check with a supervisor to learn the agency's policy and honor the request from the person for a change in SC whenever possible. Once the change has occurred, it is important for the newly assigned SC to ensure that the record indicates the change in SC. Documentation of this change might include:

- Updating the PC ISP Part I Essential Information section;
- Recording the request from the person in the progress notes;
- Completing the Virginia Informed Choice Form (DMAS 460) to include specific SC name ;and
- Notifying all collateral contacts (family members, providers, professionals, etc.)

Transfer Protocols to/from Other CSBs

When a person moves to another locality, it may become more challenging for a SC to continue to monitor services. In this instance, the SC should work with the person to transfer support coordination services to another CSB/BHA. For more detailed information about the protocol for transferring support coordination to another CSB/BHA, please see your supervisor and ask for the most current version of the CSB Case Transfer Protocol.

Discharge/Transition Planning

All licensed providers, to include CSB/BHAs, are required to have written procedures that define the process for transitioning an individual between or among services operated by the provider. At a minimum the policy shall address:

- Continuity of services during and following transition;
- Participation of the person or authorized representative in planning;
- Process and timeframe for transferring access to the record and ISP
- Process and timeframe for completing the Transfer Summary.

- For more information, read 12VAC35-105-691 (Transition of Individuals Among Services) and 12VAC35-105-693 (Discharge).

Training Center Discharges

Anyone who previously resided in a training center who now lives in the community is required to have a more intensive level of support from the SC. When a person residing in a training center is seeking discharge into the community, the SC plays an important role ensuring a smooth transition. The assessment and discharge plan development process for a person being discharged from a training center is similar to the process for someone already residing in the community. Further, there is additional funding available to help someone move into the community. SCs should ask their supervisors for assistance with local funding resources.

Virginia has approved limited funding as a part of the plan to support individuals transitioning from a training center or other state facility according to the “community move process” to a community home of their choice. Transitional funding, formerly known as “bridge funding,” can be used in a variety of ways to support the planning and move of these individuals to their own homes or to a provider home licensed by DBHDS. The application is available on the DBHDS website.

State Psychiatric Hospital Discharge

Both CSB/BHAs and state psychiatric hospitals recognize the importance of timely discharge planning and implementation of discharge plans to serve persons in the community as well as to ensure the ongoing availability of state hospital beds for people presenting in the community with acute psychiatric needs.

Please read the collaborative discharge protocols for state psychiatric hospital discharges for more information.

Private Medical/Psychiatric Hospital

The SC may support a person who is in a private hospital and is seeking discharge into the community. The SC should work collaboratively with the person, family or guardian, and the hospital staff to assess the person’s needs upon discharge; identify risks, needs and preferences; address barriers; and ultimately develop a plan that meets the person’s desired outcomes. Once the person returns to the community, the SC provides ECM services for one year and then determines if the person continues to meet the criteria for ECM services.

Discharge from Support Coordination

There are a number ofreasons why a person may be discharged from SC services. Reasons may include, but are not limited to:

- The person moves out of the CSB/BHA catchment area or out of the state;
- Death;
- The person chooses to no longer use support coordination services;
- The person is no longer eligible for support coordination services;
- The person no longer meets financial eligibility for support coordination services; and
- The person no longer has active or specialized need for support coordination services.

It is essential for the SC to work carefully through the transition and discharge process. SCs must ensure there is agreement on ending SC services with the person, the agency, and other appropriate parties. The SC should provide reasonable notice of discharge that is based upon the facts and circumstances of each person's life. The SC should document both verbal and written notice to the person leaving services and the other participating service providers. It is important to communicate pertinent information, with permission, when transitioning to other providers and supports to maximize positive outcomes. As part of a discharge summary, the SC will include linkage to other resources as needed for a smooth transition. Documentation includes completion of the required discharge summary, notice of appeal rights, final PCR, and a progress note.

Discharge from Support Coordination responsibilities:

- Complete SC agency's documentation requirements for discharge (discharge summary, case notes, final PCR, etc.) and submit a notification of right to appeal letter regarding termination, if the person is receiving Medicaid-billed State Plan Option (SPO) TCM.

- When the person moves to another locality in Virginia and the receiving CSB/BHA will continue to provide TCM services an exception to the need for a Notification of Right to Appeal letter exists. Because the SPO CM will continue, there is no need to send the appeal notification because no Medicaid services will be terminated.

See DBHDS Licensing regulation 12VAC35-105-693 regarding Discharge.

Chapter 10:
Health & Safety

Introduction

People with disabilities need health care and health programs for the same reasons anyone else does - to stay well, active, and a part of the community. Having a disability does not mean a person is not healthy or cannot be healthy. Being healthy means the same thing for all of us - getting and staying well so we can lead full, active lives. People with disabilities experience all the same common health issues as the general population, yet as a group, they have much greater health needs. People with disabilities can also be at higher risk for injuries and abuse. For these reasons, health and safety are core concerns for people with disabilities, however, these concerns do not override a person's fundamental right to the dignity of risk, the right to take risks when engaging in life experiences, and the right to fail in those activities. All too often people are limited from living their best lives under the guise of health and safety concerns when it is really a lack of a creative, committed effort to provide individualized and meaningful supports.

Resource: Disability and Health Information for People with Disabilities

Support Coordinators Role in Health & Safety

The Support Coordinator (SC) should perform the same process steps regarding a person's health and safety that they do for other supports and services for the people they support. Some of the particular duties regarding health and safety are outlined below.

Assessment

- Complete the Risk Awareness Tool at or prior to the initial Planning meeting and annually thereafter to increase awareness of the potential for a harmful event (e.g., bowel obstruction, sepsis, fall with injury, self-harm, elopement, etc.) to occur and to facilitate the process of taking action to reduce and prevent the risk.
- Complete the Crisis Risk Assessment Tool at intake and every face to face meeting thereafter to capture information that may put an individual at risk for crisis or hospitalization, and to foster proactive referrals to REACH or other appropriate programs if such a risk is determined.
- Complete the Onsite Visit Tool at one face to face meeting with each person, no less than one time per quarter to observe the person and the environment to assess for risks.
- Request copies of and/or results of health risk assessments (HRA) completed annually by CCC+ care coordinators.
- Participate in SIS® meetings.

Plan Development

- Document risk and medical and behavioral support needs, which can be gathered from a variety of sources to including but not limited to needs as determined by the SIS® assessment, the RAT, the crisis RAT, the onsite visit tool, and the CCC+ HRA.
- Parts III and V on the PC ISP must address all risks and medical and behavioral support needs. For example, assisting a person to obtain a ramp through an environmental modification, linking someone to a psychiatrist to obtain needed mental health support and medication monitoring, linking a person to a physician for an assessment for wound care, etc.
- Review provider Part V plans for supports to ensure they include supports as agreed upon in the shared planning regarding all risks and medical and behavioral needs.

Plan Implementation/Coordination

- Communicate with all providers to share vital information, for example, a residential provider reports that someone he supports has received a new order from his physician that blood sugar levels have to be tested every 2 hours. The day support program will need to be informed so that they can also make sure the blood sugar levels are tested every 2 hours while that person is at their program. Update the ISP to reflect any new medical condition.
- Communicate with care coordinators of the MCOs to update them on an individual's needs and services and obtain results of their HRAs
- Collaborate with care coordinators regarding medical issues to develop coordinated plans to mitigate risks
- Report alleged abuse, neglect, or exploitation to adult protective services (APS) and child protective services (CPS).

Monitoring

- Review provider PCRs and other documentation to obtain input on medical information, appointment information, and to ensure that all needed follow-up has been done for all medical conditions and concerns.
- Obtain input from the person using services and the authorized representative or legal guardian, as appropriate, on satisfaction with all services and providers.
- Follow through with service providers regarding implementation of physician's orders, etc.
- Obtain information on all medications a person takes and include side effect information.
- Document medication changes and communicate information to all providers.
- Review CHRIS case management reports and provider incident reports for injuries and medical concerns, and document communication with providers to ensure that all needed follow-up occurred.
- Request needed medical records from family members, group home providers, and medical providers.
- Ensure that an individual obtains a physical within 12 months prior to enrollment into a DD Waiver.
- Update PC ISP as appropriate.

Advocacy

- Advocate for annual physicals, dental exams, and other recommended preventive screenings and immunizations based on medical history, age, and gender.
- Advocate for needed referrals. Example: Someone has been having increased seizure activity. The primary care physician has not ordered any blood work, medical tests, or shown any concern about this increased seizure activity. The SC can advocate for a referral to a specialist, such as a neurologist, for more specialized care.
- Link to needed funding sources to cover someone's needs. Example: Drug companies frequently offer reduced rate medications programs for those unable to pay for their prescriptions.

Optimal Health

Maintenance of optimal health is one of the most basic supports provided by the team supporting a person with a disability. This is a shared responsibility among all entities who work with the person. It is a primary responsibility of the SC to lead the team in identifying health and safety risk factors, develop individualized supports, and to monitor the implementation of those supports and the person's wellbeing. The level of active involvement with health care practitioners depends on the risk factors of each person.

Achievement of OPTIMAL HEALTH is based upon these principles:

- **Person-Centered:** People participate in decisions about their health and are supported in making person-centered decisions about healthy lifestyles, such as food choices and activity.
- **Access:** People have adequate contact with health practitioners regarding their physical and mental health, receiving preventative health care and services, including recommended physical and dental exams, and timely assessment, treatment, and follow-up for acute and chronic health issues.
- **Support:** People are supported, as needed, in all aspects of their health care including decision-making, access, and following their prescribed treatment plans (e.g., medications, diets, mealtime instructions).
- **Documentation:** People's health-related information, both current and historical, is documented accurately and available when needed. People have some form of identification, which includes emergency contact information, with them at all times.

PROACTIVE STEPS TO HEALTH

Regular Medical and Dental Care

Regular medical and dental care is crucial in helping people enjoy a healthy life. It is important for team members to work closely with each person's primary care physician and other medical and health professionals to make sure regular routine tests and screenings are completed and to assist in communicatingto the health professional issues someone might be experiencing. All team members should be on the lookoutfor changes in appearance or behavior that may indicate some symptom of illness. Some people may not be able to fully communicate what they are feeling (physically and emotionally). It is important to be diligent in observing, monitoring, and reporting any of these changes. This role is usually done by the direct support professional (DSP) as they, are likely to have the consistency of contact needed to be aware of and note changes. It is the role of the SC to monitor changes in health and safety and to work with the person and the team to adjust supports accordingly.

Medication and Side Effects

Some people take multiple daily medications. All medications can have side effects - some of which can be harmful. Side effects may indicate that the medication dosage or type may need to change. In addition, people on more than one medication may experience symptoms related to the interactions of their medications.

While it is impossible to remember all the possible side effects for medications, it is important that the SC know where to find this information. Reputable sites that include information about drugs, dosage, uses and side effects are listed in Chapter 11.

Barriers to Quality Healthcare

Barriers to Quality Healthcare for People with Disabilities

- Difficulties communicating signs and symptoms to a health care provider about treatable yet untreated health conditions;
- Attitudes and assumptions of medical staff including discrimination and lack of empathy or caring for people with disabilities;
- Untreated specific health issues related to the person's disability due to health care providers'
- inadequate knowledge;
- Decreased access to generic/preventive health screening as well as to specialists' services
- Lack of independent mobility causing reliance on others to attend appointments;
- Behavior problems that may manifest themselves out of untreated medical conditions, fear, or disorientation; and
- Lack of time and resources.

Resource: Barriers in health care for people with disabilities: It's not what you think.

Eight Health Risks

The following is a list of areas in which changes may indicate signs of illness or a change in health status. There are **eight health issues** that are often overlooked and need to be more carefully monitored. These conditions can progress rapidly and result in bigger problems, even death. They are most likely to be identified and addressed by the DSPs who have regular contact with the person. However, the SC needs to be aware of the signs and symptoms of these health issues as well, so that they can properly monitor these conditions. The DBHDS OIH issues safety alerts on these conditions and provides a monthly newsletter that addresses health and safety issues. The eight health risks include:

Skin Care (general)

Healthy skin aids in regulating body temperature, protecting internal organs from injury and environmental elements, and protecting against infection.

Things to look for, but not limited to, and/or reports of:

- unusual or abnormal color (pale, pink, red, or bluish)
- rashes, cuts, open sores, raised bumps, blisters, bruises
- changes in skin temperature (such as moist, hot, or cool to the touch) and
- Parasites.

Decubitus ulcers/ pressure ulcers (bedsores) Decubitus ulcers are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Bedsores most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips, and tailbone. People most at risk of bedsores are those with a medical condition that limits their ability to change positions or those who spend most of their time in a bed or chair.

Bedsores can develop quickly. Most sores heal with treatment, but some never heal completely. Most pressure sores are preventable with the proper supports such as regular changes in positioning, different seating, and use of adaptive equipment. When pressure sores are a risk, physician orders for positioning protocols need to be developed and implemented. Documentation should be maintained on positioning logs that can be monitored by SCs. Skin integrity training is routinely offered by OIH.

Things to look for include:

- Unusual changes in skin color or texture;
- Swelling;
- Pus-like draining;
- An area of skin that feels cooler or warmer to the touch than other areas;
- Tender areas; and

  If there are signs of infection, such as a fever, drainage from a sore, a sore that smells bad, or increased redness, warmth or swelling around a sore, immediate medical attention should be sought, visit the Mayo Clinic website for more information.

Aspiration Pneumonia

Aspiration pneumonia is an inflammation of the lungs and airways to the lungs from breathing in foreign material. Aspiration pneumonia develops from inhaling food, vomit, liquids, or saliva into the lungs. This may occur when someone has difficulty swallowing (dysphagia) and has watery eyes or coughing while consuming food or fluids.

Things to look for, but not limited to, and/or reports of:

- Chest pain
- Cough
- Fatigue
- Nausea
- Fever
- Shortness of breath, wheezing, and
- Bluish discoloration of the skin caused by lack of oxygen (e.g., mouth, nail beds, finger tips).

Falls

Fall risk is important to address as 1 in 3 older adults fall daily. Fall complications can include broken bones, head injuries, problem with daily activities, and need for home health care.

Things to look for, but not limited to, and/or reports of:

- Health issues and medication;
- Being shoved or running into a barrier;
- Cluttered rooms, area rugs, wet or slick surfaces, improper lighting;
- Wet or slick surfaces without non-skid footwear; and
- Lack of appropriate medical adaptive equipment or inappropriate footwear.

Urinary Tract Infections (UTI)

A UTI is an infection of the urinary tract, which is the body's system for removing wastes and extra water. Women are more susceptible than men due to their anatomy and reduced bladder function later in life, and symptoms vary by age and gender. People who use wheelchairs or have reduced mobility are also more susceptible to developing UTIs. There are **two different types of UTIs:** the **lower UTI** relates to infections that occur in the urethra (a short narrow tube that carries urine from the bladder out of the body) and bladder, and the **upper UTI** is more severe and relates to infections that may involve the kidneys.

Things to look for, but not limited to, and/or reports of:

- Pain or burning during urination
- Increased frequency, urgency of urination, incontinence
- Lower abdominal, pelvic or rectal pain or pressure
- Confusion, behavioral changes, increased falls
- Mild fever or "just not feeling well" and
- Changes in urine (such as milky, cloudy, bloody or foul-smelling).

Upper UTI symptoms develop rapidly and may not include the symptoms for a lower UTI and **require emergency care**.

Things to look for, but not limited to, and/or reports of:

- Fairly high fever (higher than 101F)
- Shaking chills
- Nausea
- Vomiting; and
- Flank pain (pain in the back or side, usually only on one side at waist level).

Dehydration

Dehydration occurs when we lose more fluids than we are taking in. The lack of water in the body may result from either a decrease in fluid intake or an increase in fluid loss. Water helps transport waste, supports tissue and cell hydration and helps regulate your temperature. Dehydration can be an important factor in illness and even death. Diarrhea and vomiting are the most common reasons why someone loses excess fluid.

Things to look for, but not limited to, and/or reports of:

- Urine is concentrated and more yellow
- Dry mouth and nose
- Dry skin
- Decreased tear production
- Headache
- Dizziness
- Sleepy or tired and
- Lightheaded (especially when standing).

SEVERE dehydration symptoms can include, but are not limited to confusion, lack of sweating, little or no urination, weakness, coma, organ failure (especially kidney), changes in vital signs (increase in pulse and decrease in blood pressure), and “tenting” of skin (sticks together, stays upright when pinched together).

Constipation and Bowel Obstruction

Constipation is the slow movement of feces through the intestine which results in infrequent bowel movements and hard, dry stools. The longer it takes for stool to move through the large intestines, the more fluid is absorbed and the harder stool becomes, making it difficult and sometimes impossible to pass.

Things to look for, but not limited to, and/or reports of:

- Changes in bowel habits;
- Infrequent bowel movements (less than 3 a week or more than 3 days between);
- Difficulty passing stools - straining, painful;
- Hard, dry, lumpy, small stools;
- Belly pain relieved by bowel movements, swollen abdomen;
- Bright red blood in stools; and
- Leaks of wet, diarrhea-like stool between regular bowel movements.

Severe constipation can result in serious complications including rectal bleeding, nausea, vomiting, weight loss, bowel obstruction, fecal impaction, hemorrhoids, anal fissures and rectal prolapse. Two **serious constipation issues** are **fecal impaction** and bowel obstruction. Fecal impaction is when hard, dry stool is in the large intestines, often the rectum, and cannot be passed. Individuals with fecal impactions often have breathing difficulties due to the collection of the stool in the colon. Fecal impaction can be life-threatening. A **bowel obstruction** is either a partial or complete blockage of the small or large intestines and requires immediate medical attention! People who use wheelchairs and/or have reduced mobility are also more susceptible to developing a bowel obstruction. Use of a log to track bowel movements may be recommended to ensure people are having regular and adequate bowel movements. This log would typically be maintained by DSPs and can be monitored by SCs.

Bowel obstruction: Things to look for, but not limited to, and/or reports of:

- Abdominal pain
- Swelling and fullness
- Vomiting
- Diarrhea, and
- Odor to breath.

Sepsis

Sepsis is a serious medical condition caused by an overwhelming immune response to infection. Sepsis can arise unpredictably and can progress rapidly. Sepsis springs from two factors: an infection (such as pneumonia or a urinary tract infection) and a powerful and harmful response by the body's own immune system.

In severe cases, one or more organs fail. In the worst cases, blood pressure drops, the heart weakens and the patient spirals towards septic shock. Once that happens, multiple organs - lungs, kidneys, liver - may quickly fail and the person can die.

Seizures

Seizures are defined as abnormal movements or behavior due to electrical activity in the brain. Seizures might include shaking and convulsions, and can last a few seconds or over 5 minutes. Seizures have many causes and can lead to brain damage or even death. Diagnosis occurs when a person has had two or more seizures. Providers should track and report seizures. SCs should routinely monitor seizure activity. There are many types of seizures.

Things to look for include, but not limited to, and/or reports of:

- Brief blackout followed by a period of confusion;
- Changes in behavior;
- Drooling or frothing at the mouth;
- Eye movements;
- Shaking of the entire body;
- Grunting or snorting;
- Loss of bladder or bowel control;
- Sudden falling;
- Teeth clenching;
- Tasting a bitter or metallic flavor;
- Temporary stop in breathing;
- Uncontrollable muscle spasms with twitching and jerking limbs; and
- Mood changes such as sudden anger, unexplainable fear, paranoia, joy, or laughter.

Medical Healthcare Professionals

Healthcare professionals are broken out in the following chart for those that can assess and provide a care plan in their specialty addressing the prescribed treatment. Also consider utilizing other healthcare professionals for community supports to include, but are not limited to, DBHDS OIH Registered Nurse Care Consultant and the individual's MCO care coordinator.

Type of Risk	**Healthcare Professional**	**Who else can help?**
Constipation	Primary Care Practitioner Gastroenterology Specialist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Dietician Behavior Specialist
Gastroesophageal reflux disease (Gerd**)**	Primary Care Practitioner Gastroenterology Specialist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Dietician Occupational Therapist (OT) Physical Therapist (PT)
Aspiration Pneumonia	Primary Care Practitioner Gastroenterology Specialist Ear, Nose, Throat (ENT) Specialist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Speech Therapist (SLP) Occupational Therapist (OT)
Seizures	Primary Care Practitioner Neurologist	Registered Nurse (RN) Licensed Practical Nurse (LPN)
Dehydration	Primary Care Practitioner Urologist DBHDS: Office of Integrated Health RNCC MCO Care Coordinator	Registered Nurse (RN) Licensed Practical Nurse (LPN) Speech Therapist (SLP) Occupational Therapist (OT) Dietician Behavioral Specialist
Urinary Tract Infection	Primary Care Practitioner (PCP) Urologist Nephrologist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Occupational Therapist (OT) Dietician Behavioral Specialist
Change in Mental Status	Primary Care Physician (PCP) Neurologist	Registered Nurse (RN) Licensed Practical Nurse (LPN)

	Psychiatrist Psychologist (cannot prescribe medication)	Behavioral Specialist Counselor / Social Worker Certified Therapeutic Recreation Specialist (CTRS)
Pressure Ulcers and/or Decubitus Ulcers	Primary Care Practitioner (PCP) Orthopedist Endocrinologist (if individual has Diabetes)	Registered Nurse (RN) Licensed Practical Nurse (LPN) Occupational Therapist (OT) Physical Therapist (PT)
Sepsis	Primary Care Practitioner (PCP) Infection Disease Specialist (Emergency Room)	Registered Nurse (RN) Licensed Practical Nurse (LPC)
Diabetes	Primary Care Practitioner (PCP) Endocrinologist	Registered Nurse (RN) Licensed Practical Nurse (LPC) Dietician
Stroke	Primary Care Practitioner (PCP) Neurologist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Occupational Therapist (OT) Physical Therapist (PT) Speech Therapist (SLP) Certified Therapeutic Recreation Therapist (CTRS)
Falls	Primary Care Practitioner (PCP) Orthopedist	Registered Nurse (RN) Licensed Practical Nurse (LPN) Physical Therapist (PT) Occupational Therapist (OT)
Congestive Heart Failure	Primary Care Practitioner (PCP) Cardiologist	Registered Nurse (RN) Licensed Practical Nurse (LPN)
Cellulitis	Primary Care Practitioner (PCP) Infection Control Specialist Dermatologist (Emergency Room)	Registered Nurse (RN) Licensed Practical Nurse (LPN)
Elopement / Wandering	Primary Care Practitioner (PCP) Psychiatrist Psychologist (cannot prescribed medication)	Registered Nurse (RN) Licensed Practical Nurse (LPN) Behavior Specialist

Pain	Primary Care Practitioner (PCP) Pain Management Specialist Medical Specialist for the area of the body where the pain is located	Registered Nurse (RN) Licensed Practical Nurse (LPN)
Substance Abuse Related	Primary Care Practitioner (PCP) Psychiatrist Psychologist (cannot prescribed medication)	Registered Nurse (RN) Licensed Practical Nurse (LPN) Substance Abuse Counselor Counselor / Social Worker

Abuse, Neglect and Exploitation

It is estimated that people with disabilities are between two and five times more likely to be victims of abuseas those without disabilities (Martin et al., 2006; Mitra, Mouradian, & Diamond, 2011; Plummer & Findley, 2011). Further, research has indicated that most abuse perpetrators are known by the person with DD and often include parents, intimate partners, extended family members, caregivers, teachers, bus drivers, and other paid service providers (Stevens, 2012). People with disabilities are also at greater risk of experiencing domestic and sexual abuse by non-intimate partners, including other family members and care providers within and outside of institutions (Chenoweth, 1996; Oktay & Tompkins, 2004; Saxton, et al., 2001; Young, etal., 1997).

With these statistics in mind, the chances are great that an SC will support someone who is experiencing or has experienced abuse, neglect, or exploitation. The SC is required to report abuse, neglect, or exploitation in accordance with the Human Rights regulations and has additional reporting requirements as a “mandated reporter” as defined in Title 63.2 of the Code of Virginia.

The definitions for abuse (includes exploitation) and neglect as outlined in the Code of Virginia for the behavioral health and developmental services system in Title 37.2 of the Code of Virginia are:

- "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

  1. Rape, sexual assault, or other criminal sexual behavior;
  2. Assault or battery;
  3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
  4. Misuse or misappropriation of the individual's assets, goods, or property;
  5. Use of excessive force when placing an individual in physical or mechanical restraint;

6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice, or his individualized services plan; and

7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.as defined in the Code of Virginia.

- “Adult” means a person 18 years of age or more § 1-203 of the Code of Virginia.
- “Neglect" means failure by a person or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

In addition to Title 37.2, the laws and regulations for the social services system in Title 63.2 regarding abuse, neglect, and exploitation are relevant:

- "Abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult as defined in § 63.2-1603 of the Code of Virginia.
- “Adult” means any person 60 years of age or older, or any person 18 years of age or older who is incapacitated and who resides in the Commonwealth as defined in § 63.2-1603 of the Code of Virginia.
- “Neglect" means that an adult as defined in § 63.2-1603 is living under such circumstances that he is not able to provide for himself or is not being provided such services as are necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is written or oral expression of consent by that adult. Neglect includes the failure of a caregiver or another responsible person to provide for basic needs to maintain the adult's physical and mental health and well-being, and it includes the adult's neglect of self. Neglect includes:

1. the lack of clothing considered necessary to protect a person's health
2. the lack of food necessary to prevent physical injury or to maintain life, including failure to receive appropriate food for adults with conditions requiring special diets
3. shelter that is not structurally safe; has rodents or other infestations which may result in serious health problems; or does not have a safe and accessible water supply, safe heat source or sewage disposal. Adequate shelter for an adult will depend on the impairments of an adult; however, the adult must be protected from the elements that would seriously endanger his health (e.g., rain, cold or heat) and could result in serious illness or debilitating conditions
4. inadequate supervision by a paid or unpaid caregiver who provides the supervision necessary to protect the safety and well-being of an adult in his care
5. the failure of persons who are responsible for caregiving to seek needed medical care or to follow medically prescribed treatment for an adult, or the adult has failed to obtain such care for himself. The needed medical care is believed to be of such a nature as to result in physical or mental injury or illness if it is not provided

6. Medical neglect includes the withholding of medication or aids needed by the adult such as dentures, eyeglasses, hearing aids, walker, etc. It also includes the unauthorized administration of prescription drugs, over-medicating or under- medicating, and the administration of drugs for other than bona fide medical reasons, as determined by a licensed health care professional, and
7. Self-neglect by an adult who is not meeting his own basic needs due to mental or physical impairments. Basic needs refer to such things as food, clothing, shelter, health or medical care.

- “Exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult as defined in § 63.2- 1603 of the Code of Virginia or the adult’s funds, property, benefits, resources, or other assets for another's profit, benefit, or advantage, including a caregiver or person servingin a fiduciary capacity, or that deprives the adult of his rightful use of or access to such funds, property, benefits, resources, or other assets.

"Adult exploitation" includes:

- an intentional breach of a fiduciary obligation to an adult to his detriment or an intentional failure to use the financial resources of an adult in a manner that results inneglect of such adult
- the acquisition, possession, or control of an adult's financial resources or property through the use of undue influence, coercion, or duress, and
- forcing or coercing an adult to pay for goods or services or perform services against his will for another's profit, benefit, or advantage if the adult did not agree, or was tricked, misled, or defrauded into agreeing, to pay for such goods or services or perform such services.

Signs of abuse, neglect and exploitation

Mandated Reporting

The Code of Virginia states that mandated reporters who may have reason to suspect a child or disabled adult is being abused or neglected should immediately report to the local DSS. SCs are considered mandated reporters and are required to report all suspicions of abuse, neglect, and exploitation to APS, if the person is an adult. If the person is under 18 years or up to 21 years old while in the care of a legal guardian, CPS should be notified. For DBHDS-licensed providers, the offices of Human Rights and Licensing, as well as the Commonwealth Coordinated Care managed care organizations (MCO), if applicable for Medicaid recipients, must also be notified.

Department of Social Services/Child Protective Services (CPS)

The DSS operates a CPS Hotline 24/7 to support local DSS offices by receiving reports of child abuse and neglect and referring callers to the appropriate LDSS. The CPS Hotline is staffed by trained protective services hotline specialists.

Department of Aging and Rehabilitative Services (DARS) & Adult Protective Services (APS)

> To report suspected abuse, neglect, or exploitation of adults 60 years of age or older and incapacitated adults ages 18 or older, call the local DSS office or the 24-hour, toll-free APS hotline. If protective services are needed and accepted by the individual, local APS workers may arrange for a wide variety of health, housing, social, and legal services to stop the mistreatment or prevent further mistreatment. To access a list of mandated reporters visit Code of Virginia § 63.2-1606.

Reporting Abuse and Neglect: SC Responsibilities

- Immediately notify the local DSS if abuse, neglect, or exploitation is suspected.
- Be aware of the agency's policy on reporting and (supervisor) notification, and follow CSB/BHA internal protocols regarding reporting abuse and neglect.
- The Virginia DSS 24-hour, toll-free APS hotline at: (888) 832-3858
- The Virginia DSS 24-hour, toll-free CPS hotline at (800)552-7096.

Notify the DBHDS Office of Human Rights and Office of Licensing in addition to LDSS if there is suspicion of abuse, neglect, or exploitation from a licensed DD Waiver provider in accordance with agency policies and state requirements.

Office of Licensing/Serious Incident Reporting

The Office of Licensing oversees the serious incident reporting side of the Computerized Human Rights Information System (CHRIS). A serious incident means any event or circumstance that causes or could cause harm to the health, safety, or well-being of a person using services. As defined in the Licensing Regulations, the term "serious incident" includes death and serious injury. SCs should refer to agency policy and CHRIS roles for further guidance.

More information on serious incident reporting can be found in the licensing regulations and on the VA Department of Behavioral Health and Developmental Services website.

Computerized Human Rights Information System (CHRIS): SC responsibilities

When a provider has identified and entered a serious injury, incident or death into CHRIS:

- Follow up with the provider to monitor the corrective action plan;
- Communicate with the individual and the authorized representative in order to determine ongoing satisfaction with the provider; and
- Document ongoing monitoring and follow up as it relates to the incident.

Office of Licensing – CHRIS Serious Incident Reporting

The Office of Licensing oversees the serious incident reporting side of the Computerized Human Rights Information System (CHRIS). Licensing regulation 12VAC35-105-160 (D2) states that all serious incidents, including death, should be reported in writing to the DBHDS Office of Licensing within 24 hours. A serious incident means any event or circumstance that causes or could cause harm to the health, safety, or well-being of a person using services. The term serious incident includes death and serious injury. There are three levels of serious incidents.

Level I serious incidents do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs. * Does not require reporting*	**Level II**:	**Level III** serious incident means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:
	1. A serious injury; 2. An individual who is or was missing 3. An emergency room visit 4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services 5. Choking incidents that require direct physical intervention by another person; 6. Ingestion of any hazardous material 7. A diagnosis of: a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer; b. Bowel Obstruction or;	1.Any death of an individual 2. Any sexual assault of an individual 3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

	c. Aspiration Pneumonia	

Each CSB will have one or more staff identified as users who have capability enter information and to run reports to view allegations and complaints, and a summary of provider reports for individuals who receive support coordination from the CSB.

When a provider has entered a serious injury, incident or death into CHRIS, SC should:

- Follow up with the provider in order to monitor the plan of corrective action plan;
- Communicate with the individual and/or the family/guardian in order to determine ongoing satisfaction with the provider; and
- Document ongoing monitoring and follow up as it relates to the incident.

Office of Human Rights Allegations/Abuse, Neglect and Exploitation

Office of Human Rights

The DBHDS Office of Human Rights (OHR), established in 1978, has as its basis the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by DBHDS (the “Human Rights Regulations”) [12VAC35-115]. The Human Rights Regulations outline DBHDS’ responsibility for assuring the protection of the rights of individuals in facilities and programs operated funded and licensed by DBHDS.

Title 37.2-400, Code of Virginia (1950), as amended, and the Office of Human Rights assure that each individual has the right to:

- Retain his legal rights as provided by state and federal law;
- Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
- Be treated with dignity as a human being and be free from abuse or neglect;
- Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative;
- Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;
- Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;
- Be allowed to send and receive sealed letter mail;
- Have access to his medical and clinical treatment, training, or habilitation records and be assured of their confidentiality but, notwithstanding other provisions of law, this right shall be limited to access consistent with his condition and sound therapeutic treatment;
- Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel;
- Be afforded appropriate opportunities, consistent with the individual's capabilities and capacity, to participate in the development and implementation of his individualized services plan; and

- Be afforded the opportunity to have a person of his choice notified of his general condition, location, and transfer to another facility.

OHR advocates represent individuals receiving services from providers of mental health, developmental disabilities, or substance abuse services in Virginia whose rights are alleged to have been violated and perform other duties for the purpose of preventing rights violations. Each state facility has at least one advocate assigned, with regional advocates located throughout the state who provide a similar function for individuals receiving community services. Their duties include investigating complaints, examining conditions that impact individuals' human rights, and monitoring compliance with the Human Rights Regulations. At times, an individual receiving services or anyone acting on the individual's behalf may request to be linked with the regional human rights advocate.

Local human rights committees (LHRCs) are comprised of community volunteers who are broadly representative of various interests of individuals receiving services and professionals in the system. LHRCs play a vital role in DBHDS' human rights structure, serving as an external component of the human rights system. LHRCs review individuals' complaints not resolved at the program level; review and make recommendations concerning variances to the regulations; review program policies, procedures, and practices; make recommendations for change; conduct investigations; and review restrictive programming.

Office of Human Rights: SC responsibilities

If a person requests to be linked with their OHR advocate the SC **must**:

- Provide the contact information for the advocate;
- Reach out to the advocate on behalf of the individual; and
- Document the person's request and the action taken.
- Statewide listing of OHR staff

Caregiver Stress and Burnout

As a Support Coordinator providing in-home visits, it is important to recognize the emotional, physical, mental and financial demands of being a caregiver. Some caregivers are well connected, while others may be isolated, and you maybe one of the few people who visit the home. While you are there to support the individual, be attentive to the caregiver(s). Listen for requests they make for additional supports as well as comments about their lack of sleep or their own health (physical or mental) problems or their additional financial burdens. If possible, assess other responsibilities the caregiver may have. Don't be afraid to ask about their own support system. Offer information for resources that are available in their community. Be proactive. If you believe supports are needed sooner than later, don't hesitate to escalate those concerns to your supervisor.

Caregivers commonly experience high levels of stress, anxiety, depression and other mental health effects. Read more at the Family Caregiver Alliance (https://www.caregiver.org/resource/caregiver-health/).

Signs of caregiver stress and burnout are listed below.

Signs of caregiver stress

- Feeling overwhelmed or constantly worried;
- Feeling tired often;
- Getting too much sleep or not enough sleep;
- Gaining or losing weight;
- Becoming easily irritated or angry;
- Losing interest in activities once enjoyable;
- Feeling sad;
- Having frequent headaches, body pain, or other physical problems; and
- Abusing alcohol or drugs, including prescription medications

(https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/caregiver-stress/art-20044784)

Signs of caregiver burnout

- Withdrawal from friends, family, and other loved ones;
- Loss of interest in activities previously enjoyed;
- Feeling blue, irritable, hopeless and helpless;
- Changes in appetite, weight, or both;
- Changes in sleep patterns;
- Getting sick more often;
- Feelings of wanting to hurt oneself or the person being cared for;
- Emotional and physical exhaustion; and
- Irritability

(https://my.clevelandclinic.org/health/diseases/9225-caregiver-burnout)

Caregiver stress and/or caregiver burnout can lead to a mental health crisis. Warning signs include having trouble with daily tasks, sudden, extreme changes in mood, increased agitation, abusive behavior, isolation, paranoia and symptoms of psychosis. Warning signs are not always present when a mental health crisis is developing. Be attentive to these warning signs of **suicide**:

- • Giving away personal possessions;
- Talking as if saying goodbye;
- Taking steps;
- Making or changing a will;
- Collecting and saving pills or buying a weapon;
- Saying things like “Nothing matters anymore;”
- Withdrawing from friends, family, and normal activities; and
- Increasing drug or alcohol use.

Emotional support can help to deal with the stress of caring for someone with a disability. The impact on the caregiver cannot be minimized. Caregivers experience elevated levels of depression and anxiety, higher use of psychoactive medications, worse self-reported physical health, compromised immune function and increased risk of early death https://www.cdc.gov/aging/caregiving/index.htm.

Signs of Abuse and Neglect as a Result of Caregiver Burnout

- Injuries of unknown origin;
- More restrictive supports in the home;
- Less restrictive supports in the home;
- Reports by the individual of use of:
  - Intimidation
  - Humiliating or aggressive language;
- Failure to protect from harm; and
- Failure to meet essential needs to include:
  - Essential medical care
  - Nutrition
  - Hydration
  - Hygiene
  - Basic activities of daily living or shelter.

In extreme cases, suicide and filicide (the killing of one’s son or daughter) are carried out. Read An Overview of Filicide (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922347/) to learn more. If you have concerns with a caregivers’ level of stress or behavior, or fear for any family member in the home, please reach out to your supervisor for guidance. As a mandated reporter, you are required to report concerning suspicions. DSS has two 24-hour, toll-free hotlines (one for concerns about children and one for adults). The hotline staff are trained to provide crisis counseling and intervention if needed and can provide information and referral assistance to callers to locate prevention and/or treatment programs in their area as appropriate. The hotline numbers are provided under the DARS & APS section found earlier in this chapter.

Connecting a caregiver to resources is the first step to providing support. Chapter 11 contains resources and information related to caregiver support.

End of Life

It is inevitable that Support Coordinators will experience the death of someone they are supporting. In some instances, the SC will have had a relationship with this person for years and they will experience grief and sadness. It is important that the SC reach out and rely on their own support systems during these times of loss. The relationship is a professional one, but also a human relationship, one with feelings, caring and regard. It is okay to acknowledge this and grieve. SCs may need to assist persons in obtaining end of life care through hospice or other medical providers.

Death and Serious Incidents

When a person who uses SC services passes away, there are a number of steps the SC takes to document the event. Each CSB/BHA has internal procedures, so the SC should check with the supervisor to ensure all documentation requirements have been completed.

Licensing regulation 12VAC35-105-160 (D2) states that all serious incidents, including death, should be reported in writing to the DBHDS Office of Licensing within 24 hours. CHRIS is the state database system used to document serious incidents, such as death . Training is accessible via the following link under Advocate Information: https://dbhds.virginia.gov/quality-management/human-rights.

CHAPTER 11:
Community Resources

Introduction

In addition to the private providers who provide services and supports for individuals with developmental disabilities, the Support Coordinator (SC) relies on the supports and services of many organizations to help them carry out their job responsibilities. Below are just some of the resources.

- DBHDS (804) 786-3921
- Division of Developmental Services https://dbhds.virginia.gov/developmental-services
- Waiver Services https://dbhds.virginia.gov/developmental-services/waiver-services
- Crisis Services - (REACH Adult DD Crisis Services, REACH Children DD Crisis Services, Statewide and Regional Resources/Documents) https://dbhds.virginia.gov/developmental-services/Crisis-services
- Community Integration and Transition Supports (Training Center Transition Services, Regional Support Teams, Guardianship, Family Resource Consulting, Single Point of Entry for ICF/IIDs, Incident Management/Quality assurance) https://dbhds.virginia.gov/developmental-services/icf-iid/
- Community Support Services (Employment, Housing, Individual Family Support Program) Employment https://dbhds.virginia.gov/developmental-services/employment
- Housing https://dbhds.virginia.gov/developmental-services/housing

- US Department of Justice Settlement Agreement with Virginia.
- Home and Community Based Settings Regulations.
- My Life My Community: (844) 603-9248
  - Search for Providers
  - Virginia DD Waiver Guidance (select Navigating the DD Waivers Guidebook)

- Office of Integrated Health.
- Office of Human Rights.
- Office of Licensing
- Licensed Providers and Provider Inspection/Investigation Reports Search.

The IFSP is designed to assist those on the DD Waiver waitlist and their families to access short-term, person- and family- centered resources, supports, and services. These services and items funded through the IFSP are intended to support the continued residence of an individual in his own home, family home, or in the community. SCs can encourage families and individuals to apply for this funding and offer support, as needed, in the application process. More information can be found at the IFSP website: Individual and Family Support Program.

An alphabetical list of links for community resources follows:

American Association on Intellectual and Developmental Disabilities (AAIDD)
(202) 387-1968

The Arc of Virginia

Centers for Independent Living

Centers for Medicare & Medicaid Services

Community Health Clinics

Department for Aging and Rehabilitative Services

Department of Education: Special Education

Department of Health

Department of Medical Assistance Services
(804) 786-7933 (General Information), (800) 343-0634 (TTY)

Department of Social Services
(804) 726-7000 (General Information)

disABILITY Law Center of Virginia
(800) 552-3962

Disability Navigator

Early Periodic Supports Diagnosis & Treatment (EPSDT)

The Olmstead Initiative

Parent Educational Advocacy Training Center

Partnership for People with Disabilities/Virginia Commonwealth University

(804) 828-3876 (Voice), (800) 828-1120 (TTY)

Positive Behavioral Supports

Social Security Administration

Virginia 2-1-1

Virginia Association of Community Service Boards

(804) 330-3141

Virginia Board for People with Disabilities

Virginia Navigator

Virginia Parks & Recreation

Caregiver Stress Support

My Life My Community Website

https://www.mylifemycommunityvirginia.org

Disability & Health Information for Family Caregivers

https://www.cdc.gov/ncbddd/disabilityandhealth/family.html

Partnership for People with Disabilities – Center for Family Involvement

https://partnership.vcu.edu/programs/community-living/center-for-family-involvement/

Suicide Prevention: 1-800-273-8255 and website: https://suicidepreventionlifeline.org/

Child Abuse/Neglect hotline (Virginia): 1-800-552-7096

Adult Protective Services hotline (Virginia): 1-888-832-3858

DARS APS Division: https://www.vadars.org/aps/

Virginia Department of Social Services: https://www.dss.virginia.gov/about/abuse.cgi

Virginia COPES (Support through talking or texting about struggles and mental health; Spanish speaking counselors are available): 1-877-349-6428

Family Violence and Sexual Assault Virginia Hotline: 1-800-838-8238

LGBTQ Partner Abuse and Sexual Assault Helpline: 1-866-356-6998 (Instant messaging and texting options available – for texting: 1-804-793-9999

National Domestic Violence Hotline: 1-800-7993-7233

National Alliance for Mental Illness (NAMI): 1-888-486-8264

National Alliance for Mental Illness (NAMI) Virginia Chapter: 1-804-285-8264

CHAPTER 12:

Employment, Post-Secondary Opportunities, and Integrated Community Involvement

Why Work?

We derive meaning and a sense of self from many things in our life including our family, our friends, and our work. Employment contributes much to the way we view ourselves. Employment can impact our sense of self in many positive ways especially when we find the right job with the right support. These simple truths are no different for a person with a disability.

Impacts of Employment

Economics. Unlike the majority of the population, most people with developmental disabilities live at or near the national poverty level. Income from paying jobs can supplement resources and improve the quality of lives.

Relationships. Employment is where people develop relationships, friendships, and acquaintances with other people. Through work, people with developmental disabilities have more opportunities to become connected to the greater community. People with disabilities who are employed report havinga higher number of friendships with people without disabilities than those who do not work.

Meaning. Our society values employment for all adults. Through employment, people with developmental disabilities gain skills, experience, and often a better understanding of the world around them. Being employed, in addition to the financial benefits, can make people feel there is apurpose to their lives.

Self Esteem. Employment can contribute to a sense of accomplishment, increasing one’s sense of competence and self-worth. People with developmental disabilities who work believe more in their abilities and develop higher expectations for what they can accomplish. This can spread to other areas of their lives.

Identity. Much of who we are and how we are perceived by others is related to our employment in where we work, what we do, and the connections we make. People with developmental disabilities can benefit in the same way from employment.

Virginia’s Recognition of the Importance of Work

Through a gubernatorial proclamation signed on October 4, 2011, Virginia joined a number of states that had declared themselves Employment First states.

The **Association of People Supporting Employment First (APSE)** defines "Employment First" as:

Employment in the general workforce is the first and preferred outcome in the provision of publicly funded services for all working age citizens with disabilities, regardless of level of disability.

In its official statement on Employment First, APSE maintains the following:

- Access to “real jobs with real wages” is essential if citizens with disabilities are to avoid lives of poverty, dependence, and isolation;
- It is presumed that all working age adults and youths with disabilities can work in jobs fully integrated within the general workforce, in typical work settings, working side-by-side with people without disabilities, earning regular wages and benefits and being part of the economic mainstream of our society;
- It is presumed that individuals with disabilities are capable of working until proven otherwise, and employment in the general workforce is the first option pursued;
- As with all other individuals, employees with disabilities require assistance and support to ensure job success and should have access to those supports necessary to succeed in the workplace;
- All citizens, regardless of disability, have the right to pursue the full range of available employment opportunities, and to earn a living wage in a job of their choosing, based on their talents, skills, and interests; and
- Implementation of Employment First principles must be based on clear public policies and practicesthat ensure employment of citizens with disabilities within the general workforce is the priority forpublic funding and service delivery

Ethical Standards and Guidelines from APSE that influence SC work:

- Everyone has employable strengths and can work in the competitive labor force with the right measure of support and in jobs well-matched and sometimes customized to their interests and abilities;
- People with disabilities are the experts about themselves and should play a leading role in decisions that affect their lives;
- Companies who hire people with disabilities will profit in many ways, including financially
- The focus of publicly funded services should be strengths-based - what people can do, not what they cannot do;
- An important role of the organization is to educate policymakers, including elected officials, on advocating for equal opportunities and fair treatment in the workplace.

The case has already been made for employment for all based on economics, relationships, meaning, self-esteem, and identity. Who can argue the value of each of these aspects and how they improve one's quality of life? Yet, according to the U.S Bureau of Labor Statistics, in 2020 only 17.9 percent of people ages 16 and older with a disability were employed. This is down from 19.3% in 2019 and contrasts with61.8 percent of people without a disability who were employed.

In Virginia, the concept of Employment First means offering the option of integrated, competitive employment as the first choice of day activity to people entering services. It means no longer asking whether a person can work, but instead asking what employment best matches the person's strengths, skills, interests, and conditions for success.

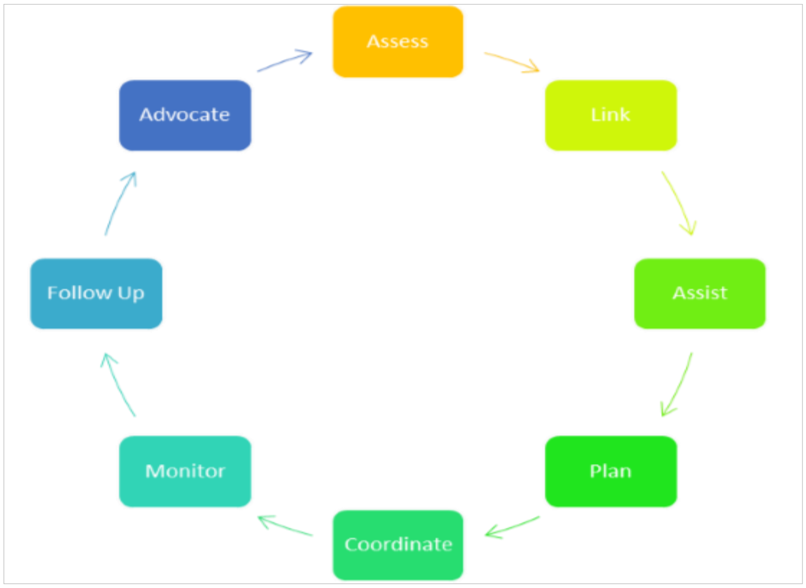
Definition of Employment

Employment means

- Working in a typical work setting where the employee with a disability works alongside coworkers without disabilities;
- Earning a competitive wage, i.e. minimum wage or better, along with related benefits; and
- Doing meaningful tasks that contribute to the organization or business, with an opportunity for career advancement.

Role of the Support Coordinator

The role of the SC is multi-faceted. A SC needs to be able to wear a variety of hats in supporting a person achieve their employment goals. Below is a diagram illustrating the diversity of the SC's role. Each facet of the wheel will be discussed along with how these activities translate into helping a person achieve meaningful employment.



Assess

A SC should begin by using active listening skills to discover how people they support view employment; whether they want to work; what their employment dreams and goals are; what interests, experiences, and skills they have that will lead the way to paid employment; and how they would be best supported in a working environment.

Often a person with DD will have no reference for choosing work. In order to appropriately assess this, the person who is being assessed has to understand what work is, what the benefits of work are, and what the possibilities of working can be. The provision and review of all the relevant information can help to ensure the person is making an informed choice. Examples of relevant information include such things as:

1. Potential opportunities to learn about work, the types of jobs people do, and exposure to working people within their interest areas;
2. The skill sets required by different jobs;
3. What the person may need to do to acquire those skills; and
4. Which supports the person may need on the job.

Information gathered from both the person who wants to work and the team who knows them well may comefrom asking the following types of questions:

1. From the personal profile, what is there that demonstrates a skill or talent that might be used in a work environment or would be valuable to a prospective employer? For example, does the person have a good memory? Is the person friendly. Is the person organized?
2. Has the person had experiences that could lead to paid work, sush as holding volunteer or paid jobs in the past? What did the person like or dislike in each of these experiences?
3. Does the person have specific career interests or places desired for a work setting? *(Word of caution: The 'obvious' isn't always the best. An interest in animals does not mean that someone wants to work with them. Also, do not make the assumption that a first job will be the only job a person will ever hold. Just as employment is an exploratory process for most of us, it is the same for a person with a disability. Imagine working in a job with the expectation of keeping that same job until retirement.)
4. From the essential information, under Employment, a conversation regarding employment is expected. Discuss all of the following topics to include employment interests; available options; satisfaction or dissatisfaction with current services; barriers related to pursuing employment options; addressing barriers, as applicable; a timeline for reviewing options in the future (at least annually); any related actions that will be taken; what the person is working on at home and school that will lead to employment; and alternate sources of funding (such as school or DARS).
5. Looking at "Important To and Important For" in the person-centered plan, is there anything that could help the person be successful in areas of interest or places where the person wants to work?
6. Does the person have behavioral support needs (either in the past or present) that are causing the person to be held to a higher standard around employment, in order to be given a chance to work, than others in the community? Should overcoming them be a requirement of

becoming employed? Isthis fair? Can some of these issues be addressed through the right job match?

A good resource for collecting information about interests, possible job avenues, best support, and involving people in writing their own resumes is the I Want to Work Workbook and Partner Guide. Free copies may be obtained, as long as supplies last, from the Partnership for People with Disabilities at VCU (804-828-3876).

Link

As a SC, linking a person with the right resources, including resources already present in their lives is another key element of success. While all efforts around work should focus on the person first, it is important to remember we all have support networks that help us to achieve our goals. Family, friends, professionals and advocates are often members of the "typical" team for a person with disabilities, yet the truth is the team can be comprised of anyone the person thinks can support them in achieving their employment goals. Part of getting the answers and helping the person achieve their goals is helping them to identify and leverage their personal networks. Many people find their first job and other jobs through people they know. This is no different for someone with a disability. Therefore, understanding and knowing the people who comprise the person's personal network can be critical to ensuring success. Success is equally dependent on linking personal networks with other professionals supporting the person in achieving their employment dreams. There can never be enough linking or educating about organizations that support people in working towards employment. The SC can:

- Explore personal networks for employment resources and connect with professionals if needed;
- Connect the person to appropriate professional resources;
    - DARS;
    - Employment Service Organizations (ESOs);
    - Benefits Planning Services;
- Connect DARS and ESOs to people in the person's network;
- Discuss educational and post-secondary educational opportunities to enhance skills for employment; and
- Connect to community learning opportunities.

Assist

Assisting people means supporting them to reach their goals. There are legitimate things that may have to occur in order for people to be successful in the job that they choose. Supporting persons in selecting among options based on the relevant information and then honoring individual choice is essential. Recognizing that the choices people make may be different from the choices other team members might make for them is fundamental to creating a respectful, supportive environment. Identifying any barriers is critical, and equally important is developing a game plan to break down those barriers. All members of the person's team are needed to address barriers. The team should not identify a barrier and simply determine it to be insurmountable. Moving from a mindset of "can't" to "how" is imperative. Team members will need to be focused and creative in addressing issues around barriers that interfere with the choices a person has made, especially issues involving staffing and transportation. In this instance, the "more heads are better than one" adage could not be truer. The more minds there are trying to find solutions to overcome barriers, the better, as there will be more creativity involved.

It is the SC's role to lead the team in creativity, ingenuity, and determination to problem-solve.

- Who is in the person's personal network that can help work toward finding and keeping employment?
- Ask the question: What could we do NOW to help the person be employed in the future?

What are skills and talents that could be tapped into?

  - What activities are available in day support or community engagement that could expand their options and knowledge of work and career possibilities?
  - What are the obstacles? What could be done NOW to help overcome these obstacles?
  - Garner support from current providers to think outside the box and put something into place in the person's current plan to address these obstacles.

Common Barriers

Barriers to employment are unique to each person served but several barriers are common. These barriers include:

Lack of funding. If someone does not have waiver services, paying for job development and support services for many families is impossible. DARS may be used as a resource, but often their resources are limited as well.

Misconceptions about benefits. Families may fear that employment will mean a loss of government benefits such as SSI and Medicaid.

Attitudes. Lack of belief that a person with DD can work may be present in families, employers, and even the person.

Lack of opportunity. This is true especially in rural areas where job opportunities for all people are limited.

Lack of transportation. Resource: Employment Programs for Persons with Developmental Disabilities-Department of Health and Human Services OFFICE OF INSPECTOR GENERAL August 1999.

Possible ways to address barriers:
- Explore local funding and new services;
- Consider natural supports;
- Use work incentives;
- Use ABLE accounts;
- Use the PASS plan;
- Educate job seekers and family members- show videos from www.realworkstories.org;
- Advertise with personal networks;

- Look at small business and local companies;
- Consider ride share, community transportation; and
- Leverage family peer mentoring.

Building a Resume

Anyone interested in working needs a resume. Throughout the process of assisting someone in securing employment, there are many activities a person can do to add to and build a resume. While working on finding a paid job, meaningful, productive activities can help increase skills, knowledge, and experiences and also be fun. As with all employment-related pursuits, these should be based on the interests and preferences of the person being supported. Activities may include but are certainly not limited to:

- Volunteer work;
- Taking classes at technical school, community college, community adult education, and/or local cultural sites, such as museums or art studios;
- Taking online courses;
- Attending workshops, seminars, or conferences;
- Pursuing internships;
- Joining service or charitable organizations;
- Participating in charitable events;
- Attending camps that stress academics, teach skills, or show team-building;
- Joining advocacy organizations; and
- Developing hobbies that facilitate job-related skills.

All of these activities should be tracked and added to a resume.

Plan

Recognizing that people know the most about their situations necessitates involving them in every decision. The person should be an active participant in developing the person-centered plan, including discussion of integrated, competitive employment services at least annually and inclusion of employment goals or goals that break down barriers to employment in an individualized support plan. Remember “nothing about me without me!” How can this be done?

In thinking about a first job, imagine it to be the only job or employment to which one is tied until retirement. Many of the general population today would be working as camp counselors, fast food employees, grass cutters, or babysitters. With people with disabilities, we sometimes forget that a person’s first job is not necessarily meant to be the last job. In fact, the people we support should have the same opportunities to grow, learn, and change as the rest of the population.

The SC’s role is to help people they support identify what they want their future to look like. This is called career planning and it involves:

- Recognition that planning goes beyond getting the person a job, yet at the same time

understandingand communicating with the job-seeker and family that most first jobs help people develop valuable work skills that may lead to advancement;
- Identifying what someone's long-term career aspirations are and assisting in developing plans for two, five, or ten years into the future;
- Identifying what additional educational or training opportunities will help the person reach set goals.

Planning is also an opportunity to expand a person's understanding of the importance of employment through conversations:

- Asking the person why he is working and explaining the importance of the tasks he is being asked to complete;
- Helping a person see where he fits in the organization and brainstorming opportunities for advancement that might exist; and
- Explaining the dignity of work, the value added to the organization through the tasks performed, and how a paycheck is earned.

It is important for the SC to talk with the person about how it is possible that advancement in a job may happen over time, but this may not be the case for everyone. Teaching the person how to grow in his current position, to master new skills, and to branch out to learn other areas, actually supports the person in becoming a more valuable and hopefully more satisfied employee.

Coordinate

Coordination of services ensures that multiple people providing support are not working on the same things. Teams can move more quickly if they divide up responsibilities and have each member take a role in helping the person achieve employment goals. Having a coordinated plan will minimize confusion.

- Coordinate responsibilities
    - Who will be carrying out which duties?
    - Who will make necessary appointments with other professionals?
    - Who will accompany them to intake appointments?
    - Does the person need supports and services? Not all of the people SCs support do.
    - Is there funding available for services or supports? How can it be accessed?
    - Are the right supports available? Who will coordinate the involvement and implementation?
- What are transportation options open to the individual if they have a job? How are they accessed? How will they be paid for?
- Is there a provider that a referral could be made to now? If not, what information could be provided that would assist in the choice of provider at a later date?

Monitor

Monitoring services will ensure that the person maintains the paid and unpaid supports and assistance that they need. The Support Coordinator's role in monitoring is different depending on whether or not the person has a job and whether or not paid supports are in place. Monitoring when the person does not have a job means ensuring the team continues to identify and address barriers, while at the same time providing education and training around realistic expectations of the person and of potential employers. When the person has a job, monitoring ensures that the person still has the desired job, that the hours are compatible, and that he is happy with the job situation. This monitoring ensures that a person has an opportunity to share when or if he is unhappy in his work or would like to pursue another job.

Questions to Ask

- Is the person working? If no
    - Are the barriers that have been identified being addressed? This requires thinking“outside the box” in many instances.
    - Is the team job developing consistently?
    - Are they (the person and other team members) satisfied with the supports and servicesimplemented towards securing employment?
    - Refer the person to experts who can provide counseling on benefits such as SSI, social security disability insurance (SSDI), Medicaid, and Medicare (see the box below under Misinformation about Employment and People with Disabilities for information about these experts).
- Is the person working? If yes
    - Is there satisfaction with the job?
    - Is it the job desired?
    - Do the hours work?
    - Are there any unmet employment needs?
    - Is the team actively involved, on the same page?

Supporting the person through training in self-advocacy and encouraging discussion with the job coach, supervisor, employer, or the employment service provider by role-playing to increase effective communication can help a person raise and address changes that are needed to ensure greater job satisfaction. It is also helpful for the SC and the rest of the support team to share with the person the fact that people aren't always completely happy in their jobs. It may be that a person cannot always be accommodated. However, there is a balance to be achieved between the perfect job and an awful job; that is a job that meets our most important needs, provides fair compensation, and engages us in meaningful work and gain skills for our next opportunity.

Follow-up

Once the SC has assessed, linked, assisted, coordinated, and monitored, the next step in supporting a person in achieving goals is follow-up. The SC, with the assistance of the right people, work together to ensure the person’s dream is not forgotten.

- Are the barriers that have been identified being worked on?
    - Have alternatives been identified?
- Is the person job developing consistently?
    - If not, why not and how can this be resolved?
- Is the person satisfied with the supports and services implemented towards getting a job?

- Who can help the person to become satisfied?
- Does the person still need the same level of supports and services?
- Does the person need assistance with managing their benefits?

Advocate

SCs serve a critical role in advocating for the person including:

- When people are unintentionally hindered by others who are acting in what they believe is the person's best interest;
- Dispelling myths and misconceptions, both positive and negative, about a person's ability or lack of ability; and
- Creatively addressing barriers and concerns that are raised. The SC need not have all the answers but instead should know where to connect the person to get them. The SC should be the initiator of brainstorming efforts and steer clear of shutting down discussions that may be "outside the box."

SCs also play an important role in system transformation, as this can only occur when advocates come together, united to educate and change the system. Often SCs are leaders in this effort as they can do much to educate the community at-large through their day-to-day responsibilities. SCs:

- Educate families, individuals, and team members about the value of employment;
- Identify barriers to employment in communities;
- Leverage personal and professional networks and communicate the value of employing individuals with disabilities; and
- When needed, work with ESOs to overcome those barriers.

Transportation Resources

As stated above, lack of transportation is a common barrier to obtaining and keeping employment. SCs can link those they support with a variety of options, granted that this may take some creativity. Some resources are:

Personal Networks

When looking for work, is it possible for the job seeker to find work within walking distance or at or near a business in which the person already knows someone? Explore networks in a person's life for transportation resources. Family, friends, or privately-paid acquaintances may be transportation resources.

"Carpooling" with a co-worker may be an option in which the non-driver contributes gas money in place of taking turns to drive. Also, private ride share companies could be used for occasional needs.

Public Transportation/Travel Training

Many people get to their places of employment by using public transportation, such as buses and subways.

Travel training may be available to teach a variety of travel skills that will enable the person to use local transportation independently. Here are some of the available resources in Virginia, but the SC should continue to search for others on the internet.

The Arc: Northern Virginia
ENDependent Center of Northern Virginia, Inc.
MetroReady Travel Training and System Orientation for People with Disabilities and Outreach
Richmond metro

Paratransit

Paratransit is a specialized, door-to-door transport service for people with disabilities who are not able to ride fixed-route public transportation. Fact Sheet: Paratransit Services.

Employment and Community Transportation

For people who use Waiver services, each of the three DD Waivers includes a service entitled employment and community transportation, which includes assistance with getting and going to a job. If someone has fee-for-service (FFS) Medicaid, MCO, or CCC+, the person may be eligible for non-emergency medical transportation (NEMT) services. This service will take a person to Medicaid-covered services such as medical and health care appointments, supported employment, and day support programs.

Parking placards and plates for people with disabilities

The Virginia Department of Motor Vehicles (DMV) offers parking placards and plates for customers with temporary or permanent disabilities that limit or impair their mobility. They are also available to customers with a condition that creates a safety concern while walking (examples are Alzheimer's disease, blindness, or developmental amentia).

These placards and plates entitle the holder to park in special parking spaces reserved for individuals with disabilities. Institutions and organizations that operate special vehicles equipped to carry persons with disabilities may also obtain parking placards and plates entitling them to special parking privileges. Parking Placards and Plates for Virginians with Disabilities.

Vehicle Modifications

For those who use waiver services, environmental modifications are included on all three DD Waivers and mayinclude reimbursement for changes to a personal vehicle. Vehicle Modifications.

Misinformation about Employment and People with Disabilities

There are assumptions about people with disabilities and employment, such as:

- **Not everyone can work!** Everyone should be given the opportunity to explore work. Even people withthe most significant disabilities can and do work. https://www.thinkwork.org/project/real-work-stories
- **You can't work and keep benefits!** SCs recognize that the person and the family may have real concerns about work, income, and its impact on benefits. It may have taken a longtime to be approved for benefits. They are concerned about losing benefits. Fear of losing cash benefits, and medical coverage under Medicaid (SSI) or Medicare (SSDI), often persuades individuals to severely limit their employment participation and earnings or, more commonly, not to enter the labor force at all. Unfortunately, beneficiaries are often told that employment will lead to the loss of their benefits.
- **You only get one chance to work!** Sometimes, a job comes along but it is the wrong job, the wrongtime or, the wrong supervisor. People with disabilities are no different in this regard; sometimes ittakes a couple of times to find the right job, at the right time, with the right people!
- **People with disabilities can only do entry level work in the food, cleaning, and manufacturing industries!** This is not true. People with disabilities in Virginia are working as advocates, data entry specialists, mechanics, hospital workers, etc. People are only limited by society's perception of them.

Additional Information about Benefits

- Special rules make it possible for an individual with disabilities receiving SSI or SSDI to work and still receive monthly payments and Medicaid or Medicare. Social Security calls these rules "work incentives."
- If the person currently receives Medicaid, eligibility should continue for Medicaid even after SSI cash benefits stop due to work. Section 1619(b) of the Social Security Act provides some protection. To be eligible, certain requirements must be met, including earnings below a threshold amount set by Virginia. Even if earnings exceed the state threshold, the person may still be eligible under certain circumstances.
- If a person earns enough that SSDI checks stop, Medicare can continue for up to 93 months.
- Individuals do not need to reapply if their benefits have ended within the past five years due to their earnings and if they meet a few other requirements, including that they still have the original medical condition(s) or one related to it that prevents them from working. This is a work incentive called "expedited reinstatement."
- Social Security ordinarily reviews an individual's medical condition from time to time to see whether they are still disabled, using a process called the medical continuing disability review, or medical CDR. If the individual participates in the Ticket to Work program with either DARS or another employment network (EN) and makes "timely progress" following the individual work plan, Social Security will not conduct a review of the medical condition. If a medical CDR has already been scheduled before the ticket is assigned, Social Security will continue with the medical CDR.

- MEDICAID WORKS is a work incentive opportunity offered by the Virginia Medicaid program for people with disabilities who are employed or who want to go to work. MEDICAID WORKS is a voluntary Medicaid plan option that will enable workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid. This program provides the support ofcontinued health care coverage so that people can work, save and gain greater independence. More information on Medicaid Works may be found at Medicaid Works (Medicaid Buy-In).

Employment Services under Waivers

If an individual has one of the three DD Waivers, there are employment services offered. All three Waivers provide:

- Supported Employment, both individual and group; and
- Community Engagement - a service where employment skills can be built.

An additional employment service, Workplace Assistance, is also provided under the Community Living Waiverand the Family and Individual Support Waiver.

Ordinarily DARS would be a first option for referral for employment services for people who use Waiver services. However, this may be bypassed when DARS has a waitlist. Acceptable documentation for this would be:

1) Written documentation from DARS or the school system, OR
2) Progress note that records the content of a communication that includes a name, date, and person contacted, documented either in the individual's file maintained by the SC on the ISP or the supported employment provider's supporting documentation.

Unless the individual's circumstances change (for example, the individual is seeking a new job), the original verification may be forwarded into the current record or repeated on the supporting documentation.

Integrated Employment Models

There are a variety of community integrated employment models used in Virginia and across the country such as:

- **Individual Supported Employment** is one person, one job, with supports based on the needs of theperson
- **Entrepreneurship** involves a person starting a business
- **Business within a business** is an employment model where someone opens a complimentary business within an existing business (for example, a barista at a local hotel).
- **Group supported employment** involves small groups (no more than eight individuals) working in a community business with ongoing supports. The supports are there to fully integrate the individuals into the work environment and help them develop meaningful relationships with their coworkers while supporting them with their tasks.

The goal of each of these employment models and services is to support individuals in integrated work settings,doing meaningful work, for which they are paid at least the minimum or competitive wage and benefits.

Benefits Counseling

SCs need not, nor should they, act as benefits advisors to the people they serve. Knowing all the rules governing work and its impact on individual benefits is best left to the experts. Benefits analysis is complicated and work incentives are specific to the type of benefit(s) a person receives. Inaccurate information can lead to an "overpayment" and even a loss of benefits. Income can also have an impact on other federal, state, and local programs including food stamps, Section-8 housing vouchers, etc. Below is information on experts to whom SCs may refer those they support.

Experts on Benefits and the Services Provided

Work incentive planning and assistance (WIPA) projects are funded by the SSA to provide information and benefits planning to enable beneficiaries with disabilities to make informed choices about work. WIPA projects hire and train community work.

Incentives coordinators (CWICs) who work with individuals receiving SSDI and/or SSI to provide in-depth counseling about benefits and the effect of work on those benefits. In Virginia, The vaACCSES - WIPA project provides community work incentives counselors and benefits specialists to provide all SSA disability beneficiaries (including transition-to-work aged youth) with access to benefits planning and assistance services. The ultimate goal of the WIPA project is to assist SSA's beneficiaries with disabilities in meeting their employment goals.

To learn more about the function of these specialists and how to contact them, go to:

- contact the Ticket to Work Help Line at (866) 968-7842 or (866) 833-2967 TTY
- visit Welcome to The Work Site
- visit Ticket to Work
- visit Work Incentives Planning & Assistance (WIPA)

Work Incentive Specialist Advocates (WISA) have been certified to provide work incentives counseling services to DARS clients who are receiving SSDI and/or SSI benefits. To learn more about the function of these specialists and how to contact them go to Grants & Special Programs.

Benefits planning service is an individualized analysis and consultation service for recipients of a DD waiver and social security (SSI, SSDI, SSI/SSDI) to understand their personal benefits and explore their options regarding working, how to begin employment, and the impact employment will have on their state and federal benefits.

Integrated Community Involvement

True community integration enables people to strive to learn, work, play, and socialize successfully, all while enjoying the benefits of an active, engaged lifestyle. Everyone has a unique potential; a potential to create, grow, learn, and adapt. The community provides opportunities to connect with others and enjoy a multitude of activities and events of many different areas of interest. There is an expectation that people with a DD Waiver have the opportunity to discuss options for integrated community involvement, explore ways to connect with community members, and have the desired supports and services to fully participate in the community in an integrated way. Discussions about integrated community involvement should occur frequently but minimally annually.

Integrated community involvement conversations explore the interests and available options for the individual. Explore their satisfaction or dissatisfaction with current services. Be sure to ask open-ended questions. Exploring barriers is also important and may include identifying and addressing barriers. Ask yourself what related actions will need to be taken to support the individual to enjoy more time in their community? Are there related actions that will be taken?

In the person-centered ISP, the life areas related to community can be defined as follows:

Life area: **Integrated Community Involvement**

Use this Life area if there are one or more community involvement outcomes in at least one service at 1:3 or fewer ratio

Life area: **Community Living**

Use this Life area if there are one or more community involvement outcomes at 1:4 or larger ratio

For individuals aged 14-17, it is important to explore what they are working on at home and school that will lead to more community participation and inclusion. The discussion for this age group also must include alternative sources for funding, such as parks and recreation, social clubs, and faith-based services. ICI outcomes can fall under most services, not just community engagement. The ratio used to implement the outcome is what matters, not the specific service.

CHAPTER 13:
Housing

Introduction

Adults with DD are increasingly choosing to live in and receive supports in integrated, independent housing settings. These settings have the following characteristics:

- The individual does not reside with a parent, grandparent, or guardian;
- The individual can live in housing types that anyone without a disability lives in, based on income;
- The individual has social, religious, educational, and personal opportunities to fully participate in community life;
- The individual owns or leases the housing unit, or has legal occupancy rights;
- Housing is affordable (the individual pays no more than 30% to 40% of his adjusted gross income);
- Housing is accessible (barrier-free);
- Housing is leased or owned by the person using services; and
- Housing is not contingent upon participation in services, and services are not contingent upon housing.

Support Coordinator's Role in Integrated, Independent Housing

SCs coordinate the person-centered planning team to help individuals with DD obtain and maintain housing, including community housing guides, residential service providers, landlords, and property owners (the Housing Collaboration Map in Appendix 1 illustrates the roles of these team players). This chart outlines the SC's primary responsibilities and describes these responsibilities in the context of supporting an individual's integrated, independent housing goals.

Support Coordinator Primary Responsibilities	Support Coordinator's Housing Responsibilities
Offer education and counseling to guide individuals	Educate individuals about integrated, independent housing options. • Review available housing resources. • Share links to videos and information sessions about housing options. • Encourage individuals to connect with peers who live in integrated, independent housing. Explore the person's vision for housing. • What does the person's desired housing arrangement look like? • Where does the person want to live? With whom? • What is important to/for the person in housing?
Assess individual needs	Assess individual's preparedness for housing and housing needs • With whom (if anyone) will the individual live? • What supports does the individual need to obtain and maintain housing? Who does the person want to provide these supports? Are these supports available? • Does the person have a realistic budget to obtain and maintain housing? What income and assets does he/she have? • Does the person have the required documents to obtain housing (e.g., Social Security card, birth certificate, government photo I.D., benefit letters, paystubs, bank statements)? • What housing features does the person need (e.g., specific location, unit size, accessibility features)? • What barriers does the person face to obtaining rent assistance and housing (e.g., poor credit, prior evictions or lease violations, criminal history, etc.)?

Develop the individual service plan	Based on the assessment above, develop the plan to help the individual transition to and maintain independent housing. • Identify and get commitments from any roommates and/or live-in aides. • Outline plans to secure needed supports in housing, including funding sources, providers, and proposed support schedule. • Determine ways to increase income, reduce expenses and access alternative resources to offset living expenses (e.g., SNAP, fuel assistance, etc.). • Define financial responsibilities (e.g., who will pay for upfront and ongoing housing expenses and how will payments be made). • Identify documents needed to apply for housing and who will help secure and complete them. • Explore properties which may meet the individual’s needs. • Identify housing assistance programs for which the individual is eligible and would like to apply. • Investigate approaches to reduce or remove barriers (e.g., reasonable accommodation requests, building or repairing credit, tenant training).

Support Coordinator Primary Responsibilities	**Support Coordinator’s Housing Responsibilities**
Link to services and resources Assist individuals with locating or obtaining needed services and resources Coordinate services	Based on the plan above, SC activities may include: • Submitting a DBHDS housing referral package for housing assistance. • Assisting the individual with completing rent assistance applications and eligibility interviews. • Supporting the individual at applicant briefings for rent assistance. • Connecting the person to affordable rental properties that may meet his/her needs and/or accept rent assistance. • Coordinating resources and services to assist with the housing search, lease review and the move (e.g., family, support services such as Community Housing Guide). • Helping individuals access funding sources to cover upfront costs to secure housing (e.g., application fees, security and utility deposits, etc.). • Assisting individuals with requesting reasonable accommodations and modifications in rent assistance programs and rental housing.

Support Coordinator Primary Responsibilities	Support Coordinator's Housing Responsibilities
Monitor whether services are achieving intended outcomes*	If an individual lives in independent housing and receives no Waiver services in the home, the SC should: • make two in-home visits per year to review whether the housing environment continues to meet the person's needs. • complete two telephone contacts per year with the individual to monitor rent and utility payments and satisfaction with the housing arrangement. • make two collateral contacts per year with the landlord and two contacts with the rent assistance program to support compliance with the lease and the rent assistance program's participation requirements. If an individual lives in independent housing and receives Waiver services in the home, the SC should: • make one or more, in-home visits per year (depending on the individual's case management status) to review whether the housing environment continues to meet the person's needs. • complete two telephone contacts per year with the individual to monitor rent and utility payments, and satisfaction with housing arrangement. • make two collateral contacts per year with the landlord, and two contacts with the rent assistance program,to support compliance with the lease and rent assistance program participation requirements. • review quarterly reports from the service providers to determine whether service providers that support the individual in the home report changes in the person's housing needs, satisfaction with the housing arrangement, rent/utility payment status, or compliance with lease or rent assistance program requirements.

*SCs should reference case management and support coordination requirements for frequency of face-to-face contacts and where these contacts must occur.

Support Coordinator Training, Resources and Tools

SCs are required to complete the Independent Housing Training for Support Coordinators within the first 30 days of employment. This training consists of three modules and is available on the Commonwealth of Virginia Learning Center (COVLC). After logging into COVLC, type "Housing" in the search bar. Select the Independent Housing Training for **support coordinators** (not Community Housing Guides).

DBHDS also has a housing webpage with tools and resources SCs can use to support people as they pursue integrated, independent housing: https://www.dbhds.virginia.gov/developmental-services/housing/resources-for-support-coordinators-and- case-managers

DBHDS Regional Housing Coordinators

Helping someone obtain and maintain housing can be a daunting task. DBHDS has housing coordinators available in each DBHDS region to provide SCs technical assistance throughout this process. Find your regional housing coordinator at https://dbhds.virginia.gov/developmental-services/housing/housing-team

Housing coordinators provide information and guidance on:

- Accessing available housing resources;
- Submitting a DBHDS housing assessment and referral;
- Developing a housing action plan and implementing the plan;
- Locating housing and completing rental and rent assistance applications;
- Preparing reasonable accommodation or modification requests;
- Developing strategies to address fair housing and/or tenant-landlord concerns; and
- Securing resources to cover transition expenses such as security deposits, utility connection fees, and basic furniture and household supplies.

DBHDS Housing Resources

The DBHDS Office of Community Housing (OCH) coordinates access to the following integrated, independent housing resources for people with DD. Eligible individuals with developmental disabilities must be age 18 or older and either:

- Transitioning from a skilled nursing facility, an intermediate care facility, a state training center, a group home or other congregate setting and meet the level of functioning criteria for a DD Waiver; or
- Currently receiving BI, FIS, or CL Waiver Services; or
- Determined eligible for and currently on the waitlist to receive a BI, FIS, or CL Waiver slot.

Housing Choice Voucher Special Admissions Preference and the State Rental Assistance Programs

These two rental assistance resources are for eligible people with DD. Typically, the individual/household receives a voucher or certificate that can be used at any rental property in the community. Both programs have maximum subsidy limits based on household size. The "gross rent" (e.g., rent plus tenant-paid utilities) of the selected unit must meet the program's requirements for rent reasonableness and affordability. The unit must also pass a safety inspection. If the unit is approved, the individual or household will pay 30-40 percent of its monthly adjusted income towards rent, minus an allowance the household can use to offset the cost of tenant-paid utilities. The balance of rent (up to the maximum allowable by the program) is paid directly to the landlord by the rental assistance program administrator.

Rental Properties with a Leasing Preference for the Settlement Agreement Population

Certain rental properties that receive special financing from the low income housing tax credit (LIHTC) program have a leasing preference for eligible people with DD. The leasing preference gives individuals in the settlement agreement population priority in applying for available units at these rental properties. Individuals must still qualify for the apartments (e.g., meet income and other tenant selection criteria). Rental assistance may or may not be available at the property. For information about rental properties with a leasing preference in your region, contact your regional housing coordinator.

DBHDS Flexible Funding

The Flexible Funding program helps people with DD in the Settlement Agreement Population afford the costs associated with (1) making the ***initial*** transition to their own rental housing or (2) maintaining housing if they are at risk of eviction. Six Community Services Boards administer this program for the DBHDS regions in the Commonwealth. Examples of costs that Flexible Funding may help cover include:
Assistance with the Initial Transition to Housing (one-time allotment of up to $5,000 for the **initial move only**)

- Holding fees;
- Utility deposits and connection fees;
- Security deposits;
- Moving expenses;
- Essential furniture and other household supplies (these items have maximum allowable payment and reimbursement limits);
- Non-reimbursable environmental modifications or assistive technology;
- Temporary rent to allow completion of environmental modifications;
- Direct support with housing location and pre-tenancy activities;
- Temporary support staff to help individuals acclimate to new housing (e.g., orienting individuals to a new apartment and neighborhood, instruction in use of appliances and environmental controls); and
- Shared living provider start-up activities (e.g., identifying roommate preferences, advertising for and interviewing potential roommates, performing background checks, arranging for required trainings, facilitating discussions of support expectations, developing a supports agreement).

Assistance with Maintaining Housing/Eviction Prevention (one-time allotment of up to $5,000 – can be drawn down until allotment is depleted)

- Security deposits and moving expenses for subsequent transitions;
- Emergency rent and associated late fees;
- Last resort utility assistance;

- Household management activities (specialized cleaning, pest extermination);
- Unit repairs; and
- Temporary relocation.

SCs complete and submit applications for flexible funding on behalf of individuals. CSB/BHA flexible funding program administrators can either reimburse individuals or their families for eligible expenses, purchase items on behalf of individuals, or pay vendors directly. Documentation of expenses is required. Applications and supporting documentation must be submitted by the deadline. Applications must meet program requirements and flexible funding request approval is based on availability of program funding. For more information, contact your regional housing coordinator or visit https://dbhds.virginia.gov/developmental-services/housing/flexible-funding.

DBHDS Housing Referral Package

SCs employed by CSB/BHAs and by CSB/BHA-contracted support coordination agencies are the sole referring agents for DBHDS housing resources. CSB/BHAs may utilize Medicaid SPO case management to complete support coordination activities associated with housing for eligible individuals on the waiver waitlist.

SCs must submit a DBHDS Housing Assessment and Referral Form to access DBHDS housing resources for individuals in the target population. The housing assessment and referral is currently available at https://www.dbhds.virginia.gov/developmental-services/housing/resources-for-support-coordinators-and-case-managers.

If the housing assessment and referral reveals the individual (i) could face major barriers to housing, (ii) has not firmed up the household composition, or (iii) does not have a feasible budget or needed supports, the DBHDS OCH will require that the SC submit a housing action plan for review. The housing action plan addresses issues that could negatively impact the individual’s ability to obtain or to maintain housing. The individual, the SC, and the planning team work together to develop and implement the action plan. Once DBHDS OCH determines the person has a viable plan to address these issues, DBHDS OCH will place the referral in the queue to be assigned a rent assistance resource.

CHAPTER 14:
Reviews

Importance of Reviews

There are several different types of reviews and audits in the DD service system. Some are intended to ensure that people are being provided with supports that ensure their health and safety, some reviews examine compliance with regulations, some are quality reviews, and some reviews look at documentation for Medicaid billing justification. It is important for SCs to know and understand the different entities that currently review the DD service system.

Internal

All DBHDS-licensed providers are responsible for conducting qualitative and quantitative reviews to evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. SC supervisory and internal quality assurance reviews are conducted regularly to ensure the SC is consistently interpreting and applying licensing regulations and Medicaid requirements. Internal reviews allow the SC to learn methods to improve the quality of services they provide and ensure that the supports are in line with agency standards and state regulations.

External

Reviews and audits are conducted by several agencies that are not part of the CSB/BHA or SC organization. External reviews are often conducted by an independent review organization or a state or federal organization. The goals of external reviews are to provide a review free from conflict of interest, establish standard requirements and qualifications, and to provide fair and impartial reviews.

Department of Behavioral Health and Developmental Services (DBHDS)

DBHDS provides oversight to a number of different offices or entities that provide regular reviews of the DD service delivery system. Some of those units are employed by DBHDS and others are contracted to provide the reviews. Below is a description of the four review functional areas associated with DBHDS.

DBHDS Office of Licensing (OL)

DBHDS licenses services that provide treatment, training, support and rehabilitation to people who have mental illness, developmental disabilities or substance use disorders, to people using services under the Medicaid DD Waiver, or to people with brain injuries using services in residential facilities.

Licensing specialists are employed by DBHDS in the Office of Licensing (OL) to license, monitor and provide oversight and technical assistance to licensed public and private providers that deliver services to people with mental illness, developmental disabilities or substance use disorders. They conduct announced or unannounced onsite inspections, inspect buildings and locations, review staff qualifications, review individual plans, and investigate complaints regarding potential violations of licensing regulations.

More information about this office is available on the licensing section of the DBHDS website.
Permanent licensing regulations can be found here:
https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/.
Permanent children's residential facility licensing regulations are here:
https://law.lis.virginia.gov/admincode/title12/agency35/chapter46/.
Emergency (temporary) regulations for either licensing chapter would be listed here:
http://register.dls.virginia.gov/emergency_regs.shtml.

DBHDS Office of Human Rights (OHR)

Human rights advocates are employed by DBHDS in the Office of Human Rights (OHR). They advocate for the rights of people using services in DBHDS-licensed programs and facilities. They monitor provider compliance with the Human Rights Regulations, and provide consultation and education to people with disabilities, their families, and providers about the regulations. OHR manages the DBHDS human rights dispute resolution process by investigating complaints regarding potential violation of the human rights regulations, reviewing provider's policies to ensure compliance with the human rights regulations, and providing technical assistance to the local human rights committees (LHRCs).

SCs help protect the basic human rights of people with disabilities. They ensure that people are treated with dignity and respect and are free from abuse, neglect, and exploitation. The SC should ensure that the person and the legal guardian (LG) or authorized representative (AR) are involved in all aspects of care including person-centered planning and signed consents for treatment. If a person's rights are found to have been violated, the SC should ensure the person, the family, and the LG or AR know who to contact if they have a complaint.
More information about OHR is available at the following sites:
https://dbhds.virginia.gov/quality-management/human-rights
https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

Quality Service Reviews

DBHDS contracts with a separate agency, the Health Services Advisory Group (HSAG), to conduct Quality

Service Reviews (QSRs) of those with a developmental disability (DD) who use services under the Department of Justice (DOJ) settlement agreement. This includes people using services through the Medicaid Home and Community-Based (HCBS) Services DD Waivers who live the community. The purpose of the QSRs is to evaluate the quality of services and determine if people are achieving outcomes, particularly in the areas of person-centered planning, integrated settings, and community inclusion. The QSR consists of person-centered reviews and provider quality reviews. The person using services has a voice as part of each process which is measured through interviews with the person, and the LG or AR, as appropriate. During a QSR, the SC can expect to be interviewed by HSAG reviewers. QSRs also include provider and SC record reviews. HSAG recommends that CSB/BHAs:

- Ensure SC understanding of the expectation for documentation of activities and efforts made to address individual risks by providing additional clinically-based training focusing on proper identification and inclusion of all medical needs documented in most recent assessments to all support coordinators.
- Ensure SC understanding of the expectation for completion of the RAT prior to, or in conjunction with, ISP planning.
- Ensure SC understanding of the expectation for documentation of activities and efforts made to address individual risks by providing additional clinical- based training focusing on proper inclusion of all risks in appropriate Part III outcome.
- Ensure SC understanding of the expectation that ISP documentation contains signatures for all licensed providers responsible for implementation, including the individual and the guardian or authorized representative, as applicable.
- Provide additional clinically-based training focusing on: ensuring SC understanding of proper identification and assessment of new or previously unidentified risks; how to properly document changes in status including relevant follow-up; how to identify deficiencies or discrepancies in support plan or its implementation; and best practices for how to address and mitigate risks incorporating individual’s strengths and preferences with support of planning team.

National Core Indicators (NCI)

DBHDS contracts with the Partnership for People with Disabilities at VCU to collect national core indicators (NCI). NCI is a voluntary effort by public DD agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. NCI gathers information through face-to-face interviews about satisfaction with supports and services from the people who use them. The survey instruments are used by a majority of states in the U.S. Information is also gathered from families about satisfaction with supports and services via mail-in surveys. Major activities of NCI include conducting interviews with people who use supports and services across the state and sending mail-in surveys to family members of people who use supports and services. Analyses and reports of findings may be found at Virginia's NCI website and at the National NCI website.

Department of Medical Assistance Services (DMAS) Reviews

Quality management reviews (QMRs) are conducted by QMR reviewers employed by DMAS. QMR reviews are intended to help ensure the health, safety, and welfare of individuals receiving home and community-based waiver services. Federal regulations require that DMAS ensure that necessary safeguards have been taken to protect the health and welfare of the recipients of services, ensure that all providers are in compliance with applicable state and federal standards, and ensure financial accountability for funds. Reviewers complete QSRs of provider documentation and personnel records for compliance with Medicaid policies and regulations, and provide technical assistance related to onsite reviews. They may refer providers to the DMAS program integrity unit when fraud is suspected or retractions in funding are warranted. A link to the website is provided on this slide. More information about the QMR is available on the LIS website.

Utilization reviews are financial audits conducted by DMAS program integrity staff or its contractor, Myers and Stauffer, LLC. Audits are conducted to: (i) ensure that Medicaid payments are made for covered services that were actually provided and properly billed and documented; (ii) calculate and initiate recovery of overpayment; (iii) educate providers on appropriate billing procedures; (iv) identify potentially fraudulent or abusive billing practices and refer fraudulent and abusive cases to other agencies; and (v) recommend policy changes to prevent waste, fraud, and abuse.

Support Coordination Quality Review (SCQR)

The support coordination quality review (SCQR) process was established to assess and improve the quality of support coordination (also referred to as "case management") services provided by CSB/BHAs to individuals on one of the home- and community-based services waivers (HCBS Waivers). The results of the SCQR are designed to help determine if these services comply with the Department of Justice Settlement Agreement and CMS requirements. The SCQR has been designed as a tool for CSB/BHAs to utilize for internal review of information as they wish as well as targeted monitoring by DBHDS. The Case Management Steering Committee oversees the development and implementation of the SCQR.

Questions were written to assess compliance with the ten settlement agreement case management indicators (see below) as well as other facets of high-quality support coordination. The purpose of the QSR process is to ensure continuous quality improvement in the services provided to individuals with developmental disabilities through the assessment of provider services. As a SC, your records must show that these ten indicators are being addressed.

Indicators

1. The CSB has offered each person the choice of case manager. (III.C.5.c)
2. Individuals have been offered a choice of providers for each service. (III.C.5.c)
3. The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. (III.C.5.b.i; III.C.7.b)
4. The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. (III.C.5.b.i; III.C.5.b.ii)
5. The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs. (III.C.5.b.iii; V.F.2)

6. The case manager assists in developing the person’s ISP that addresses all of the individual’s risks, identified needs and preferences. (III.C.5.b.ii; V.F.2)
7. The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. (III.C.5.b.ii; V.F.2)
8. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary. (III.C.5.b.i; III.C.5.b.ii; III.C.5.b.iii; V.F.2)
9. The case manager completes face-to-face assessments that the individual’s ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences. (III.C.5.b.iii; V.F.2)
10. The case manager assesses whether the person’s status or needs for services and supports have changed and the plan has been modified as needed. (III.C.5.b.iii; V.F.2)

Department of Justice (DOJ) Settlement Agreement Independent Reviewer

As a result of the DOJ settlement agreement, an independent reviewer appointed by the federal court, who is separate from the Commonwealth of Virginia, conducts reviews and submits reports every six months on their findings. These reviews can include document reviews and discussions with SCs, providers, DBHDS staff, and others in Virginia’s DD system of supports and services. To learn more about the settlement agreement and read past reports, visit: https://dbhds.virginia.gov/doj-settlement-agreement.

CHAPTER 15:
Forms

Forms that may assist you in supporting individuals with disabilities are available by clicking on the name of each document.

DBHDS

- Acronyms
- CRC Contacts by Capacity Area
- Post Move Monitoring Report
- REACH
- Office of Human Rights map

DMAS

- Medicaid or FAMIS appeal request form
- Service Authorization Board Assignments at DBHDS
- Sample Right to Appeal letter at-a-glance
- Service Authorization Guidance at-a-glance
- When to Submit What at-a-glance

Enhanced Case Management

- Enhanced Case Management Worksheet
- Enhanced Case Management Q&A

Housing

- Community Housing Guide Collaboration map
- Regional Housing Specialists list

Individual and Family Support

- A Guide for Developing Preliminary Essential Lifestyle Plan Conversations for Families
- A Guide for Developing Preliminary Essential Lifestyle Plan Conversations with the Person with whom you are Planning
- Conversation Book with Family Support
- Cover letter Choice Packet
- Cover letter Second Reminder

Person Centered Individualized Service Plan and PCR

- Checklist for ISP Plan Development
- Person Centered Review (Quarterly)
- 2021 Person Centered ISP Guidance
- Life Areas Cheat Sheet
- Integrated Community Involvement Fact Sheet

Medical

- A Brief Overview of Psychotropic Medication Use
- Neurodevelopmental Disorders
- Office of Integrated Health

Person Centered

- Myths and Misconceptions PCP Manual

Resources

- Social Security Benefits

Supports Intensity Scale

- SIS Scheduling Procedures
- SIS Reassessment Request Form
- SIS Reassessment Request Instructions
- SIS Standard Operating Procedures and Review Process
- Standard Operating Procedures Review Form
- SIS Virginia Interview Respondent Info
- SIS & PCP Process in Virginia (SIS-A & SIS-C)
- SIS PCP Process in Virginia (SIS-A)

Supported Decision-Making

- SDM Training and Resources at DBHDS
- SDMA Frequently Asked Questions
- SDMA Frequently Asked Questions – Plain Language
- Supported Decision-Making (VITC)

Training

- CSB Staff Account Registration Guide
- DSP Orientation Manual
- Therapeutic Consultation Training for SCs

Transition

IDEA Part C to Part B technical assistance guide

Transitional Funding

Transitional Funding Application
Transitional Funding Guidelines

Virginia Informed Choice

VIC Form

Waivers

At-a-glance Diagnostic Eligibility Review
BI Waiver at-a-glance
Case management and waitlist eligibility flowchart
CL Waiver at-a-glance
Compatible-Incompatible Services Grid
Navigating the DD Waivers
Navigating the DD Waivers (Spanish)
Needed services for people on the Waiver waitlist
Reserve slot request form
Resources for those on the waitlist IFSP First Steps
Slot Assignment Review form
Waiver Services at-a-glance

WaMS

WaMS CSB User Guide

Waiver Slot Assignment Committee (WSAC)

WSAC Application
WSAC Introduction Letter
WSAC Membership Parameters
WSAC Session Operations
WSAC Name-ID Key
WSAC Review Schedule

Others

Signs of Abuse & Neglect
Cultural Competency and Self-Assessment Checklist
DARS DBHDS Memorandum of Understanding
Discharge Protocols