Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: SUPPORTED LIVING CRITICAL CASE PROTOCOL POLICY 4.24

Authority:	Title 71A RCW	*Developmental Disabilities*
	Chapter 388-101D WAC	*Requirements for Providers of Residential Supports*
	Chapter 388-101 WAC	*Certified Community Residential Services and Supports*
Reference:	DDA Policy 3.01	*Service Plans*
	DDA Policy 4.02	*Community Residential Services: Referral, Acceptance and Change of Residential Provider*
	DDA Policy 5.06	*Client Rights*
	DDA Policy 5.14	*Positive Behavior Support Principles*
	DDA Policy 5.18	*Cross System Crisis Plans*
	DDA Policy 5.21	*Functional Assessments and Positive Behavior Support Plans*
	DDA Policy 12.01	*Incident Reporting and Management for DDA Employees*
	DSHS Administrative Policy 18.64	*Standards of Ethical Conduct for Employees*

PURPOSE

This policy establishes procedures for identifying clients at risk of disruption of services in supported living programs and engaging in a person-centered planning process to prevent avoidable disruptions by implementing a Client Critical Case Protocol (CCCP).

INTENT

The intent of the CCCP is to ensure supported living clients' Person Centered Service Plans are implemented to meet their residential support needs and prevent the risk of unnecessary institutionalization or hospitalization. The CCCP will include, as needed, a redetermination by DDA of a client's eligibility for residential habilitation services, a redetermination of a client's residential service level, and amendments to the PCSP and Individual Instruction and Support Plan (IISP) that are feasible and necessary to avoid a disruption in service. The CCCP requires SL providers to make reasonable efforts to implement changes to the PCSP.

SCOPE

This policy applies to DDA Field Services, Central Office staff, and DDA-contracted SL providers.

DEFINITIONS

Critical case means any case in which a supported living client is at risk of losing their supported living services.

Extended support team includes any individuals who provide professional or unpaid supports to the client, and may include but would not be limited to, family members, friends, guardians, payees, clinical professionals, employment supports, self-advocacy peers, or community/faith-based members whom the client/legal representative authorizes to participate in care planning. Clients or legal representatives must authorize members of the extended support team to participate in the CCCP and receive information about their case.

Habilitative support plans is a general term for plans that supported living providers are responsible for implementing, including Person Centered Service Plans (PCSP), Individual Instruction and Support Plans (IISP), Individual Financial Plans, and as applicable, Psychoactive Medication Treatment Plans, and Positive Behavior Support Plans (PBSP).

Person-centered service plan is a document that identifies a client's goals and assessed health and welfare needs. A person-centered service plan also indicates the paid services and natural supports that will assist a client to achieve goals and address assessed needs.

Suspension of services means when a provider gives emergency notice to temporarily suspend direct support services assigned under the supported living contract.

POLICY

Supported living providers are required to engage in the CCCP prior to giving notice of intent to terminate services to the client. When the provider provides documentation demonstrating that ongoing services could endanger the health or welfare of the client, staff, or others, the provider must still engage in the CCCP prior to giving notice of intent to terminate services to the client which will result in DDA removing the client from the provider's contract. This does not prevent providers from accessing any necessary emergency medical or behavioral health services, including taking the client to the hospital or other appropriate services.

In certain situations, the provider may be able to provide notice of emergency suspension of services.

During the course of the CCCP DDA may redetermine a client's eligibility for services including those available through Home and Community Based Services waivers per WAC 388-845-3085.

A. Critical case identification:

1. The request for the CCCP may be initiated by the Supported Living (SL) provider, client/legal representative, or DDA when:

   a. A client's Habilitative Support Plans cannot be fully implemented;
   b. A client is at risk of losing their home;
   c. A client is at risk of losing their residential provider;
   d. A client is hospitalized without a discharge plan; or
   e. There is other indication of a critical case.

2. A client's case manager must initiate the CCCP if the case manager learns of any concerns that the client is at risk of losing residential supports with current SL provider, including, but not limited to, the following circumstances:

   a. The client needs additional support in maintaining positive behaviors toward themselves or others in order to maintain safety;

   b. The client needs additional physical, behavioral, or medical health support;

   c. The client or client's legal representative voices concern about exercise of client rights that puts residential services at risk;

   d. The client or client's legal representative requests diversion services;

   e. The client or client's legal representative and SL provider continue to disagree about the quality, manner, type, or amount of services being delivered;

   f. Client is experiencing problems such as:

      i. Frequent crisis contacts for possible mental health detention;

      ii. Pending eviction from their home without an identified housing option;

      iii. Frequent and negative interactions with community members;

      iv. Frequent use of emergency services;

      v. Dangerous or unhealthy condition of their home environment;

      vi. A disagreement with their provider regarding which supports or services are vital to their residential support needs;

vii. An inability to access desired services vital to their residential support needs;

viii. Ongoing struggles with substance abuse;

ix. Persistent contact or risk of contact with law enforcement.

Note: the request may be escalated by the provider or client to the supervisor or FSA

PROCEDURES

A. If a provider is struggling to support a client:

1. The provider must work with the client, and the client's extended support team, at the client's request to resolve the issue; and

2. *If the issue remains unresolved, the provider* must submit a written request for consultation, including possible CCCP, to the client's DDA case manager to explore potential solutions. The case manager must respond to the providers request as soon as possible and no later than five working days.

B. If a case manager and the case manager's supervisor identify a critical case:

1. The client's case manager must:

a. Notify Resource Manager Administrator and the Field Services Administrator the same day the client's situation is identified as a critical case;

b. Act as the point person and main contact on the case;

c. Contact the client and the client's legal representative to ask what support is needed to meet the client's needs;

d. Evaluate the case to determine whether a significant change assessment is needed to reflect the client's current support needs;

e. Facilitate contact with the Managed Care Organization (MCO) and/or Behavioral Health Administrative Service Organization (BH-ASO) when support is needed with medical or behavioral health concerns;

f. Convene the Critical Case Protocol team meeting to identify gaps or barriers and develop solutions and action steps in accordance with Section D. below;

g. Consult with specialists, the regional clinical team, quality assurance manager, or other subject area experts as needed;

h. Consider client's goals—both short-term and long-term; and

i. Create a referral packet following process in DDA Policy 4.02, *Community Residential Services: Referral, Acceptance, and Change of Residential Provider* if necessary.

2. Upon initiation of CCCP, Resource management must:

a. Contact the current provider within three business days to discuss what additional support may be needed to meet the client's needs and continue services;

b. Ask the provider what support they may need to meet the client's needs;

c. Discuss the concerns leading to the initiation of the CCCP with the provider;

d. Conduct home visits as needed to review the client's plans and assess the current situation;

e. Coordinate with the case manager to gather information about the client's perspective, preferences, and concerns;

f. Review and offer additional resources (technical assistance and consultation, rate assessment, staff add-on, etc.), as appropriate; and

g. If necessary, initiate referral process per DDA Policy 4.02, *Community Residential Services: Referral, Acceptance, and Change of Residential Provider*.

C. Critical case conference

1. The case manager, appropriate DDA field staff, the supported living provider, and a representative from DDA central office must conduct a critical case conference with the client and any active members of the client's extended support team to engage in Person Centered Planning to identify what support is needed to meet the client's needs, and take any additional steps the group determines are reasonable and necessary. The initial meeting should occur within 10 business days. Person- centered planning should enable the client to make informed choices and decisions about the services and supports they receive and from whom, and otherwise comply with the elements set out in 42 C.F.R. § 441.301(c).

2. The critical case conference team may include other partner entities to assist in addressing any barriers to services. The client should be supported to engage in the conference to the maximum extent possible.

3. The critical case conference should identify remedies, which may include but is not limited to, additional services from partner entities, updates to the client's habilitative support plans, and/or exceptions to rule or policy as appropriate.

4. If a plan has been established to implement remedies, the Case Manager or other designee must schedule follow up meetings with identified members of the conference team to monitor implementation of identified remedies and determine whether additional remedies are necessary to prevent service disruption.

5. The case manager should update the client's CARE assessment and the Person Centered Service Plan (PCSP) if the critical case conference identifies a change in client need.

6. The Resource Manager will update the rate assessment if necessary to adequately reimburse the agency. The effective date of change will be the date the rate assessment is completed.

7. The SL provider must update the client's Individual Instruction and Support Plan (IISP) if there are any agreed changes to the PCSP.

8. If the client and their legal representative are unable to participate within the agreed upon time frames, the CM must reach out to the client to see how this can be accommodated and document this in a SER. The initial meeting will proceed within the time frames of this policy, and follow up meetings may be scheduled as needed.

D. Suspension of Services

1. The SL provider may give emergency notice of temporarily suspending services when a client's needs cannot be safely met in their home and while both of the following conditions are present:

   a. The actions or continued presence of the client endangers the health or safety of the client, other clients, those working with the client, or members of the public, and

   b. The client is in a hospital, jail, health care facility, or a setting to address the client's need.

2. The SL provider must give written notice to client, the client's legal representative, and the DDA Regional Administrator before suspending services.

3. The notice must specify the reasons for suspending services to the client.

4. The provider will remain engaged in the CCCP to the extent necessary to either transition the client back to the provider's contract/services in full (removed from suspension), into another service, or to another SL provider or give termination notice.

5. The suspension status must be addressed at the CCCP meeting.

6. The provider will inform the client and the department if the status of the suspension changes.

E. Transitioning

1. The SL provider may not initiate termination of supported living services until they have engaged in the CCCP and provided documentation that they have made reasonable efforts to implement additional supports/resources identified during the critical case conference and can demonstrate that these changes did not sufficiently resolve the barriers for the agency to meet the client's residential support needs. The notice of termination must include documentation of specific facts demonstrating required grounds for termination.

2. Under no circumstances may a provider threaten or give notice of termination in retaliation for reporting complaints or otherwise asserting client rights.

3. When a client receives notice of termination or notifies the case manager that they wish to find a new SL provider, the case manager must begin to develop a transition plan with the client and their legal representative per RCW 71A.26.030 that includes:

   a. The referral process to choose a different provider;

   b. Any bridge services necessary to maintain client health and safety if a new provider is not immediately available;

   c. The location of the new residence;

   d. The mode of transportation to the new location;

   e. The name, address, and telephone number of the DD Ombuds; and

   f. Keeping the client and current provider informed of the progress of the transition plan.

4. The SL provider terminating services must participate in a planning meeting with the client and DDA to assist with transition to new provider, if requested by DDA, the client, or new provider.

F. Documentation

1. The case manager must:

a. Indicate "Critical Case Protocol" as the purpose code in a service episode record (SER); and

b. Enter the client's information into the critical case database.

c. An outcome summary must be written for the CCCP conference, and distributed to participants for review and correction.

d. The outcome summary must be entered in a SER.

2. A SER must be entered for all CCCP staffing, telephone calls, meetings, emails and other related activity.

3. Whenever possible, updates should be recorded in a SER.

4. One person who attended the case staffing may be designated to enter the SER and update databases as appropriate.

G. Effect of Critical Case Protocol on Other Case Management Duties

CCCP occurs concurrently with regular case management activity. Case managers must complete all standard case management activities, including all necessary reporting requirements outlined in policy and procedures.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

None.

Approved: _____ Date: March 1, 2021

Director, Division of Field Services
Developmental Disabilities Administration