Developmental Disabilities Administration
Coordination of Community Services Monitoring and Follow-Up Guidance

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Contents

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Audience

This guidance applies to Coordinators of Community Services (CCS), Developmental Disabilities Administration (DDA), DDA providers, DDA participants, their representatives, and families.

Purpose

This guidance outlines DDA's requirements related to monitoring and follow up activities completed by CCS for the people they support.

As CCS build relationships with the people on their caseload, they begin to understand someone's wants, needs, goals, and strengths which further enhances the ability for CCS to ensure overall health, safety, and satisfaction with support.

Additionally, monitoring and related follow up can help build trust with the person, their family, and providers by establishing a relationship and follow through on identified needs and wants a person may have.

There are monitoring specific timelines and criteria that need to be met and are facilitated by CCS. This guidance is in place to ensure consistency and compliance with state and federal requirements related to monitoring and applicable follow up activities.

Definitions

A. "Annual Plan" means the person-centered plan (PCP) completed within 365 days of the agreed upon Annual PCP date.

B. "Annual Plan Date" or "APD" is the date chosen by the person when they

first enter services, and the initial PCP is developed.

C. "Applicant" is an individual who is applying to receive services through the Developmental Disabilities Administration.

D. "Behavior Support Plan" or "BSP" is a written plan designed to modify behavior through the use of clinically accepted techniques that:

    1. Is person-centered and trauma-informed;

    2. Is based upon:

        a. positive behavior supports; and

        b. the results of a Functional Behavioral Assessment (FBA); and

        c. Includes a description of the problem behavior, along with a specific reason as to why the problem behavior occurs.

E. "Caregiver" is an individual who provides support or direct care services to an applicant or participant.

F. "Community Coordination Services" are targeted case management services for people who are enrolled in a DDA Medicaid Waiver or State-Funded program

G. "Coordinator of Community Services" or "CCS" is an individual who provides Coordination of Community Services. They can be either an employee or a contractor of a DDA Approved Provider of Coordination of Community Services.

H. Coordination of Community Services (CCS)" are targeted case management services to help people receiving and/or requesting

services funded by the DDA. Targeted case management services are provided in accordance with COMAR 10.09.48.

I. "Coordinator's of Community Service (CCS) Support Squad" means the DDA team who serves as the liaison between DDA and CCS Agencies to aid in compliance efforts towards CCS' Core Functions and responsibilities as per COMAR 10.09.48. The CCS Support Squad includes the Regional Office CCS Lead and CCS Support Staff.

J. "DDA" is the Developmental Disabilities Administration.

K. "DDA Medicaid Waiver Program" is one of three Medicaid Home and Community-Based Waiver Programs operated by the Developmental Disabilities Administration that serve eligible children and adults with intellectual and developmental disabilities. These programs are approved by the Centers for Medicare & Medicaid Services and include the:

1. Family Supports Waiver;
2. Community Pathways Waiver; and
3. Community Supports Waiver.

L. "DDA Provider" is an individual or entity, licensed or certified by the Maryland Department of Health, that provides DDA-funded services to people in accordance with the DDA's requirements.

M. "Department" is the Maryland Department of Health.

N. "Direct Support Services" are services provided directly to a person that help them keep, learn, or improve skills and daily functioning. These include supports for skills development, community integration and engagement, and addressing personal, behavioral, communication, or other needs.

O. "Electronic Visit Verification" or "EVV" is the technology that electronically verifies and records time associated with the delivery of services so that services are delivered at the right time, in the right place and to the right person.

P. "Emergency Back-Up Plan" is a plan that outlines the steps you will take in case of an emergency. It is a plan that helps you prepare for unexpected events that may disrupt your normal routine.

Q. "Face-to-Face" means 'in-person'.

R. "Fraud" means the intentional misuse of goods, services or money used to benefit yourself or others.

S. "Good Life" is a person's vision for what they want in their life, including what is important to and for them.

T. "Health Risk Screening Tool" or "HRST" is a screening tool utilized by teams to determine health and safety risks for a person.

U. "LTSS*Maryland*" is an electronic information system, developed and supported by the Department. It is used by the DDA, the CCS, and DDA Providers to create, review, and maintain records about:

1. An individual's eligibility status for DDA-funded services; and
2. The individual's person-centered plan, and services and funding authorized by the DDA.

V. "Monitoring and Follow-Up" is a targeted case management core responsibility that ensures people are healthy and safe, satisfied with DDA funded services and supports, and are receiving services as outlined in their person centered plan.

W. "MyLTSS" is a user-friendly, accessible electronic platform where people can log on directly to see their PCPs, information on service delivery, and Medicaid eligibility.

X. "Person" is an individual who receives DDA-funded services.

Y. "Person-Centered Plan" or "PCP" is a written plan developed through a planning process driven by a person with a developmental disability in order to:

1. Identify their goals and preferences;
2. Identify services to support them in pursuing their personally defined outcomes in the most integrated community setting;
3. Direct the delivery of services that reflect their personal preferences and choice; and
4. Identify their specific needs that must be addressed to ensure their health and welfare.

Z. "Person-Centered Thinking" is thinking focused on language, values, and actions toward respecting the views of the participant and their loved ones. It emphasizes quality of life, well-being, and informed choice.

AA. "Policy on Reportable Incidents and Investigations" or "PORII" is policy, required by COMAR 10.22.02.01 to ensure the health, safety and welfare of people receiving DDA-funded services by formalizing a process to identify, report, investigate, and resolve incidents in a timely manner.

BB. "Positive Behavior Support" (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment.

Positive behavior support combines: valued outcomes, behavioral and biomedical science, validated procedures, and systems change.

CC. "Relative" is a natural or adoptive parent, step-parent, child, step-child, or sibling of an applicant or participant who is not also a legally responsible person.

DD. "Restrictive technique" is a technique that is implemented to impede an individual's physical mobility or limit free access to the environment, including but not limited to physical, mechanical, or chemical restraints or medications used to modify behavior.

EE. "Seclusion" means involuntarily isolating an individual as a means of controlling the person's behavior.

FF. Service Implementation Plan " or "SIP "means the DDA required form used to document the DDA provider's or direct support professionals' service delivery implementation strategy for the requested services to support the participant's chosen outcome. Service Implementation Plans must include specific strategies for goal implementation that are specific, measurable, achievable, relevant to the participant's identified outcomes, and have clear proposed timelines for achievement.

GG. "Team" means a collaborative effort to support a person receiving DDA services to develop and implement their individual PCP that outlines their needs, goals, and desired outcomes to achieve their personally defined good life. This collaboration is driven by the person, coordinated by their CCS, and enhanced by important people chosen by the person such as family members, significant others, providers, support brokers, friends, colleagues and others.

HH. "Transition Coordination Services" are targeted case management services to people transitioning to the community from an institution.

II. "Waiver Program Service" is a service funded by a DDA Medicaid Waiver program.

JJ. "Waiting List Coordination Services"are targeted case management services for people found eligible for services and are placed in either the crisis resolution, crisis prevention, or current request priority category, as set forth in COMAR 10.22.12.07B.

Overview

To ensure people who are eligible for DDA are living a full life based on their needs and preferences, Coordinators of Community Service (CCS) are responsible for monitoring the implementation of a person's PCP for quality service delivery, and identifying and helping to mitigate risks related to a person's health and welfare.

In accordance with COMAR 10.09.48.06F monitoring and related follow-up activities include:

- Satisfaction of services
- Progress towards identified goals
- Health and safety
- Change in need

Monitoring and follow up can also occur outside of the minimally required frequency depending on the person's needs. A CCS is expected to engage in monitoring and related follow up based on the following criteria as applicable:

- Change in living arrangement
- Change in jobs
- Change in provider
- Recent abuse or neglect allegations or other incidents outlined in PORII
- Changes in medical or behavior status
- Non–compliant CSQ
- Services "flagged" for review by the person in MyLTSS or any ISAS inquiries on service deliveries
- Supports needed in applying/reapplying that prevent gaps in eligibility
- When a person is enrolled in the waiver and no services are being provided

A CCS is responsible for documenting any monitoring and related follow up, as outlined above, in the LTSS*Maryland*-Module using the manual Monitoring and Follow up form. The LTSSMaryland-Module system generated forms should be completed for in person visits and address all of the monitoring and follow-up activity requirements.

Applicability

Monitoring and Follow-up is required to be provided to people who receive any CCS Service Type which includes:

- Waiting List Coordination
- Community Coordination or;

- Transition Coordination

The frequency of monitoring visits depends on which CCS service type a person receives, a person's needs, and the required follow up as outlined below. **Please remember all monitoring required by frequency, is to be completed face-to-face with the person. It is not to be completed virtually or via the telephone.** Additional monitoring based on need as outlined in the overview section, can be virtual or telephonic depending on the situation as assessed by the CCS and their supervisor.

CCS Service Type	Monitoring Frequency	Monitoring Activities	Monitoring Due Date
Waiting List Coordination *"Crisis Resolution"*	Monthly (for the first 90 days) then quarterly	• Health and Safety • Change in need	Based on the date the Priority Category Assessment (PCA) was finalized
Waiting List Coordination *"Crisis Prevention"*	Quarterly	• Health and Safety • Change in need	Based on the date the PCA was finalized
Waiting List Coordination *"Current Request"*	Annually	• Health and Safety • Change in need	Based on the date the PCA was finalized

Community Coordination	Quarterly	• Satisfaction of services • Progress towards identified goals • Health and Safety • Change in need	Based on the Annual Plan Date (APD) *Note: The CCS should visit the person in the setting of the service; and, for each quarterly visit, a different service setting
Transitioning Coordination	Monthly (for the first 90 days) then quarterly	• Satisfaction of services • Progress towards identified goals • Health and Safety • Change in need	Based on the date the CCS Agency was assigned. *Note: When receiving services, the CCS should visit the person in the setting of the service; and, for each quarterly visit, a different service setting *Transitioning Coordination also

			includes participants living in a State operated facility or living in a nursing home who do not have a long term Preadmission Screening and Resident Review (PASRR) and have plans to move back into the community(i.e. Holly Center, Potomac, SETT, or BHA).

Monitoring is an opportunity to be curious and ask questions to the person, their family, and provider. It's an opportunity to take a deeper dive on the needs and wants of the person to ensure their goals are being achieved and that they are healthy and safe. It’s a moment in time to paint a picture or tell a story of where a person is at in their trajectory of their defined good life.

While monitoring is a requirement, it is also a critical tool a CCS must have in order to be able to advocate, to help a person achieve their hopes and dreams, and to ensure accountability. The role of a CCS, as it pertains to monitoring, is one of the most important. Monitoring and follow up drives much of the other work you complete on a day to day basis whether that be assessment of need, PCP development, or resource coordination.

Below is an outline of considerations to make when monitoring, and applicable confirmation sources to review. **Please note this is not an exhaustive outline**. A CCS must always use their **professional judgment** and knowledge of each individual person on their caseload to ensure the best questions are being asked and the most supportive confirmation sources are being reviewed.

Monitoring: Waiting List Coordination

When a person is receiving Waiting List Coordination Services, the CCS should aim to understand if the person is healthy, safe and what their current and projected support needs are. The CCS can utilize the Services and Supports Planning Tool and Charting the LifeCourse Tools to aid the person and their family in identifying their goals and aspirations, to understand what they want and do not want in their life, and what works and what does not work for them. With this information, the CCS can make recommendations such as:

- Advocacy and peer support groups
- Other state services and benefits
- Local community resources
- Opportunities for community engagement

If there are conditions in which the health, safety, and wellbeing of someone becomes of concern, in accordance with COMAR 10.22.12.07(B)(1)(2), the CCS will request a new Priority Category. The CCS should also recommend other community/government options for immediate support to the person and their family. If there is a crisis that requires emergency services, per COMAR 10.22.12.11(B), the CCS must notify the affiliated DDA Regional

Office and complete an Emergency Situation Form in the LTSSMaryland-Module. The CCS is required to immediately support the person by explaining and supporting them through these next steps.

Is the person healthy and safe?

Considerations	Applicable confirmation sources
• Is the person homeless or at risk of being homeless? • Does the person appear healthy and safe? Observe their physical appearance, bruises, lesions, weight, hygiene, etc. • Is the person at serious risk of harm in their current environment? • Is the person at risk of harming themselves or others in the current environment? • Is the person at risk of not receiving care from the primary caregiver due to caregiver impaired health? • Is the person able to communicate and/or would they be able to communicate if something else was in place like technology? • Have they visited their doctor or specialist more than they	• The person • The person's team: relatives, involved support planners, school system • CCS activity/progress notes • Environmental observations

usually do? Have they seen an increase in medical care? • Has the person had a change in their mental health? • Has the person had recent legal involvement? • Have there been any arrests? • Has the person missed multiple days of school or work? • Do they appear sad and withdrawn? Are they expressing that they are unhappy? • Is the person's home and environment accessible? • Is the home accessible? • Is the person accessing their community? • Does the person need support in identifying community resources? • Have there been any successes made by the family?	

Monitoring: Community & Transition Coordination

CCS will continue to ensure the people they support are healthy and safe. When a person is actively receiving DDA services or is transitioning into the community, the CCS monitoring responsibility evolves.

CCS will also inquire about progress towards the person's identified needs and goals and whether additional support is needed to achieve those. Similarly, CCS will learn more about whether or not the person on their caseload is happy with the support they are receiving.

After discussing with the person and reviewing other confirmation sources, the CCS will help the person identify and discuss any available resources, next steps, or mitigation strategies.

Is the person healthy and safe?

Considerations	Applicable confirmation sources
• Does the person appear healthy and safe? Observe their physical appearance, bruises, lesions, weight, hygiene, etc. • Is the person at serious risk of harm in their current environment? • Is the person at risk of harming themselves or others in the current environment? • Is the person at risk of not receiving care from the primary caregiver due to caregiver impaired health?	• The person • The person's team including their family • CCS activity/progress notes • Environmental Observations • Incident Reports and applicable Corrective Action Plan • The PCP: o Risks/Restrictions o FAE: Health and safety

• Have they gone into the hospital multiple times? • Have they visited their doctor or specialist more than they usually do? Have they seen an increase in medical care? • Are they taking any new medications? Which? • Has the person had recent legal involvement? • Have there been any arrests? • Have they missed multiple days of school or work? • Do they appear sad and withdrawn? Are they expressing that they are unhappy? • Is the person's home and environment accessible? • Is the person accessing their community? • Is the person's technology/equipment working to maintain as it pertains to their health and welfare? • Is their environment safe? • Are there pests? • Have they had access to recommended mental health	o Important to me and important for me o Service Authorization o Outcomes • Nursing Care Plan (NSP) • Behavioral Plan • The Community Settings Questionnaire (CSQ) when applicable • Rights and Responsibilities Form • Emergency Back-Up Plan

and medical services/professionals? • Are the mitigations in place to address any health and safety risks utilized? • What types of incidents have been reported since the previous follow up? How many? Are there new restrictions in place because of them? Has corrective action been implemented? • Have any unauthorized restrictions occurred or are any unauthorized restraints in place? • Have their rights and responsibilities been reviewed? • Does the emergency plan need to be updated? • Are the current services helping them? • Does the person need support in identifying community resources? • Have there been any successes made by the family?	

Is the person receiving services as described in their PCP and are they satisfied? Is there progress towards their identified goals?

Considerations	Applicable confirmation sources

• How many days of services were missed? What were the reasons??
• Are they acquiring any new skill/s that would help them meet their goals? What skills?
• Are staff delivering services in accordance with the SIP?
• Are staff trained on the PCP?
• Do staff know how to use any necessary equipment as noted in the PCP?
• Are the person's devices working?
• What has community integration looked like?
• Does the person express they want new staff/providers?
• What is working for the person? What is not working for the person?
• Are there any barriers in achieving their goals? What are those barriers?
• Have they had any opportunities for employment and/or meaningful opportunities in their
	• The person
	• The person's team:relatives, involved support planners, providers, staff
	• Service Observation
	• EVV Services Rendered Report when applicable
	• CCS activity/progress notes
	• Person Centered Plan
	  o Outcomes
	  o Important To/For Me
	  o Service Implementation plan
	• Provider's Staff Training Log
	• The Community Settings Questionnaire (CSQ) when applicable
	• Providers Daily Activity Log
	• Charting the LifeCourse Tool: Goal Attainment: Planning and Tracking Success
	• FMCS Web Portal for Electronic Billing

community? Have they been successful? • Do you see the environmental modifications made as they were requested? • Does the person have more friends? • Does the person talk about new and exciting activities?	

Is there a change in need?

Considerations	Applicable confirmation sources
• Any support needs to maintain eligibility for Medicaid, Medicaid waiver programs, DDA services, and any other relevant benefits or services? • Do they still want to work towards the same goal(s)? • Does the person bring up new topics of interest? • Have there been any recent life changing events such as:moving to a new home/residence, medical changes, a close relative getting married, family related death, the person was proposed to or wants to	• **Comprehensively review all considerations*** • The person • The person's team:relatives, involved support planners, providers, staff • Service Observation • EVV Services Rendered Report when applicable • CCS activity/progress notes • Person Centered Plan o Outcomes o Important To/For Me

propose, the person is pregnant, etc. • Do they like their job? • Are there any changes in their community such as: limited public transportation, public health emergency declared, increased weather conditions, etc. • Are they aware of new opportunities in their neighborhood? • Are there any new resource options to recommend to the person that could elicit new interest? • Have there been any successes made by the family?	o Service Implementation plan • Provider's Staff Training Log • The Community Settings Questionnaire (CSQ) when applicable • Providers Daily Activity Log • Charting the LifeCourse Tool: Goal Attainment: Planning and Tracking Success • Letters from the Eligibility Determination Department (EDD) • Level of Care Due Date • Redetermination Date • Emergency Back-Up plan

DDA Support

DDA's CCS Support Squad will review and provide Monitoring and Follow-up data to ensure compliance, in accordance with COMAR 10.09.48.06, on at least a bi-monthly basis with their assigned CCS Agency's Leadership team. CCS Staff will include information specifically regarding the Monitoring and Follow-up forms due within the next 90, 60, 30 days and Monitoring and Follow-up forms that had not been completed in the previous 30 days. This

information is pulled from the LTSS*Maryland*-Module using the "CCS Monitoring Form Report".

The DDA Regional CCS Support Staff review data reports with their assigned CCS Agencies to identify trends and provide technical assistance when there are CCS barriers in monitoring. Technical assistance can include: providing and summarizing applicable DDA policy/guidance, troubleshooting the LTSS*Maryland*-Module, brainstorming and providing more hands-on support when there are unusual circumstances, and more.

As the DDA Regional CCS Support Staff and CCS Agency's proactively collaborate, they track any barriers in monitoring for trend analysis. DDA's CCS Director and Regional Office Directors will review statewide barrier trends with CCS Agency Leadership Teams to collaborate on strategies for resolution and prevention in order to continue to enhance our monitoring system within the state.

Liberty Healthcare Corporation has been contracted by DDA to conduct Targeted Case Management (TCM) reviews to evaluate compliance with DDA standards. To find more information on how the CCS' Monitoring and Follow-up forms are reviewed to verify timely submissions and completed to include person specific details, refer to the Quarterly Targeted Case Management Reviews Standard Operating Procedure Guidance.

References

A. **RELEVANT RESOURCES:**

1. Billable Activities 2022
2. Case Note Documentation Training Module
3. Coordination of Community Services: Community Settings Questionnaire Manual

4. CCS and ISAS Partnership Reminders
5. Coordinator of Community Services (CCS) Reference Guide to I Home Supports Assurance System (ISAS) Policies , Billing Processes, and System Navigation
6. Charting the LifeCourse
7. DDA CCS Coordinator User Manual (LTSS)
8. DDA Person Centered Planning Webpage
9. Facilitating the Community Settings Rule Conversation" June 1, 2023
10. Policy on Reportable Incidents and Investigations (PORII)
11. Supports and Services Planning (SSP) Tool*(video)*
12. SSP Tool Form
13. Quarterly Targeted Case Management Reviews Standard Operating Procedure Guidance

B. **LEGAL REFERENCES**

1. Md. Code, Health Gen. Art §7–1006.
2. Code of Federal Regs: 42 CFR 441.725(b)(12)

C. **REFERENCE MATERIALS**

1. COMAR
    a. 10.22.09.04(E)
    b. 10.22.09.05(A)(B)(C)(D)
    c. 10.22.09.06(A)
    d. 10.22.12.07
    e. 10.22.12.11(B)

f. 10.09.48.04(D)(6)(c)

g. 10.09.48.05(C)(3)(h)

h. 10.09.48.06(F)(1)(2)(3)

i. 10.09.26.04(A)(B)(C)(D)(E)(F)(G)

2. DDA CP Waiver, January 2021

   a. Appendix B: Participant Access and Eligibility B-6: Evaluation/Reevaluation of Level of Care, Page 62-63

   b. Appendix D: Participant-Centered Planning and Service Delivery D:1: Service Plan Development, Page 309

   c. Appendix D: Participant-Centered Planning and Service Delivery D-2: Service Plan Implementation and Monitoring, Page 313

3. DDA CP Waiver, Effective July 1, 2023

   a. Appendix B: Participant Access and Eligibility
      B-6 (a)(ii): Evaluation/Reevaluation of Level of Care, Page 60-61
   b. Appendix D: Participant-Centered Planning and Service Delivery D:1: Service Plan Development, Page 277
   c. Appendix D: Participant-Centered Planning and Service Delivery D-2: Service Plan Implementation and Monitoring, Page 280