

**1915(c) HOME AND COMMUNITY
BASED SERVICES (HCBS)
MEDICAID WAIVER FOR
INDIVIDUALS WITH INTELLECTUAL
AND DEVELOPMENTAL DISABILITIES**

**WAIVER
PROVIDER
STANDARDS
MANUAL
Version A**

**Use Standards A until the participant's ISP
between July 1, 2017 and June 30, 2018.**

**State of Hawai'i
Department of Health
Developmental Disabilities Division
Effective October 1, 2017**

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SECTION 4: APPENDICES & RESOURCES

Located in separate document

NAVIGATING THE DOCUMENT:

The Waiver Standards are organized into four main sections:

1. General Requirements and Information
2. Waiver Agency Provider General Requirements and Standards
3. Service-Specific Performance Standards
4. Appendices & Resources

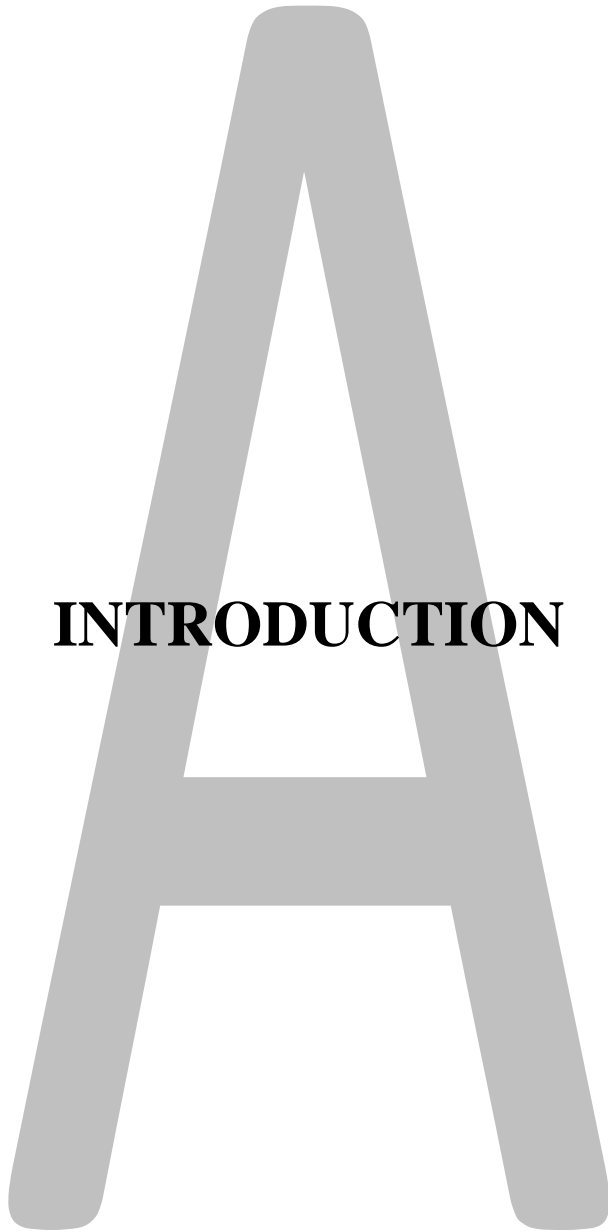
The word “*participant*” is used throughout the Waiver Standards to describe an individual who is enrolled and participating in the Medicaid I/DD Waiver. Throughout the document, the waiver is referred to as the “Medicaid I/DD Waiver.”

Definitions used in the Medicaid I/DD Waiver Standards Manual are found in Appendix 1.

Acronyms and abbreviations used throughout the Waiver Standards Manual are found in Appendix 2.

The Medicaid I/DD Waiver Standards Manual will be reviewed at regular intervals and updated if needed. Updated versions will be numbered and dated in the lower left corner of the document. Changes in the Standards document will be highlighted and dated. When a new version is completed, it will be posted on the DDD website at <http://health.hawaii.gov/ddd/>

The Waiver Standards Manual Version A includes current services that the participant may receive until their Individualized Service Plan (ISP) meeting is held during Year 1 of the phase-in (July 1, 2017 through June 30, 2018). Waiver Standards Manual Version B will include services available to participants as they transition to new services, fee schedules and billing codes based on their date of ISP and their cohort group. At the end of fiscal year 2018, Standards Manual Version A will be sunset and Standards Manual Version B will be used for the Medicaid I/DD Waiver.



The Hawai'i Department of Health (DOH), Developmental Disabilities Division (DDD) administers a statewide system of services and supports so individuals with intellectual and developmental disabilities (I/DD) in Hawai'i can maximize their opportunities to have full lives in their communities. The purpose of these Waiver Standards is to provide clear and consistent guidance about the intent and approach of services, and the way they are to be provided. The Standards apply to all services provided through the Medicaid 1915(c) Home and Community Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities.

The Medicaid Waiver I/DD Standards Manual was written to include information about the Medicaid I/DD Waiver for participants, families, DDD Case Managers, Providers and stakeholders. Changes from the previous standards reflect input and feedback from stakeholders to include information that all stakeholders can use that is easy to read and navigate.

Your feedback is important. If you have comments, questions or suggestions about the Waiver Standards Manual, please send an email to doh.dddcrb@doh.hawaii.gov.

A. DOH-DDD Mission/Vision/Guiding Principles

Mission:

Foster partnerships and provide quality person-centered and family-focused services and supports that promote self-determination.

Vision:

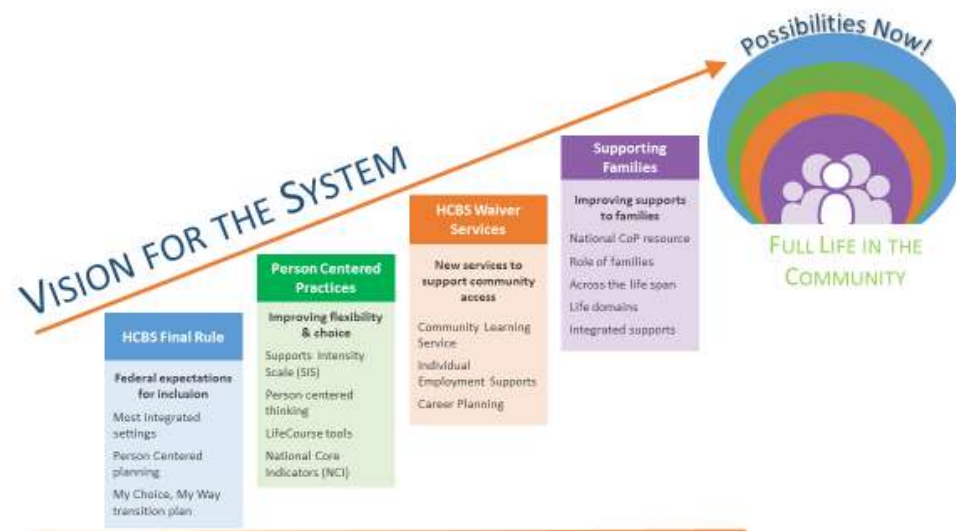
Individuals with intellectual and developmental disabilities will have healthy, safe, meaningful and self-determined lives.

Guiding Principles:

Individuals:

1. are treated with respect and dignity,
2. make their own choices,
3. participate fully in the community,
4. have opportunities to realize their goals including economic self-sufficiency,
5. achieve positive outcomes through individualized services and natural supports, and
6. are empowered to live self-determined lives.

B. Possibilities Now! - Person-Centered/Family-Centered Practices



DOH-DDD’s approach is to support a trajectory for each participant toward an inclusive, quality life in the community. This involves partnerships with participants, their families and their communities. Supporting the possibilities for each person across the lifespan will include relationship-based supports, technology, community resources, and eligibility-specific supports such as services through the Medicaid I/DD Waiver. It also emphasizes the skills, strengths, and life experiences of the individual and family when it comes to planning and carrying out their vision of a good life. DOH-DDD calls its overall

initiative to provide supports that help participants have the life they want throughout the course of their lives: Possibilities Now!

Supporting families of participants is a key aspect of achieving each person's vision of a good life in the community. The overall goal of supporting families, with all of their complexities, strengths and unique abilities, is so they can best support, nurture, love and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion of their family members in all facets of community life (*Administration on Intellectual and Developmental Disabilities (AIDD) National Agenda on Family Support Conference*, 2011).

DOH-DDD uses person- and family-centered practices across all aspects of planning and service delivery. Person- and family-centered practices include thinking and acting in ways that see people using services as equal partners in planning, developing and monitoring care to make sure services and supports meet their needs. This means putting people and their families at the center of decisions, and seeing them as experts working alongside professionals to get the best outcomes.

The person-centered Individualized Service Plan (ISP) must be developed through a person-centered planning process as described in Section 1.5. The Individualized Service Plan (ISP) is the written agreement between the waiver participant, circle of supports, Providers and DOH-DDD.

C. Community Integration and the HCBS Final Rule

CMS issued a final rule (79 FR 2947) addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. The HCBS final rule on community integration:

- supports enhanced quality in HCBS waivers,
- adds protections for individuals receiving services,
- defines person-centered planning requirements,
- defines and describes the requirements for HCBS settings appropriate for the provision of HCBS under section 1915(c) waivers, and
- creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics.

The HCBS final rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS waivers have full access to the benefits of community living and are able to receive services in the most integrated setting. Since Hawai'i's Medicaid I/DD Waiver operates under the authority of section 1915(c) of the Social Security Act, all waiver services must align with the HCBS final rule. CMS has granted states an extension until March,

2022 to reach full compliance. Each state specifies its timelines to reach the milestones toward full compliance in the CMS-approved transition plan. Hawai'i's state transition plan is called *My Choice My Way*. Information for *My Choice My Way* is located at <http://www.med-quest.us/>.

For Medicaid I/DD Waiver Providers, the transition period until March 2022 applies only for current Medicaid I/DD Waiver Providers that were in operation and providing the HCBS service(s) prior to the waiver renewal effective July 1, 2016. Any Providers that are not in full compliance as determined by the *My Choice My Way* validation, must develop and implement remediation plans to achieve full compliance with the HCBS final rule requirements and maintain compliance on an ongoing basis per timelines specified in the *My Choice My Way* transition plan.

The transition period is not available for a new Provider applicant or an existing Provider seeking to add a new service or a new location (setting). Any new Provider or service or setting approved after July 1, 2016 must be fully compliant with the HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings prior to the approval and delivery of a waiver service.

For more detail, please refer to the CMS website at: <https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>.

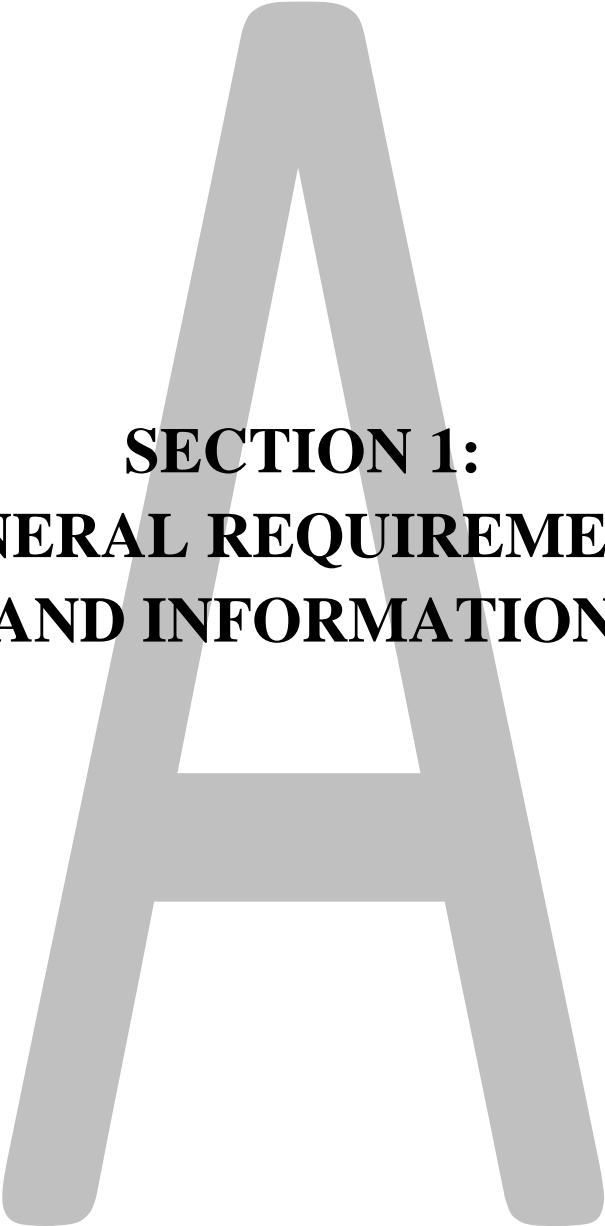
D. Individual Rights and Protections

Waiver services must be delivered to participants in accordance with the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Public Law 106–402) that ensures participants “*live free of abuse, neglect, financial and sexual exploitation, and violations of their legal and human rights.*” Providers must afford the rights and protections specified in Section 1.6 in any setting where waiver services are delivered.

E. Freedom of Choice

Participants are informed and supported to exercise their freedom of choice in selecting:

1. between institutional or home and community based waiver services,
2. among services and supports from the array based on the Individualized Service Plan (ISP), and
3. their providers.



**SECTION 1:
GENERAL REQUIREMENTS
AND INFORMATION**

1.1 WAIVER OVERVIEW

A. Medicaid I/DD Waiver Purpose and Objectives

Medicaid waivers provide home and community-based services in communities where people live rather than in institutions. Medicaid Home and Community-Based Services (HCBS) Waivers are authorized in §1915(c) of the Social Security Act. This federal law permits a state to furnish an array of home and community-based services that help Medicaid beneficiaries live in the community and avoid institutionalization. The states have broad discretion to design their waivers to address the needs of the waiver's target population.

Waiver services complement and supplement services available to participants through the Medicaid State Plan and other federal, state, and local public programs, as well as the supports that families and communities provide.

Hawai'i's Medicaid I/DD Waiver (authorized under Section 1915(c)) enables individuals with intellectual and developmental disabilities (IDD) who meet institutional level of care the choice to live in their homes and communities with appropriate quality supports designed to promote health, community integration, safety and independence.

The goals of the Medicaid I/DD Waiver are:

1. to provide necessary supports to participants in the waiver to have full lives in their communities and to maximize independence, autonomy and self-advocacy; and
2. to evaluate and continuously improve the quality of services to participants, including measuring the satisfaction of the benefits and services the participants receive, to improve them.

The Medicaid I/DD Waiver uses federal Medicaid funds plus State matching funds for HCBS as an alternative to institutional services, provided that the overall cost of supporting individuals in their homes and communities is no more than the institutional cost for supporting that same group of individuals. This is called "cost neutrality."

The Medicaid I/DD Waiver also requires that the State meet assurances required in the law. Hawai'i must report to CMS annually its performance measures to demonstrate compliance with the federally-mandated assurances.

The federal Centers for Medicare and Medicaid Services (CMS) recently approved the State's request to amend the Medicaid IDD Waiver. These new changes are part of the phase-in of new services that begins during fiscal year

2018. Waiver Standards Manual Version A reflects services before the phase-in to new services with the approved amendment. Waiver Standards Manual Version B reflects the new services and other changes with the phase-in.

B. Eligibility for Waiver Services

Individuals interested in applying for Hawai‘i’s Medicaid I/DD Waiver must first be determined eligible for DOH-DDD services (STEP 1). Only after that determination of eligibility is made, the individual may apply for admission to the waiver by completing STEP 2 and STEP 3.

STEP 1: Meets DOH-DDD eligibility requirements. Once eligible, the individual will receive DDD services such as case management.

STEP 2: Meets DHS-MQD Level of Care eligibility criteria; and

STEP 3: Meets DHS-MQD Medicaid and/or Long Term Care (LTC) eligibility criteria. If determined to meet STEP 2 and STEP 3, the individual may be admitted to the waiver.

The application process is described in Section 1.3: Application for Waiver Services.

Waiver Eligibility and Admission Process Flow Chart



C. Definition of Developmental Disability and Intellectual Disability

Hawai‘i has defined Developmental Disability and Intellectual Disability in Chapter 333F, Hawai‘i Revised Statutes (HRS).

1. “Developmental Disabilities” means a severe, chronic disability of a person which:

- a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- b. Is manifested before the person attains age twenty-two;
- c. Is likely to continue indefinitely;
- d. 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, and economic sufficiency; and
- e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

An individual from birth to age nine 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 above, if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. "Intellectual Disability" means significantly sub average general intellectual functioning resulting in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period.

D. Coordination with Medicaid State Plan Services through QUEST Integration

DDD will coordinate services with QUEST Integration health plans for participants needing supports to transition.

E. Access and Availability

Waiver participants must have access to all Medicaid I/DD Waiver services, regardless of where the participant lives. Providers must ensure the following:

1. The Providers must have capacity to serve the geographic area for every service proposed in its Waiver Provider application;
2. If the Provider no longer has the capacity to serve an area and/or island or provide a particular waiver service, even though it may still be providing services elsewhere, the Provider must immediately notify DOH-DDD in writing, at a minimum of 30 calendar days in advance of the requested

change. The written notification must include the reason for the request and information detailing coordination efforts with the Case Manager to transition participants who are currently receiving services to a new Provider.

- a. DOH-DDD may request additional time beyond the 30 calendar days to allow for smooth transition for participants to locate other Providers.
- b. DOH-DDD will update the master waiver service list as appropriate.

1.2 ROLES AND RESPONSIBILITIES

A. Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services, is the federal agency that administers the Medicare and Medicaid programs that provide health care to the aged and indigent populations. The Social Security Act §1915(c) enables states to provide HCBS through a waiver to a target group, such as individuals with intellectual and developmental disabilities.

CMS reviews all waiver requests, applications, renewals, amendments, and financial reports. Additionally, CMS performs management reviews of all HCBS waivers to ascertain their effectiveness, safety, and cost-effectiveness. CMS requires states to assure that federal requirements for Hawai'i's Medicaid I/DD Waiver service are met and verifies that the State's assurances in its waiver are upheld in the day-to-day operations.

B. State Medicaid Agency

The Department of Human Services (DHS) is the single State agency that is responsible for the Medicaid program for the State of Hawai'i. The Med-QUEST Division (MQD) within the DHS is responsible for overall administration of the Hawai'i Medicaid program, including the Section 1115 demonstration program known as QUEST Integration (QI) and the Medicaid I/DD Waiver.

Additional information about the roles and responsibilities for DHS-MQD is located in Appendix 11A.

C. State Operating Agency

The Department of Health (DOH) is the State agency that is responsible for providing services to individuals with developmental disabilities and/or intellectual disabilities. The Developmental Disabilities Division (DDD) within

DOH has statutory responsibilities to “develop, lead, administer, coordinate, monitor, evaluate, and set direction for a comprehensive system of supports and services for persons with developmental disabilities and/or intellectual disabilities within the limits of state or federal resources allocated or available ...” (HRS §333F-2)

DOH-DDD is delegated by DHS-MQD to operate the Medicaid I/DD Waiver.

Additional information about the roles and responsibilities for DOH-DDD is located in Appendix 11B.

D. Waiver Providers

A Medicaid I/DD Waiver Provider is an individual, company or organization that DOH-DDD has recommended approval to enter into a Medicaid Provider Agreement with DHS-MQD. Approved Providers are paid by Medicaid to provide direct services to Medicaid I/DD Waiver participants in compliance with all waiver requirements, federal and state laws, and waiver standards. Providers may be for-profit or non-profit. Provider requirements and responsibilities are specified in Section 2 of this manual.

E. Participant, Family and Guardian

These are the general responsibilities of individuals including guardians and family interested in or already receiving services from the Medicaid I/DD Waiver:

1. Participate in the application process for Medicaid I/DD Waiver;
2. Provide information needed to determine Level of Care Re-evaluations (LOC) within 365 days of the last re-evaluation. Participants will submit verification of a physical examination or evaluation once a year;
3. Participate in redeterminations for DOH-DDD eligibility. The participant must continue to meet the criteria for services per HRS §333-F;
4. Maintain Medicaid eligibility at all times. Complete and return paper work for initial and ongoing Medicaid eligibility determinations. Inform the Medicaid eligibility worker of all pertinent changes;
5. Be financially responsible for payment of Medicaid waiver services received when Medicaid eligibility is lost. The State will not pay for Medicaid waiver services when the participant is not Medicaid eligible;
6. Work with Case Manager to complete the assessment prior to the ISP meeting;
7. Participate in the ISP meeting within 365 days of the last ISP meeting;

8. Approve the ISP within fourteen calendar (14) days of receiving a copy of the ISP;
9. Inform the Case Manager if there is reason to believe that services are not being provided according to the ISP;
10. Meet with the Case Manager at least once every quarter to review services according to the ISP;
11. Inform the Case Manager of changes to contact information and living arrangement, such as address and phone number changes;
12. Inform the Case Manager of any hospitalization and scheduled vacation(s) as soon as possible;
13. Inform the Case Manager of satisfaction or lack of with any services from DDD or call the Consumer Complaints Resolution Unit (see Assistance Directory);
14. Provide true and complete information about coverage, services, and any required financial information;
15. Use resources wisely and responsibly, and;
16. Work with Medicaid I/DD Waiver Provider service supervisors to schedule and complete required face-to-face observations of staff performing in-home tasks.

1.3 APPLICATION AND START OF WAIVER SERVICES

The DOH-DDD Case Manager (CM) must inform the participant of all options regarding services and available Providers within the Medicaid I/DD Waiver. The CM will assist individuals who are already enrolled with DOH-DDD and have requested to participate in the Medicaid I/DD waiver. An individual seeking waiver services cannot apply until enrolled with DOH-DDD. Enrolling with DOH-DDD does not automatically enroll the individual in the Medicaid I/DD waiver because there are additional eligibility requirements. As described in Section 1.1.B, an individual must meet all three of the steps before being admitted to the Medicaid I/DD waiver.

If DHS determines the applicant ineligible, DHS-MQD will issue a Notice of Action (NOA) to the applicant, stating the reason for ineligibility and the applicant's appeal rights.

A. Medicaid "Cost Share" for Adults

An individual who does not fully meet the financial requirements for Medicaid eligibility due to the amount of his/her monthly income may be required to pay a

portion of the medical expenses each month to be eligible for Medicaid. The portion of medical expenses the individual must pay each month is referred to as their “cost share.” The individual becomes Medicaid eligible once he/she has met the cost share requirement.

1. If a participant has a monthly cost share amount, the cost share must be paid by the participant directly to the Waiver Provider agency(ies) servicing the participant.
2. If there is more than one Provider of services, the cost share should be paid to the Provider with the largest amount of authorized services.
3. If the participant has a cost share due to the Provider agency, the Provider agency must adjust the monthly billing invoice for waiver services by the participant’s cost share amount.
4. The Provider agency which is “assigned” the cost share is responsible to collect the cost share amount from the participant.

B. Financial Eligibility Requirements for Children

1. A child may be Medicaid eligible if the family is financially eligible for Medicaid.
2. If the child’s family is not Medicaid eligible, but the child has been determined to meet the LOC criteria, a process called “deeming” is used by DHS-MQD. When the estimated medical expenditures exceed the family’s excess income and the parents agree to pay the amount of the excess income, the child is deemed eligible for the first month of admission.
3. The parents will be responsible to pay for the excess income which will be treated as a cost share for that month only. From the second month of admission, the child will be separated from the parents’ household due to the child’s institutionalized (LOC) status and there will be no cost share

C. Waiver Admission

1. At a minimum, one (1) service under the Medicaid I/DD Waiver Services must be provided on the day of admission.
2. In the event of unforeseen circumstances precluding the provision of waiver service delivery on the date of admission, the DOH-DDD CM may suspend the participant until service can be provided.

3. The participant and/or parent, or the legal guardian when indicated, are required to notify the DOH-DDD CM when the participant does not or will not receive any waiver service(s) at start of services or at any time thereafter.

D. Hawai'i Medicaid Identification Card

1. A plastic Hawai'i Medicaid identification card (ID card) will be issued by a Medicaid health plan to each participant when initial Medicaid eligibility has been determined by DHS-MQD. The ID card will only list the participant's name, Medicaid number and date of birth. The ID card will not list the participant's eligibility dates. As a result, the ID cards will not serve as evidence of current eligibility as participants will keep their ID card throughout any changes in eligibility dates. Medicaid I/DD Waiver Providers must verify each participant's eligibility.
2. Participants who have lost their ID card should be directed to contact the Medicaid health plan. Contact information is contained in the Assistance Directory in Appendix 3.

E. Verification of Medicaid Eligibility

1. The Medicaid program will only reimburse Providers for services rendered to participants with current Medicaid eligibility. If a Medicaid I/DD Waiver Provider is unable to verify a participant's eligibility at the time of service, the Provider renders the service at his/her own risk.
2. Providers should verify participant eligibility on a routine basis as there are times when Medicaid eligibility may lapse due to an incomplete or untimely re-application to Medicaid. Participants are not eligible to receive Medicaid I/DD Waiver services if Medicaid eligibility has lapsed.
3. To assist Providers in verifying participant eligibility, DHS-MQD has developed several options for a Provider to verify eligibility: Automated Voice Response System (AVRS) and DHS Medicaid Online (DMO). (See Appendix 3, Assistance Directory for contact information.)

1.4 RE-EVALUATION OF ELIGIBILITY FOR CONTINUED WAIVER SERVICES

In order to continue to receive waiver services, a participant must continue to need services through the Medicaid I/DD Waiver (determined by a Qualified Intellectual Disabilities Professional [QIDP]) and be eligible for Medicaid and LTC services (determined by the DHS Eligibility office). The following are the three (3) components that a participant must meet:

A. Level of Care Re-Evaluation

Participants who receive Medicaid I/DD Waiver services must be re-evaluated annually or more frequently if needed to determine whether they continue to meet the Intermediate Care Facility for Individuals with Intellectual Disabilities Level of Care (ICF-IID LOC). A physician's evaluation (or physical exam) is required and must be submitted to the Case Manager prior to the re-evaluation date.

B. Medicaid Annual Renewal

An annual renewal form is mailed to each participant in the Medicaid I/DD Waiver from DHS. The participant's information is listed on the upper portion of the renewal form. If there is no change, no action is required. This is referred to as a "passive renewal." If there are any changes, the participant will need to complete the form with updated information written on the bottom half of the form and return to the DHS eligibility worker by the due date stated.

C. Long Term Care (LTC) Annual Renewal

Around the same time the annual renewal form is mailed from DHS, the annual renewal for LTC is mailed out. If the responsible party receives the LTC forms, that person must complete the forms and return to the DHS eligibility worker by the due date stated.

1.5 INDIVIDUALIZED SERVICE PLAN (ISP)

A. ISP Development

All participants who receive Medicaid waiver services from the DOH-DDD must have a written ISP that is developed by the participant, with the input of family, friends, and other persons identified by the participant as being important to the planning process. The plan must be a written description of what is important to the participant, how any issue of health and safety must be addressed, and what needs to happen to support the participant in his or her desired life (see Appendix 12 for ISP form). The ISP is developed according to the HRS §333F.

1. The person-centered planning process also follows the requirements of the CMS HCBS final rule for community integration. The person-centered planning process:
 - a. is driven by the individual and includes people chosen by the individual;
 - b. provides necessary information and support to the individual to ensure that the individual directs the process to the maximum

extent possible, and is enabled to make informed choices and decisions;

- c. is timely and occurs at times/locations of convenience to the individual;
- d. offers informed choice regarding services and supports the individual receives and from whom;
- e. reflects cultural considerations and uses plain language;
- f. includes strategies for solving conflicts or disagreements within the process, including clear conflict-of-interest guidelines for all planning participants;
- g. reflects what is important to the individual to ensure delivery of services in a manner reflecting personal preferences, strengths and ensuring health and welfare;
- h. identifies strengths, preferences, needs, and desired outcomes of the individual;
- i. includes goals and preferences which are related to relationships, community participation, employment, and health;
- j. includes risk factors and plans to minimize them;
- k. includes a method for the individual to request updates to the plan as needed; and
- l. is signed by all individuals and Providers responsible for its implementation. A copy of the plan must be provided to the individual and his/her representative.

2. The ISP is used by the DOH-DDD Case Manager (CM) to document the information above and includes an “Action Plan” which describes the services and supports, both paid and unpaid, to meet the goals and outcomes identified by the participant.
3. The Provider will develop an initial Individual Plan (IP) at or within seven (7) calendar days of the ISP meeting based on the goals outlined in the ISP. The initial IP consists of the priority goals and outcomes based on the ISP with timeframes for achievement to be implemented.

4. A copy of the ISP is sent from the CM to the Provider(s) within thirty (30) calendar days from the completion date of the ISP meeting with the following documents, if applicable:

- a. Individualized Educational Plan (IEP),
- b. Assessments and recommendations of health professionals (e.g., physical, occupational and speech therapists), and
- c. Positive Behavior Support Plan.

B. ISP Updates and Revisions

The ISP is updated annually and may be amended at any time upon request of the participant or when situations and/or circumstances present itself that requires adjustments to the written plan.

C. Service Authorizations

All approved Medicaid waiver services written in the Action Plan will be authorized by the CM. The Provider will be given a prior authorization notice from the designated fiscal agent (Conduit) before the delivery of services. The absence of a prior authorization will result in a denied claim for payment. The Provider must follow-up with the CM if a prior authorization has not been received for a service identified in the Action Plan.

Requests for services that exceed the authorization level that the CM can approve must be reviewed by DOH-DDD on a case-by-case basis.

D. ISP Implementation and Monitoring

At a minimum, the CM must monitor the implementation of the ISP by performing quarterly face-to-face visits with the participant. The CM must also conduct periodic contacts with caregivers, parents, guardians, providers, teachers, and employers etc. to assess/reassess the participant's status.

1.6 PARTICIPANT RIGHTS AND PROTECTIONS

Participants are afforded rights and protections, including those specified in Hawai'i Revised Statutes, §333F-8.

- Receive appropriate services in accordance with the person's Individualized Service Plan (ISP);

- Live in an appropriate residence;
- Interact with persons without disabilities;
- Live with, or in close proximity to, persons without disabilities, which closely approximates conditions available to persons without disabilities of the same age;
- Are given reasonable access to review medical, service, and treatment records and be informed of all diagnoses;
- Develop an ISP, with the input of family and friends, that identifies the supports needed to accomplish the plan;
- Direct the use of resources, both paid and unpaid, that will help the individual to live a life in the community rich in community association and contribution;
- Contribute to their communities and offer a valued role through employment, community activities, and volunteering, and be accountable for spending public dollars in ways that are life enhancing;
- Are ensured privacy and confidentiality. The information will be kept private according to the Health Insurance Portability and Accountability Act of 1996;
- Choose their services, supports, and providers. This includes the choice to receive home and community based services as an alternative to institutional placement;
- Complain about their services or to ask for changes without fear that they will lose services because a complaint is made;
- Be treated with respect and dignity;
- Be free from abuse and neglect;
- Be informed of all services that DOH-DDD provides;
- Be able to discuss options for services with their Case Manager and providers;
- Be informed of agency policies on individual conduct;
- Be able to ask for a different agency or Case Manager;
- Receive a written notice at least ten (10) business days prior to the effective date from the DOH-DDD when services are being reduced, denied, suspended, or terminated;

- Receive thirty (30) calendar day notice of any changes in services from the agency, except in emergency situations wherein a participant's health and safety is at risk;
- Look at and have an explanation of any bills for services paid by the DOH-DDD;
- Have privacy and confidentiality in treatment and care;
- Have access to an interpreter, if needed;
- Be free from being restrained or secluded; and
- Refuse from being included in research projects.

1.7 PARTICIPANT SAFEGUARDS

Sub-sections A, B, and C below focus on positive behavior supports and the Behavior Support Plan (BSP). DOH-DDD promotes a positive behavior support (PBS) approach in all relationships with waiver participants. Practices and procedures must allow people to engage in adaptive and socially desirable behaviors that lead to meaningful and productive lives. A positive approach assumes that all behavior has meaning and that a person's behavior can be a means to communicate a need or a manifestation of a medical or clinical issue such as trauma. DOH-DDD is committed to eliminating the use of aversive procedures and restrictive interventions. Seclusion is prohibited. Restrictive interventions are only to be utilized in emergency situations where there is an imminent risk of harm to self or others. Less restrictive interventions must always be attempted first, and documentation must demonstrate that restrictive interventions are not effective. The required additional safeguards include training, supervision, reporting, documentation, debriefing, and monitoring by qualified individuals.

All restrictive interventions must be part of a formal BSP that is developed by a licensed professional or qualified designee in accordance with Hawai'i state law following the completion of a Functional Behavioral Assessment (FBA). The BSP shall include interventions that always starts with the least restrictive intervention possible.

There are three DOH-DDD Policies & Procedures (P&P) that support the use of PBS for all participants:

P&P #2.01 *Positive Behavior Supports* (see Appendix 4A)

P&P #2.02 *Restrictive Procedures* (see Appendix 4B)

P&P #2.03 *Behavior Support Review* (see Appendix 4C)

Please refer to the above-mentioned P&Ps which describe the requirements for Medicaid I/DD Waiver Providers. DOH-DDD will provide overview training to Providers on these P&Ps, and the practices that support the emphasis on a positive behavior support approach with all participants. Provider agencies must implement training for its staff to use positive behavior support procedures and practices. DOH-DDD will monitor Providers for adherence to these P&Ps.

A. Positive Behavior Supports

Historically, interventions used for people with I/DD have been unacceptably intrusive, focused primarily on punitive consequences, inappropriate for integrated settings, and/or ineffective in producing meaningful changes. PBS are preferable because they are effective in improving behavior and quality of life for people with behavioral challenges. While the goal of DOH-DDD P&P #2.01, *Positive Behavior Supports*, is to safely support participants who may engage in challenging behaviors, its underlying purpose is to promote participants' engagement in integrated activities.

The fundamental features of this policy include a foundation built on person-centered values, a commitment to outcomes that are meaningful, and services individualized to each participant's unique interests and strengths. The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant, and engage each participant's circle of support as partners in developing and implementing PBS approaches using least restrictive interventions. When a participant presents behavior that puts them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and documentation demonstrates that less restrictive interventions were not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary (refer to P&P #2.02, *Restrictive Interventions*). Behavioral Support Plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, P&P #2.01, *Positive Behavior Supports*, sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.

Full definitions and procedures for P&P #2.01, *Positive Behavior Supports* can be found in Appendix 4A.

B. Restrictive Interventions

DOH-DDD P&P #2.02, *Restrictive Interventions*, details the guidelines when using restrictive interventions and can be found in Appendix 4B. The purpose of this policy is to ensure that participants are supported in a caring and responsive manner that promotes dignity, respect, trust and is free from abuse. Participants

have all the same rights and personal freedoms granted to people without disabilities.

When a participant presents behavior that put them at imminent risk of hurting themselves or others, positive behavior supports (PBS) must be used, whenever possible, to decrease the behaviors that pose a risk and prevent the need for restrictive interventions (P&P #2.01, *Positive Behavior Supports*). When PBS techniques have been used and documentation demonstrates that they are not effective in resolving the immediate risk of harm, restrictive procedures that involve temporary restrictions may be necessary.

Restrictive interventions are only to be utilized for the protection of the participant and others from imminent risk of harm. These interventions are the least desirable approach to supporting participants and must be detailed in a formal BSP that is developed by a licensed professional or qualified designee in accordance with Hawai'i state law following the completion of a Functional Behavioral Assessment (refer to pages 4 - 7 of P&P #2.01, *Positive Behavior Supports*, for specific procedures and requirements when developing a formal BSP).

DOH-DDD P&P #2.02, *Restrictive Interventions*, dictates that restrictive interventions are only to be used when a participant's behavior(s) pose an imminent risk of harm to themselves and/or others and less restrictive interventions have been attempted with documentation demonstrating their limited effectiveness at reducing and/or replacing the challenging behavior. The restrictive interventions utilized must be the least restrictive method to address the challenging behavior and shall be terminated when there is no longer an imminent risk of harm and/or a less restrictive intervention would achieve the same purpose. The fundamental features of this policy specify that restrictive interventions are as follows:

- only meant to address situations of imminent risk of harm.
- not to be used as threats or punishment to change behavior as participants have the right to be free from any restrictive intervention imposed for the purpose of discipline, retaliation and/or staff convenience.
- not therapeutic in nature nor designed to alter behavior in a long-term manner so should not be utilized with this intent.

1. Formal Behavior Support Plan (BSP)

When behavioral data and the Individualized Service Plan (ISP) team confirms an imminent risk of harm to the participant and/or others, and it is documented that less restrictive interventions have been attempted and deemed ineffective at decreasing the risk of harm, a formal BSP with restrictive intervention(s) must be developed and contain the following features.

- a. PBS methods are the primary interventions to safely address challenging behaviors and increase a participant's independence and integration into community activities.
- b. Restrictive interventions that are only used to protect the participant and/or others from imminent risk of harm after less restrictive interventions have been applied and deemed ineffective at addressing the challenging behavior, with appropriate documentation demonstrating their ineffectiveness.
- c. The specific conditions that warrant the use and removal of a restrictive intervention, or the use of a less restrictive intervention, must be specified. A timeframe should be provided for which termination of a restrictive intervention should occur.
- d. Specific information on how to apply and remove *each* restrictive intervention is addressed, including photographs and other descriptions detailing how the restrictive intervention should be applied, maintained, and removed.
- e. Detailed information on how the author of the BSP plans to train all members in the participant's circle of support *prior to* their independent use of a restrictive intervention as well as how documentation will be maintained regarding how these individuals respond to the training (e.g., are they able to independently apply interventions appropriately).
- f. Information regarding how the restricted right(s) of the participant will be restored following the use of a restrictive intervention is addressed.
- g. Strategies to prevent or minimize the challenging behaviors from occurring as well as identification of replacement skills that will be taught to the participant that serve the same function as the challenging behavior.

- h. Goals that enhance the participant's overall quality of life are included, so that treatment objectives are not limited to addressing challenging behaviors only.
- i. Specific instructions are included on how documentation and/or data collection should be completed following the use of a restrictive intervention for the purpose of monitoring and evaluating the use and effectiveness of an intervention.
- j. Specific information is included on how relevant data will be collected and analyzed by the licensed professional or qualified designee who developed the BSP in accordance with Hawai'i state law. The purposes of the data analysis is to provide ongoing monitoring of the implementation of the BSP, analysis of the effectiveness of the interventions included in the BSP, oversight of the accuracy of data collection methods by individuals implementing the BSP, and assessment of the need for and provide retraining on the BSP, if necessary.
- k. The plan must include the process for debriefing within 24 hours of the initial application of the restrictive intervention.
- l. Adjustments to the BSP may be made by the author of the BSP or qualified designee, if needed.
- m. A detailed plan for the eventual elimination of the restrictive intervention must be included.

2. Training in BSPs with Restrictive Interventions

- a. All paid Medicaid I/DD Waiver personnel who will implement and/or oversee the implementation of the formal BSP must meet General Staff Requirements (refer to Section 2) and DOH-DDD Service Specific Performance Standards (refer to Section 3).
- b. Prior to implementing a formal written BSP that includes a restrictive intervention,
 - (1) all staff implementing and/or supervising the BSP must complete a nationally-recognized curricula approved by the DOH-DDD for positive behavior supports/safe interventions and

- (2) complete an initial in-person training that includes all aspects of the BSP including, but not limited to, the positive behavior support approaches, interventions, documentation and monitoring procedures, and techniques for teaching replacements skills proposed for use in the BSP.

The initial training in implementing the BSP shall be completed by the author of the BSP; any follow-up trainings and/or ongoing monitoring of the BSP shall be completed by the author of the BSP or his/her qualified designee.

- d. Individuals who implement a restrictive intervention shall be trained, monitored, and evaluated on an ongoing basis to ensure appropriate application of the restrictive intervention both prior to and throughout their independent application of the intervention.
- e. Documentation of all training(s) on the individualized BSP shall be maintained in the Provider agency's files. Training records shall be available for review by the DOH-DDD.

3. Prohibited Restrictive Interventions

The procedures that are *prohibited* and shall not be used with participants include but are not limited to the following:

- a. Seclusion
- b. Aversive procedures involving:
 - (1) Electric shock (excluding electroconvulsive therapy);
 - (2) The non-accidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint;
 - (3) Unpleasant tasting food or stimuli; and
 - (4) Contingent application of any noxious substances which include but are not limited to noise, bad smells, or squirting a participant with any substance that is administered for the purpose of reducing the frequency or intensity of a behavior.

c. The following types of restraints:

- (1) Restraints that cause pain or harm to participants. This includes restraint procedures such as arm twisting, finger bending, joint extensions or head locks;
- (2) Prone Restraints;
- (3) Supine Restraints;
- (4) Restraints that have the potential to inhibit or restrict a participant's ability to breathe; excessive pressure on the chest, lungs, sternum, and/or diaphragm of the participant; or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;
- (5) Restraint Chairs;
- (6) Restraint Boards;
- (7) Any maneuver that involves punching, hitting, poking, or shoving the participant;
- (8) Straddling or sitting on the torso;
- (9) Any technique that restrains a participant vertically, face first against a wall or post; and
- (10) Any maneuver where the head is used as a lever to control movement of other body parts.

d. Interventions involving:

- (1) Verbal or demonstrative harm caused by oral, written language, or gestures with disparaging or derogatory implications;
- (2) Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation;
- (3) Denial of food, beverage, shelter, bedding, sleep, physical comfort or access to a restroom as a consequence of behavior;

- (4) Restricting or disabling a communication device;
- (5) Placing a participant in a room with no light;
- (6) Overcorrection; and
- (7) Removing, withholding or taking away money, incentives or activities previously earned.

Specific procedures regarding Restrictive Interventions are found in Appendix 4B.

C. Behavior Support Review

The purpose of Behavior Support Review is to ensure that PBS methods are the primary interventions utilized when working with DOH-DDD participants and that appropriate safeguards and oversight are in place when restrictive interventions are proposed for use in a BSP. The DOH-DDD Behavior Support Review Committee (BSRC) may review BSPs that include a restrictive intervention and may provide recommendations to ensure appropriate, effective, and safe application of an intervention by service Providers as per P&P #2.03, *Behavior Support Review*.

P&P #2.03 describes how the DOH-DDD Behavior Support Review will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others.

Full procedures for authority and operations of the BSRC are found in P&P #2.03, *Behavior Support Review*, in Appendix 4C.

D. Nurse Delegation by Agency Providers

1. The Medicaid I/DD Waiver Provider's Registered Nurse (RN), who is licensed in the State of Hawai'i in accordance with HRS §457-2.5 and §457-7, must develop the nurse delegation plan for each direct support worker (DSW) or consumer-directed employee performing the delegated task. A Licensed Practical Nurse (LPN) shall not develop a delegation plan. This plan must be a part of the participant record. Nurse delegation is in accordance with HRS §457-7.5.
2. The nurse delegation plan must:
 - a. identify the nursing task to be delegated;
 - b. list the equipment needed;
 - c. describe each step needed to complete the task;

- d. review the expected outcomes of the task;
- e. review the possible adverse reaction(s) to the task;
- f. specify a clear emergency plan that includes:
 - (1) who to call with the number and backup numbers
 - (2) when to initiate Emergency Medical Service (EMS), call 911
- g. document the task and observations noted.

Each nursing task needs a Plan that should be signed by the delegating RN and each delegate completing the task.

The signed plan will be placed in the participant’s folder at the service site.

- 3. The following table provides examples of nursing tasks that may be delegated and tasks that licensed nurses must perform. This table is used as a guide. The registered nurse determines whether tasks can be delegated and who can perform those tasks under nurse delegation.

TABLE #1.7-1: NURSE DELEGATION

| Examples of Nursing Tasks that may be Delegated | Tasks for Nurses Only (LPN or RN) <i>(subject to review by DOH-DDD prior to authorizing Skilled Nursing)</i> |
|---|---|
| | Assessment, evaluation, and teaching must be completed by the RN only and must not be delegated to an LPN |
| | Accepting telephone (or other non-face-to-face) orders from professionals with prescriptive authority must be done by the RN only and must not be delegated to an LPN |
| | Intravenous (IV) medications or Peripherally Inserted Central Catheter (PICC line) must be done by RN only and must not be delegated to an LPN |
| Scheduled medications administered by Provider agency worker or consumer-directed employee [routes: oral, gastrostomy, jejunostomy, ocular, otic, inhaled, nebulized, rectal, topical/transdermal] | Intramuscular (in the muscle) injection – non-prepared |
| All PRN medications administered. NOTE: Verbal RN consult must occur prior to administration of any PRN narcotic analgesic. Verbal RN consult must occur prior to administration of any medication prescribed for the purpose of behavior control. | PRN medication administered via intramuscular injections |
| Diastat (Valium) [route: rectal suppository] | |

| | |
|--|--|
| Prepared medication. Requires order and specific individualized seizure protocol from the professional with prescriptive authority (see Appendix 4E, Seizure Action Plan). | |
| Prepared subcutaneous (under the skin) dose of insulin with no recent history of hypoglycemia Prepared intramuscular (in the muscle) epinephrine (e.g., Epi-Pen) given as first aid | Sliding scale insulin |
| | Non-prepared subcutaneous (under the skin) injection (the drawing up of the medications is not delegated) |
| Oropharyngeal suctioning - Insertion of a rigid suction catheter or Yankauer into the mouth and pharynx for the purpose of removal of excess saliva or mucous secretions and foreign material (vomitus or gastric secretions) from the mouth and throat not to extend beyond the pharynx | Nasotracheal and endotracheal suctioning - (usually in acute care) A sterile technique requiring insertion of a soft, sterile flexible catheter into the nose, pharynx, trachea and the endotracheal or tracheostomy tube for artificial removal of excess secretions from the lower airway. Tracheostomy suctioning - Intermittent insertion of a sterile soft catheter into the tracheostomy (connected to suction apparatus) for artificial removal of excess mucous secretions from the trachea and lower airway. Tracheostomy Tube Change |
| Cough Assist machine | |
| Chest Percussion – manual or via vest | |
| Gastrostomy (GT) feedings - Liquid nutrition provided into a surgically implanted tube in the stomach. May be intermittent (bolus) or continuous via pump. Jejunostomy (JT) feedings – Liquid nutrition provided into a surgically implanted tube in the jejunum (the small bowel). | Total Parenteral Nutrition (TPN) - Parenteral nutrition, also known as intravenous feeding, is a method of getting nutrition into the body through the veins. While it is most commonly referred to as total parenteral nutrition (TPN), some patients need to get only certain types of nutrients intravenously |
| Nebulized meds - Liquid medications prescribed to be administered via vaporization into a fine spray | |
| General first aid | |
| Dressing changes without assessment <ul style="list-style-type: none"> • Clean • Sterile • Stoma | Sterile dressing changes requiring wound assessment |
| Glucose monitoring | |
| Oxygen therapy with specific parameters from prescriber | Oxygen therapy that requires assessment and intervention by a nurse due to instability |

| | |
|---|--|
| Straight urinary catheterization or indwelling Foley catheter Suprapubic catheter care | |
| Other tasks not specified in this require use of the Nursing Delegation Decision Making Tree (see Appendix 4D). | |

E. Medication Management

This section applies to medications that are self-administered, assisted with, or administered during the time the participant is receiving paid waiver services from a Provider agency DSW or consumer-directed employee. All medications must be ordered by a practitioner with prescriptive authority.

1. Definitions

Medication is defined as any over-the-counter, legend, or controlled drug.

- a. Over-the-counter (OTC) drug means medicines sold directly to a consumer without a prescription from a healthcare professional.
- b. Legend drug means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider.
- c. Controlled drug substance means any drug or therapeutic agent—commonly understood to include narcotics, with a potential for abuse or addiction, which is held under strict governmental control, as delineated by the Comprehensive Drug Abuse Prevention & Control Act passed in 1970.

2. Nurse Delegation for Medication Assistance and/or Administration

Waiver Providers who assist with or administer medications during waiver service hours can only do so with an order from a practitioner with prescriptive authority and by a registered nurse or as part of nurse delegation. The following are components of the nurse delegation plan:

- a. The nurse delegation plan must be in the participant’s record for any medication assistance or administration tasks performed during the waiver service hours with the exception of self-administered medications as defined below.
- b. The nurse delegation plan must include the following for each medication:

- (1) Brand or generic (as applicable) name,
- (2) Identifying photo (if available),
- (3) Intended purpose,
- (4) Potential adverse effects,
- (5) Drug/food interactions,
- (6) General information on recommended dosages and the medication's effect, and
- (7) Instructions for monitoring the participant's response to the medication.

- c. Staff assisting with and/or administering medications in any way must be trained by an RN. The RN must verify and document the staff's skills competency and provide a copy of the delegation plan in the participant folder.
- d. The DSW or consumer-directed employee must follow the procedures for Adverse Event Reporting (see Section 2.6 Provider Agency Quality Assurance), including medication errors and unexpected reactions to drugs or treatment.
- e. Medications are managed efficiently and appropriately in accordance with applicable State laws.

3. Medication Self-Administration

The participant can demonstrate his or her ability to independently initiate the ingestion, inhalation, or injection of prescribed medications as evidenced by all of the following to the RN. A participant may use words, signs, pictures, assistive devices or other means of communication to demonstrate the ability to self-administer medications.

- a. Ability to identify the medication,
- b. Ability to state the reason for taking the medication,
- c. Ability to state the prescribed dosage,
- d. Ability to state the scheduled time, and

- e. Ability to take the medication as prescribed or communicates the directions to a worker and can accurately direct others to physically assist the participant are considered self-administration.

4. Medication Assistance

Medication assistance may be performed by a Provider agency DSW or a consumer-directed employee under the delegation of an RN in accordance with HRS §457-7.5. Medication assistance includes, but is not limited to, any of the following steps:

- a. Placing the labeled container with the medication in the participant's hand,
- b. Placing the "pill organizer" with medications pre-arranged by the hour, day, or week in the participant's hand,
- c. Assisting the participant with opening the container and dropping the medication into the participant's hand when needed,
- d. Instructing or prompting the participant to take the medication,
- e. Assisting the participant to take the medication,
- f. Helping the participant to drink a liquid in order to swallow the medication, or
- g. Watching and observing the participant to ensure that the medication has been swallowed.

5. Medication Administration

Medication administration must be performed by an RN or an LPN under the supervision of an RN and or by a direct support worker under the delegation of an RN in accordance with HRS §457-7.5.

6. Documentation

- a. All participants receiving medication during waiver service hours must have documentation of the medication in a Medication Administration Record (MAR) to be kept in the participant folder (see Appendix 4F).
- b. Documentation in the MAR includes the following:
 - (1) Medication given as ordered,

- (2) Date and time,
 - (3) Route, and
 - (4) Initials of staff.
- c. Documentation in the progress note includes a description of observation of the participant's response to the medication.
- d. Documentation for PRN medication includes:
- (1) Documentation of the verbal consultation with the name of the delegating RN,
 - (2) Reason given, and
 - (3) The outcome after medication was administered.

1.8 ADVERSE EVENT REPORTING

The Provider must follow the current procedures for Adverse Event Reporting. The current form and instructions are in Appendix 5, 5C. Within its internal quality management program, the Provider must utilize Adverse Event Reporting in its discovery process to assure quality assurance (see Section 2.6 Provider Quality Assurance Process). DOH-DDD will monitor Providers for adherence to this policy and send to DHS all written reports for the use of restraints and deaths.

- A. The Provider must notify the DOH-DDD CM of the following adverse events by means of a verbal report and a written report utilizing the most current DOH-DDD Adverse Event Report Form:
1. Changes in the participant's health condition requiring medical or dental treatment or hospitalization. Medical or dental treatment is defined as treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization;
 2. Death of the participant regardless of cause or location of death;
 3. Injuries of a known or unknown cause sustained by the participant requiring medical or dental treatment. Medical or dental treatment is defined as treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization;

4. Suspected abuse and neglect, as referenced in HRS §350-1 for children and HRS §346-222 for adults, and financial exploitation as referenced in HRS §346-222 (see also DOH-DDD P&P #2.05, Mandatory Reporting of Abuse and Neglect, located in Appendix 5, 5A).
 5. Medication errors and unexpected reactions to drugs or treatment. Medication errors includes wrong medication, wrong dose, wrong time, or missed dose.
 6. Participant's whereabouts unknown regardless of the amount of time the participant is missing or unaccounted for;
 7. Change in the participant's behavior, including but not limited to aggression, self-injurious behaviors, property destruction, or sexualized behaviors that may require a new or updated BSP as a result of the intensity and/or severity of the behavior;
 8. Any use of restraints such as chemical, mechanical, or physical interventions used as a last resort on an emergency basis to protect the participant from imminent self-harm or harm to others using the least restrictive intervention possible and for the shortest duration necessary;
 9. Any use of prohibited restrictive intervention or procedure that restricts the participant's freedom of movement, access to other locations, property, or rights, or requires the participant to do something which the participant does not want to do.
- B. The Provider must provide a verbal report of an adverse event to the DOH-DDD CM or the designee (on-duty Case Manager, if applicable, or supervisor) within twenty-four (24) hours or the next business day of an adverse event. A verbal report consists of the Provider speaking to a Case Manager or the designee to verbally report (gives details of the event, actions taken for the participant's immediate safety, etc.) what occurred. If the Provider leaves a message during non-work hours (i.e., evenings, weekends, and holidays), this is not considered a verbal report. A message may be left; however, the Provider must call the Case Manager or the designee on the immediate next business day to report the adverse event.
1. For events involving suspected abuse, neglect, or financial exploitation, the Provider must report the event to Child Welfare Services or Adult Protective Services within twenty-four (24) hours or the next business day of the suspected abuse, neglect, or financial exploitation. Actions taken by the direct support worker and Provider are determined by the nature of the critical event and the Provider's Policies & Procedures.

2. The Provider must submit the written DOH Adverse Event Report to the DOH-DDD CM within seventy-two (72) hours of the adverse event with details that include immediate actions taken to safeguard the participant, and actions taken or will be taken to prevent the recurrence of the event, including timelines for implementation. Narrative portions of the report must be either typewritten or completed in legible print.
3. The Provider must ensure that the information on the DOH Adverse Event Report is accurate and complete. Any form that has missing, inconsistent, or incomplete information must be revised and re-submitted to the DOH-DDD CM within twenty-four (24) hours of the request. The DOH-DDD CM will retain the original copy.
4. The Provider must review the DOH-DDD CM's assessment of the Provider's immediate action taken and plan of action to prevent the recurrence of the adverse event.
5. The Provider must implement and monitor the plan of action and make revisions as necessary, including additional actions recommended by the DOH-DDD CM to ensure the participant's health and safety.

1.9 CONSUMER DIRECTION

Under the Consumer Direction option, participants and/or their designated representatives may recruit, hire, train, supervise, and terminate their direct support workers. Waiver services provided under the option have the same definition and purposes identified in the service standards. Participants and their legal representative, if applicable, are informed of this option during the ISP development process. The following Medicaid I/DD Waiver services can be consumer-directed:

- Chore
- Personal Assistance Habilitation
- Respite
- Non-Medical Transportation

The participant may elect to receive any of the above-listed services through the Consumer Direction option or may choose a combination of the Consumer Direction option and Waiver provider-delivered services.

Waiver services using the Consumer Direction option must be implemented as authorized in the participant's ISP. Consumer-directed services are provided in accordance with Consumer Direction Policies & Procedures and the Consumer Direction Employee or Employer Manual. Consumer-directed employers submit employee timesheets and

vouchers which are completed with required information and submitted by specified due dates.

1.10 APPEAL RIGHTS OF PARTICIPANTS

The participant, or the legal representative if applicable, will receive a Notice of Action (NOA) from the Case Management Branch when services are being decreased, terminated, or denied, or when individuals are being suspended or discharged from the Medicaid I/DD Waiver. The participant or the participant's legal representative has the right to request an appeal of the NOA. Waiver services currently authorized continue while the appeal is pending.

The participant or legal representative may ask for one or more of these options:

- An informal review of the action with staff from the DOH-DDD,
- An administrative hearing from the DOH, and/or
- An administrative hearing from the DHS.

A. Informal Review

1. The participant or legal representative is given an opportunity to present information to members of the DOH-DDD staff to show that the proposed action is incorrect. They can choose to explain circumstances about the participant's needs and situation that the DOH-DDD staff may not be aware of and that might result in a different action.
2. The written request for an Informal Review must be submitted to

Hawai'i State Department of Health
Developmental Disabilities Division
Outcomes and Compliance Branch
Consumer Complaints Resolution Unit
2201 Waimano Home Road, Hale A
Pearl City, Hawai'i 96782

B. Administrative Hearing from the DOH and/or DHS

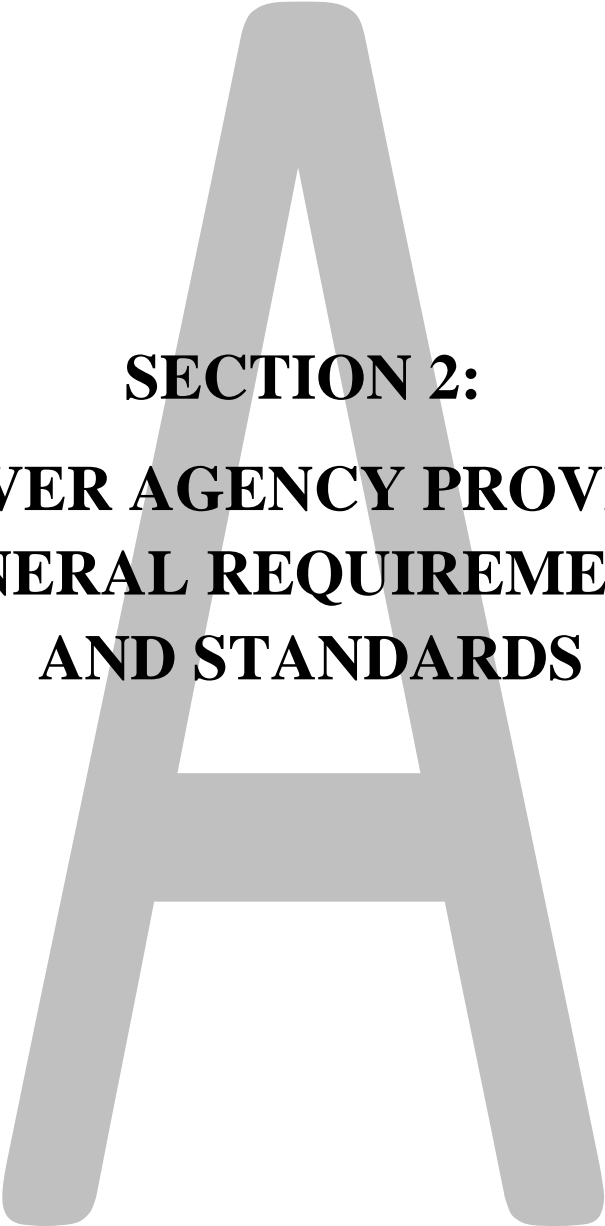
1. The participant or legal representative may present relevant evidence and argument on the issues raised. The participant may examine and cross-examine witnesses and present exhibits. After the administrative hearing is held, the action may be affirmed, modified, or reversed by the Hearings Officer.
2. The request for administrative hearing **from DOH** should be sent to:

Hawai'i State Department of Health

Director of Health
P.O. Box 3378
Honolulu, Hawai'i 96801

3. The request for administrative hearing **from DHS** should be sent to:

Hawai'i State Department of Human Services
Administrative Appeals Officer
P.O. Box 339
Honolulu, Hawai'i 96809



**SECTION 2:
WAIVER AGENCY PROVIDER
GENERAL REQUIREMENTS
AND STANDARDS**

2.1 PARTICIPATION AS A MEDICAID PROVIDER

A. General Information

Payment for covered goods, care, and services must only be made to Providers that have been recommended by DOH-DDD and approved by DHS-MQD to enter into a Medicaid Provider Agreement for the Medicaid I/DD Waiver. The following pertain to any exemption that a Provider requests from the Standards requirements:

1. Requests for exemptions from the Standards by a Provider agency must be submitted in writing to the DOH-DDD.
2. Requests for exemptions shall be denied if the exemption will create a hazard to health or safety as determined by DOH-DDD and DHS-MQD.
3. Exemptions granted by DOH-DDD and DHS-MQD, whether expressed or implied, must be documented and must not be transferred from one Provider agency to another.

B. General Requirements for Participation as a Medicaid I/DD Waiver Provider

The following are general requirements for an applicant to become a Medicaid I/DD Waiver Provider:

1. License or Certification

If required, and in accordance with Hawai'i state law, an individual provider must be licensed to practice within the scope of his/her profession. Permits, temporary licenses or any form of license or permit that requires supervision of the licensee do not serve to qualify as an eligible provider of services under the Hawai'i Medicaid Program.

DOH-DDD certifies Adult Foster Homes and the DOH-Office of Health Care Assurance (OHCA) licenses Developmental Disabilities Domiciliary Homes, Adult Residential Care Homes, Extended Care Adult Residential Care Homes, assisted living facilities, and special treatment facilities/therapeutic living programs.

Providers of any other waiver services must comply with standards and all licensure, certification, and other requirements as applicable.

2. Application for Participation

a. New Provider Application

Any entity (individual, business, or organization) wishing to become a Medicaid I/DD Waiver Provider must complete and submit a DOH-DDD Medicaid I/DD Waiver Proposal Application.

- (1) The Medicaid I/DD Waiver Proposal Application and Addendum Application may be obtained from DOH-DDD's Community Resource Management Section in the Community Resources Branch (CRB). See the Assistance Directory in Appendix 3.
- (2) The Medicaid I/DD Waiver Services Proposal Application must be reviewed by DOH-DDD for programmatic and fiscal requirements.
- (3) Upon receipt of the Medicaid I/DD Waiver Proposal Application or Addendum Application, the submitting agency will receive acknowledgement of receipt of the proposal. DOH-DDD will then notify the applicant of its findings within ninety (90) business days of submission.
- (4) A site visit to the applicant's setting(s) will be scheduled as needed to assist in the review process.
- (5) If the applicant meets the waiver standards, DOH-DDD will submit its recommendations to DHS-MQD for final approval and execution of the written Provider Agreement.
- (6) Once DOH-DDD recommends a new provider application to DHS-MQD, the provider must submit the [Medicaid Application/Change Request Form \(DHS 1139\)](#) (see Appendix 6) with a \$500 application fee to DOH-DDD which will be forwarded to DHS-MQD.
- (7) The applicant may submit one revised proposal within the fiscal year to address issues that resulted in a finding of "not approved." DOH-DDD will respond with their findings within 90 business days of resubmission.

b. Current Medicaid I/DD Waiver Provider

Providers requesting to deliver additional services to be included in their array of services must complete and submit a DOH-DDD Medicaid I/DD Waiver Addendum Application.

- (1) The Provider must demonstrate the capacity and qualified staff to deliver the additional services requested.
- (2) If the change involves a new setting where the participants will receive waiver services, the new location must be approved and validated by DOH-DDD to ensure compliance with the CMS Community Integration final rule. Validation must be completed prior to recommending the Provider to DHS-MQD for approval to deliver the new waiver service(s).

c. Changes to Current Information

Any Medicaid I/DD Waiver Providers requesting changes, including but not limited to location, address, and phone number, must complete the DHS 1139. Providers must mail the DHS 1139 to the DOH-DDD.

3. Provider Agreement with the Department of Human Services (DHS)

Providers participating in the Medicaid I/DD Waiver must have a current and valid written Provider Agreement on file with DHS-MQD and comply with all of the terms of the Provider Agreement and the Standards. The completed and executed Provider Agreement and any attachments constitute the full written agreement.

The Provider must maintain documentation of current insurance coverages:

- a. general liability insurance in the amount of \$1,000,000 per occurrence for bodily injury or property damage and \$2,000,000 in aggregate
- b. professional liability, if applicable, in the amount of \$1,000,000 per occurrence and \$2,000,000 in aggregate
- c. automobile insurance in the amount of \$100,000 per occurrence and \$300,000 in aggregate

C. Adherence with Health Insurance Portability and Accountability Act (HIPAA)

The Provider must have an internal P&P that meets state and federal requirements on the following:

1. Confidentiality of individuals' records pursuant to HRS §333F-8 (a) (9); and 333E-6 and HIPAA. The Provider must comply with HIPAA.
2. The Provider may be a "health care provider" or "covered entity" as defined by HIPAA. If the provider is or becomes a "covered entity," the Provider must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions and code sets, and national employer and provider identifiers. See 45 CFR Parts 160, 162, and 164.

D. Compliance with Limited English Proficiency Requirements

Medicaid I/DD Waiver Providers are required to adhere to federal and state laws for limited English proficiency. All Medicaid I/DD Waiver Providers are covered entities under Hawai'i Revised Statutes section 321C-2. The Provider must provide interpreter services to assist a participant to access waiver services.

The State of Hawai'i State Procurement Office (SPO) offers a cooperative purchasing program with the State for organizations that qualify. This program enables organizations enrolled through this program to obtain telephonic interpretation services at a government/discounted per-minute rate. The link to learn more about the cooperative purchasing program is at:

<http://spo.hawaii.gov/for-vendors/non-profits/cooperative-purchasing-program/>

E. Compliance with DOH-DDD's Policies & Procedures (P&P)

Provider agencies must have written P&Ps that align with DOH-DDD P&Ps where applicable. Provider agencies must have P&Ps for emergency protocols, alcohol and drug-free workplace, protection of participant rights and confidentiality of participant records. The following P&Ps must be in accordance with DOH-DDD's P&P: Positive Behavior Supports, Restrictive Interventions, and Adverse Event Reporting.

F. CMS HCBS Final Rule on Community Integration

All Providers must achieve full compliance with the final rule requirements and maintain compliance on an ongoing basis per timelines specified in the **My Choice My Way** transition plan. Existing Providers delivering services prior to the Waiver renewal effective July 1, 2016 must use the transition period to meet the HCBS final rule requirements. Any Providers that are not in full compliance as determined by the **My Choice My Way** validation process must develop and implement remediation plans to reach compliance.

The transition period is not available for a new provider applicant or an existing Provider seeking to add a new service or a new location (setting). Any new

Provider or service or setting approved after July 1, 2016 must be fully compliant with the CMS HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings prior to the approval and delivery of a waiver service.

G. Transition, Coordination, and Continuity of Care

Participants may experience transitions at various times. When changes occur, Providers will coordinate with participants, families, guardians, and case managers to support continuity and smooth transitions. Examples of transitions include but are not limited to the following:

1. A participant transfers from one waiver Provider to another waiver Provider.

A Provider who currently delivers services and the Provider who will begin services must share information, upon request and with proper releases of information, in order to ensure a smooth transition.

2. A Provider ends all waiver services (closing of an agency).
 - a. Providers must notify of any termination of all waiver services at least thirty (30) calendar days prior to the change.
 - b. The Provider must coordinate with respective CMs and allow at least thirty (30) calendar days for CMs to transition their participants to alternative services chosen by participants, their families, and guardians if applicable.
3. A participant chooses Medicaid-funded Consumer-Directed services instead of Waiver Provider agencies.

H. Service Limitations/Exclusions/Restrictions

The following situations are service limitations, exclusions, and restrictions to the use of the Medicaid I/DD Waiver:

1. Services under the Medicaid I/DD Waiver are used only when mandated resources have been sought and secured (e.g. Hawai'i Medicaid State Plan; Early Periodic Screening, Diagnosis and Treatment Services [EPSDT]; Division of Vocational Rehabilitation; and Department of Education), and family and community resources are not available.
2. Services by Responsible Adults

Services paid through the Medicaid I/DD Waiver shall not be provided to a minor child, under 18 years of age, by the parent, stepparent, or legal guardian of the minor or to an adult participant by their spouse.

3. Non-billable Activities

Examples of activities performed by staff that are not billed to the Medicaid I/DD Waiver include, but are not limited to:

- a. Attendance at general staff in-service training;
- b. Preparation and submission of progress reports; and
- c. Preparation of billing statements.

2.2 GENERAL STAFF QUALIFICATION REQUIREMENTS

A. Staff Training Requirements

1. New Employee Orientation

- a. The Provider will ensure that staff requirements are met prior to providing services by completing the New Employee Orientation and remaining current during service delivery. Until the necessary clearances are obtained, staff must work only under line of sight supervision and never be left unattended with a participant.
- b. New Employee Orientation for all new staff must include the following 15 topics. Providers may require and provide additional training topics.
 - (1) CMS Home and Community Based Services (HCBS) final rule on community integration overview and implementation*
 - (2) Person Centered Planning*
 - (3) Positive Behavior Supports*
 - (4) Adverse Event Reporting (AER)*
 - (5) Overview of Intellectual and Developmental Disabilities
 - (6) Orientation to Medicaid I/DD Medicaid Waiver Services
 - (7) Overview of ISP/IP Process

- (8) Basic Health and Safety
- (9) Preventing Abuse and Neglect
- (10) Documentation
- (11) Communication (agency, family, participants, DOH-DDD staff)
- (12) Job Responsibilities
- (13) Ethical Conduct
- (14) Emergency Preparedness
- (15) Participant Rights, Grievances and Responsibilities

**Mandatory topics to be trained on annually*

2. Continuing Education

- a. The Provider must train each direct support worker on the four (4) mandatory topics identified with the (*) in the New Employee Orientation topics list on an annual basis.
- b. In addition to the mandatory topics, DOH-DDD requires that direct support workers receive, at a minimum, two additional topics from the New Employee Orientation topics list on an annual basis.
- c. All changes related to State and agency policies affecting the operations of the Medicaid I/DD Waiver e.g., new forms or procedures, must also be included in the continuing education program.

B. General Staff Qualifications

1. All direct support workers must possess satisfactory skills (skill level defined and identified in the IP) as verified and documented by a service supervisor in accordance with service-specific standards prior to service delivery and in the event of any changes to the IP.
2. Table 2.2-1 describes general staff qualifications and requirements. Table 2.2-2 describes the frequency of criminal history record checks and registry screen (see Appendix 7B, Hyperlinks to Resources for Required Clearances).

3. Some of the waiver services include additional provider qualifications to reflect the specialized skills required to deliver the service. Service-specific qualifications are included in Section 3 of the Waiver Standards Manual.
4. If any outstanding staff requirement documentation and clearances are identified during the DOH-DDD provider validation process, the identified staff must work only under line of sight supervision and never be left unattended with a participant until the necessary clearances are obtained and accepted by DOH-DDD.
5. Employees must complete face-to-face training for first aid and CPR. On-line programs are not accepted to meet General Staff Qualifications.
6. Effective July 1, 2017, Providers must begin obtaining TB testing, first aid training and Cardiopulmonary Resuscitation (CPR) training for employees who are family members of participants and who previously were waived from meeting all General Staff Requirements. All employees who are family members must complete the additional requirements (TB testing, first aid, and CPR) by June 30, 2018.

TABLE 2.2-1: General Staff Qualifications and Requirements for Provider Staff

| General Staff Qualifications and Requirements for Provider Staff | | | | | | | | |
|---|-------------------------------------|---|------------------------------|--|---|---------------------------------------|--|--|
| | A | B | C | D | E | F | G | H |
| Clearance | Service Supervisor (Svc Sup) | Direct Support Worker – Agency (DSW) | Employment Specialist | Direct Support Worker – Consumer-Directed Services (DSW-CD) | Registered Nurse – RN (applies whether RN is Svc Sup or providing direct Skilled Nursing services) | Licensed Practical Nurse - LPN | Training & Consultation Licensed Professional or qualified designee | Vendor, Contractor, Transportation Provider |
| Orientation upon hire | X | X | X | - | X | X | Waived | - |
| Annual Training | X | X | X | - | X | X | Waived | - |
| TB clearance | X | X | X | - | X | X | X | - |
| First Aid | X | X | X | - | Waived | X | Waived | - |
| CPR | X | X | X | - | X | X | Waived | - |
| Criminal History Check | X | X | X | X | X | X | X | - |
| Fingerprinting | X | X | X | - | X | X | X | - |
| Adult Protective Services clearance | X | X | X | - | X | X | X | - |
| Child Abuse and Neglect Registry Clearance | X | X | X | - | X | X | X | - |
| Bachelor's Degree | X | - | X | - | X (Associates Degree or certificate accepted with valid license) | - | Refer to waiver service for specific qualification requirements. | - |
| RN license | - | - | - | - | X | - | Refer to waiver service for specific qualification requirements. | - |
| LPN license | - | - | - | - | - | X | Refer to waiver service for specific qualification requirements. | - |
| Trained in implementation of ISP and IP if applicable | X | X | X | X | X | X | Waived | Waived |
| Continuing education | Mandatory annual topics | Mandatory annual topics | - | - | Mandatory annual topics | Mandatory annual topics | Continuing education in accordance with licensure requirements | - |

C. Exceptions to Provider Qualifications Process

1. In the rare situation where a Provider requests an exception to the general and/or additional service-specific provider qualifications, the Provider must submit a written request with justification to DOH-DDD-CRB (see Appendix 3, Assistance Directory, for DOH-DDD-CRB address.)
2. If additional information is required to make the decision for an exception, the Provider must submit all documentation within fifteen (15) business days.
3. A DOH-DDD committee will review the request and make a decision, which will be issued to the Provider in writing within fifteen (15) business days once all documentation has been received from the Provider.

TABLE 2.2-2: FREQUENCY FOR THE REQUIRED CLEARANCES

| | Upon Hire | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 | Year 7 | Year 8 |
|---|-----------|--------|--------|--------|--------|--------|--------|--------|--------|
| FBI and State Fingerprint (AFIS) (Fieldprint) | X | X | | | | | | | |
| State Name Check e-Crim (HCJDC) | | | | X | | X | | X | |
| APS/CAN (Fieldprint) | X | X | | X | | X | | X | |

Example:

1. DSW hired on 1.15.17. Upon hire, the employee will submit the first FBI and State fingerprinting (Fieldprint) and APS/CAN (Fieldprint). A “greenlight” must be received prior to delivering any direct services.
2. On 1.15.18 (year 1), the employee will submit the second FBI and State fingerprinting (Fieldprint) and APS/CAN (Fieldprint). A “greenlight” must be received to continue to provide services. Once the second fingerprinting is submitted, the DSW is not required to submit another fingerprinting. **From this time forward, APS/CAN will be required every other year.** The next time the APS/CAN clearances are required is on 1.15.20 (year 3).
3. On 1.5.19 (year 2) - No clearances are required.
4. On 1.15.20 (year 3) - APS/CAN clearances and Certified e-Crim required.
5. On 1.15.21 (year 4) - No clearances required.
6. On 1.15.22 (year 5) - APS/CAN clearances and Certified e-Crim required.
7. On 1.15.23 (year 6) - No clearances required.
8. On 1.15.24 (year 7) - APS/CAN clearances and Certified e-Crim required.
9. On 1.15.25 (year 8) - No clearances required.

2.3 GENERAL SUPERVISION RESPONSIBILITIES

The Provider is responsible for the supervision activities of the service supervisor. The service supervisor is responsible for the staff's development to perform the work required and learn new skills to best support the participant to achieve his/her ISP goals.

A. Supervision Responsibilities

Service supervision practices include, but are not limited to, the following:

1. ensuring that the needs of each participant are matched with a direct support worker who has received training in the services to be provided to the participant and is knowledgeable about the needs and preferences of the participant;
2. ensuring that the place where the service is delivered is suitable to the activity and can physically accommodate the participant in a safe, comfortable manner, and that the participant's privacy and preferences are known to direct support workers and are respected;
3. performing face-to-face observation of services being delivered to participant;
4. coaching, modeling, teaching, demonstrating, and watching staff perform return demonstrations of approaches and strategies in the IP before the worker starts with the participant and on an ongoing basis; and
5. supervising at the intervals specified in the ISP or if not specified, at least monthly, either on a scheduled or non-scheduled basis.

Providers are strongly encouraged to implement best practice supervision to help direct support workers develop new skills, improve skills and problem-solve. Best practice supervision includes, but is not limited to:

1. meeting face-to-face with each worker implementing the IP on a monthly basis; and
2. varying the visits to observe workers at different times during the participant's scheduled hours, on weekdays, night-time, and weekends. For example: If a participant has PAB services in the family home in the morning and in the evening, the service supervisor should alternate observing morning and evening activities.

B. Documentation

Supervisory notes must be written for each worker's supervisory visit. At a minimum, the notes should address the following:

1. assessment of the quality of service implementation and activities as specified in the IP, with focus on how the worker implements the activities to reach outcomes;
2. the participant's response and progress toward achieving outcomes; such assessments must be documented in the participant's record;
3. each worker is trained in the manner and method of providing service to the participant before the direct support worker works independently with the participant;
4. each worker is made aware of all information from the participant's record that is essential for the direct support worker to work effectively and safely with the participant; and
5. identification of barriers to services and achieving outcomes including recommendations for IP interventions and/or discussions with the DOH-DDD CM and circle of support for IP revisions, as necessary.

2.4 MINIMUM DOCUMENTATION AND REPORTING REQUIREMENTS

A. Individual Plan Development and Updates

The Provider will develop an initial Individual Plan (IP) at, or within seven (7) calendar days of, the ISP meeting. The initial IP consists of the priority goals and outcomes based on the ISP with timeframes for achievement to be implemented. The Provider will then have thirty (30) calendar days to develop the detailed plans and approaches, methods, activities, and/or strategies to support the goals and outcomes.

1. The IP must:
 - a. be developed and must be approved by a service supervisor as defined in the Standards;
 - b. include the participant in the development as evidenced by the participant's signature, mark, or acknowledgement on the Provider sign-in (attendance) sheet;
 - c. include the DOH-DDD CM and members of the participant's circle of supports in its development,
 - d. be approved by the participant and/or legal guardian;

- e. include behavioral supports and any other applicable protocols, including medical protocols;
- f. meet the requirements as specified in the Medicaid I/DD Waiver Standards of each waiver service; and
- g. be written in terms easily understood by the participant, the primary caregiver, and direct support worker.

2. The Provider must assure that:

- a. direct support workers required to implement the IP are trained as identified in the Provider Qualifications;
- b. training is conducted prior to the implementation of the IP;
- c. training is documented;
- d. the participant or the participant's legal or designated representative and the DOH-DDD CM receive copies of the initial basic IP within seven (7) business days of its initiation and any subsequent revisions; and
- e. distribution of copies of the IP must be documented.

B. Reports to Case Manager

The Provider must review and report participant outcomes for each Medicaid I/DD Waiver service quarterly or more frequently as identified in the Standards or ISP. Services that are for an episode or ongoing technology supports are excluded from the quarterly reporting requirement. These services include: Assistive Technology, Personal Emergency Response System, Specialized Equipment and Supplies, Environmental Accessibility Adaptations, Vehicular Modifications, and Non-Medical Transportation.

Through on-site and regular reporting from the Provider, the DOH-DDD CM will monitor the following:

1. participant's progress in the achievement of priority goals and outcomes;
2. review of the Provider's supervision summary of participant progress or lack of towards outcomes identified in the IP, any significant events that may impact on the participant's progress and recommendations, if any;
3. data collection reflected by measurable outcomes and/or service delivery documentation;

4. on-site observation by the CMs at intervals specified in the P&P;
5. assessment of plans and approaches, methods, activities, and/or strategies to support the goals and outcomes;
6. evaluation of the progress or lack of to meet outcomes and recommendations for revisions, if necessary; and
7. participant satisfaction of services.

The following are report distribution requirements.

1. Provide copies of the reports to the DOH-DDD CM at frequency specified in the ISP or Action Plan.
2. Provide copies of the reports to the participant and the participant's legal or designated representative as requested.
3. Assure reports are completed and distributed thirty (30) calendar days after the end of the quarter or frequency identified in the service or ISP and/or Action Plan (for example, quarter ends on December 31, report is due on January 30).
4. Document the distribution of reports and the mode of distribution (fax, mail, and hand-delivery).

2.5 MAINTENANCE OF RECORDS

A. Participant Records

The Provider must maintain a confidential case file for each participant. The individual case file must include but is not limited to the following:

1. Emergency and personal identification information including, but not limited to, the following:
 - a. participant's address, telephone number;
 - b. names and telephone numbers of the family, licensed or certified care provider, relative, designated representative and/or guardian;
 - c. physician's name(s) and telephone number(s);
 - d. pharmacy name, address and telephone number if necessary to assure participant health and safety;

- e. health plan information;
 - f. participant's ISP and IP;
 - g. medical information, which must include, but is not limited to:
 - (1) medical orders as applicable for waiver services;
 - (2) precautions for participation in an activity;
 - (3) diagnoses or conditions;
 - (4) infections, contagious or communicable conditions;
 - (5) current medications;
 - (6) known allergies including food allergies;
 - (7) special health care needs such as aspiration precautions, fall precautions, and high risk for skin breakdown; and
 - (8) special nutritional needs, to include the specific diet order or limitations.
 - h. crisis contingency plan, if one is necessary, for the participant;
 - i. PBS plan, if one is necessary, for the participant;
 - j. documentation that the participant and/or family/guardian acknowledges that he/she has been informed of the participant's rights, responsibilities, and grievance procedures.
2. The Provider must maintain service delivery documentation, records and reports for all participants that include, at a minimum, the following:
- a. date, time (in and out), duration, and location of service delivery;
 - b. documentation of activities or type of service rendered during service delivery:
 - (1) progress notes, contact logs, attendance, medication administration records (s) and other service delivery documentation;

- (2) data collected that measures participant's progress in relation to the participant's IP objectives, if applicable; and
 - (3) documentation that minimum staffing ratios are maintained, when applicable.
 - c. name of worker providing services; and
 - d. date, time, location, name and title of supervisor conducting the required on-site supervision and/or telephone contacts.
3. The participant record is a legal document that must be kept in detail to permit effective professional review and provide information for necessary follow-up and care.
- a. Individual participant records must be kept in a manner that ensures legibility, order, timely signing and dating of each entry in black or blue ink.
 - b. Documentation of verbal or written reports and follow-up, as necessary, received from other agencies, the participant's family, the participant's legal, designated representative, or caregiver to determine whether action needs to be taken by the Provider.

B. Personnel Records

The Provider must maintain a personnel file for all staff (supervisors and direct support workers) providing services under the Medicaid I/DD Waiver that documents qualifications and employment/contractual requirements, as applicable. The files must be maintained in a current and organized manner. Qualifications and employment/contractual requirements must include, but are not limited to, the following:

1. current Hawai'i professional licenses, certificates, and liability insurance if applicable;
2. relevant education and/or work experience;
3. high school diploma or General Equivalency Diploma (GED). This requirement applies to all staff providing direct waiver services who are hired on and after July 1, 2017. Staff hired prior to this date are exempt from this requirement and personnel records do not need to contain the diploma or GED. For any staff who graduated from a secondary education program where a high school diploma is a pre-requisite, such as an associate's degree or a bachelor's degree, DOH-DDD will accept the copy

of the degree in lieu of the high school diploma or GED in the Provider's personnel record;

4. be at least 18 years of age;
5. be able to work in the United States;
6. current valid driver's license in accordance with Hawai'i state law and access to a vehicle if required as part of the staff duties. The vehicle must have current motor vehicle registration, safety check, and insurance;
7. current job descriptions. Additionally, the Provider must maintain an updated central file showing all the Direct Support Workers' and Service Supervisors' personnel qualifications;
8. the provision of an orientation to the Medicaid I/DD Waiver Services and job responsibilities; and
9. a signed statement, updated annually, indicating no history of any criminal conviction such as convictions of theft, abuse, neglect, or assault.

C. Availability of Records for Review

Providers must cooperate with the DOH-DDD and DHS-MQD, and the United States Department of Health and Human Services or their authorized representatives, when evaluations or reviews are conducted, both announced and unannounced, on the quality, adequacy, accuracy, and timeliness of services provided. The following pertain to evaluations or reviews:

1. The files must be maintained in a current and organized manner in order to be readily available to the waiver program monitors and/or fiscal monitors at the time of a site review or upon request of DOH-DDD. "Readily available" is defined as the duration of the on-site monitoring visit or if completed in DOH-DDD offices as a desk audit, by the due date for documentation to be submitted to DOH-DDD.
2. Evaluations or reviews may be in-person at the Provider agency's location or at the DOH-DDD offices (desk audit). The following may occur:
 - a. review of administrative, fiscal, program, quality assurance and personnel records;
 - b. review of participant's service delivery notes and records;
 - c. review of documentation of service delivery time and efforts for participants;

- d. observations of service delivery; and
 - e. interviews with participants, families, direct support workers and supervisors.
3. For desk audits at DOH-DDD, the Provider will submit copies of records or files by secured mail or encrypted electronic files. Originals will not be accepted.
 4. For fiscal monitoring, copies of corresponding ISP Action Plans and time sheets must be provided. The Provider will submit copies of records or files by secured mail or encrypted electronic files. Originals will not be accepted.
 5. For staff validation, the Provider must complete the Validation Worksheet and submit copies of all supporting documents. The Provider will submit copies of records by secured mail or encrypted electronic files. Originals will not be accepted.

2.6 PROVIDER QUALITY ASSURANCE PROCESS

All Providers must be responsible to document all quality assurance activities and will be subject to review and oversight by DOH-DDD.

A. Quality Assurance Process

1. In keeping with the Quality Management Strategy set forth by the Centers for Medicare and Medicaid Services (CMS), each Provider must have an internal quality management program to ensure discovery, remediation, and improvement.
 - a. Discovery processes involves collecting data and documentation of participant experiences (e.g., satisfaction survey/interview) to assess the ongoing implementation of the services and supports, identifying strengths and opportunities for improvement.
 - (1) Data sources must be identified, e.g., Adverse Event Reports, IP for service outcomes;
 - (2) Timelines for reviews must be identified, e.g., frequency of reviews;
 - (3) Person(s) responsible for reviews must be identified, e.g., staff, committee membership.

b. Remediation involves taking action to remedy specific problems or areas for improvement that arise.

- (1) Process of reviews and recommendations must be described;
- (2) Process for follow up of recommendations must be described;
- (3) Process for documentation of review, recommendations and follow up completed must be described;
- (4) Types of remediation must be identified; and
- (5) Trending analysis process must be described.

c. Continuous Improvement involves utilizing data and quality information to engage in actions that lead to continuous improvement of services and supports:

- (1) Quarterly reports are available for review by DOH-DDD
- (2) System improvement includes:
 - (a) issues resolved
 - (b) recommendations.

B. Provider Quality Management Program

The internal quality management program must describe the processes, policies and procedures for the focus areas:

1. Person centered planning and delivery

a. The Individual Plan (IP) for each service addresses goals and outcomes for which Provider services have been identified to meet, including the process for identifying and reviewing IPs that are not resulting in the desired outcomes, as well as the process for revising IPs where indicated and training staff to implement those IPs.

- b. Each service is delivered in accordance with the IP for the service, including type, scope, amount, duration, and frequency specified in the IP.
- c. The IP for each service aligns with participant's preferences, personal goals, needs and abilities, and health status.
- d. Participants have the authority and are supported to direct and manage their own service(s) to the extent they wish.
- e. Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in each IP for service(s), e.g., health status deteriorates, increased frequency of behaviors, outcomes met.

2. Provider Capacity and Capabilities

The Provider must:

- a. demonstrate that required licensure and/or certification standards are met and adheres to other standards prior to their furnishing waiver services.
- b. have policies and procedures to administer and implement the Medicaid I/DD Waiver.
- c. demonstrate that training is provided in accordance with State requirements and these Standards.
- d. demonstrate that direct support workers possess the requisite skills, competencies and qualifications to support participants effectively.
- e. demonstrate the ability to provide services and supports in an efficient and effective manner consistent with the IP(s) for service(s).
- f. track and analyze timeliness of verbal and written Adverse Event Reports (AER) and implements strategies for improvement when necessary.

3. Tracking of Workforce Development

- a. For participants with a formal BSP based on Functional Behavior Analysis (FBA), the Provider must track and review its progress

toward increasing its workforce of Registered Behavior Technicians (RBT).

- b. As part of the Quality Management Program, the Provider must analyze data to determine progress toward developing the workforce required to implement formal BSP. This includes status of employees working toward achieving RBT (not started, completing 40 hours of coursework, supervised competency work with Licensed Behavior Analyst, exam completion, and comments to explain status if needed); and supervising Licensed Behavior Analyst employed by or under contract with the agency.
- c. Reports must be made available to DOH-DDD upon request.

C. Provider Safety Measures

In addition to participant safeguards described in Section 1.7, the following safety measures for participants must be addressed by Providers.

1. Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence, and safety with the informed involvement of the participants.
2. There are systematic safeguards in place to protect participants from critical incidents and other life endangering situations.
3. Behavioral interventions are implemented according to approved behavioral support plans.
4. Medications are managed efficiently and appropriately in accordance with applicable State laws.
5. There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.
6. In situations where serious health and safety issues are identified through the AER process or other methods, wherein immediate correction is required to avoid imminent harm to participants, the Provider will complete an internal investigation and specify actions to be taken to prevent the situation from occurring again. DOH-DDD may request a copy of the internal investigation and remediation activities. DOH-DDD may also make recommendations for remediation based on the results of the internal investigation.

D. Provider Responsibilities for Informing Participants

Participants are informed and supported to freely exercise their fundamental constitutional and federal and state statutory rights. Participants must receive information that, at a minimum, includes the following:

1. Individual Rights and Protection (see Section 1.6);
2. the services to be provided by the Provider must be given to the participant prior to or at the time of service start date;
3. the Provider's P&P governing participant conduct;
4. how to freely exercise their Medicaid due process rights; and
5. how to register grievances and complaints and are supported in seeking their timely resolution.

E. Participant Outcomes and Satisfaction

Providers must institute a program of continuous quality improvement of their waiver services to measure if their waiver services are truly enhancing the lives of participants. In doing so, the following information is used to inform the Provider's quality assurance program:

1. Participants achieve desired (positive) outcomes.
2. Participants and their families/guardians, as appropriate, express satisfaction with their services and supports (i.e., surveys, face-to-face meetings)

2.7 BILLING AND CLAIMS PROCESSING

A. Billing for Claims

1. Medicaid I/DD Waiver Providers must bill claims to the DHS Fiscal Agent. Refer to Appendix 3, Assistance Directory, for contact information. Payment for services is based on compliance with billing protocols. Completed supporting documentation is required as proof of delivery of services.
2. Billing for Services with 15-minute Units:

One 15-minute unit is 8 or more minutes. To determine the number of units to bill, the Provider must aggregate the total time for the day and then round to the nearest number of 15-minute units. For example:

- a. If a participant's day starts at 9:52 AM and ends at 10:53 AM, the Provider delivered 61 minutes of service and would bill for four (4) units.
- b. If a participant receives services from 9:00 AM to 9:25 AM (25 minutes) and then from 3:00 PM to 3:25 PM (25 minutes) on the same day, the aggregate total would be 50 minutes, which would be rounded to three (3) units.

B. Claims Submission

1. Prior Written Authorization Required

- a. All approved Medicaid waiver services written into the ISP will be prior authorized by the DOH-DDD CM. The Provider must receive a prior authorization notice before the delivery of services. The lack of a prior authorization will result in a denied claim for payment.
- b. The prior authorization specifies the covered period of time in which to deliver services. When a direct support worker's shift will cover two authorization periods, the Provider must submit two claims, one for the portion of the shift that ends at 11:59 p.m. on the last day of the authorization period and a second claim for the portion of the shift that begins at 12:00 a.m. on the first day of the next authorization period.

For example, John is scheduled to work an overnight shift starting at 10 p.m. on September 30 that will extend into October 1. The participant's authorization period ends on September 30 and a new authorization period starts on October 1. The Provider must submit two claims: 1) September 30 for two hours (10 p.m. to 11:59 p.m.) and 2) October 1 for six hours (12 a.m. to 6 a.m.).

- c. The Provider must follow-up with the DOH-DDD CM if a prior authorization has not been received and the service is identified in the ISP.
- d. Prior authorization numbers are not required to be on the claim. However, the system will edit for a prior authorization. Any claim for service without a prior authorization will be denied.

2. Cost Share

If the cost share has been assigned to a Provider, the Provider will deduct the cost share amount from the claim.

3. Hard Copy Claims

Providers may submit either hard copy or electronic claims to the DHS Fiscal Agent. The following must be adhered to for submitting hard copy claims:

- a. the claim must be filed on a standard CMS 1500 form and within the existing claim line limitation;
- b. all required fields must be completed; and
- c. the form must be signed.

4. Electronic Submission of Claims

All claims submitted electronically must be submitted via a secure system that is tested and certified to be HIPAA compliant. Providers desiring to electronically submit HIPAA compliant claims should request an Electronic Claims Manual from the DHS Fiscal Agent. Alternatively, Providers may use the DHS Fiscal Agent's free software WinASAP to submit claims.

C. Timely Submission of Claims

All claims for payment of services must be submitted within twelve (12) months following the date the service was rendered (42 C.F.R. §447.45). Any claims beyond the 12-month filing period must be submitted with a waiver of filing deadline. Only situations with extenuating circumstances will be considered for a waiver. Extenuating circumstances include the following:

1. claims from third party,
2. court order, or
3. administrative hearing decision.

D. Claims Adjustment

Providers may file a claims adjustment or void previous claims:

1. Most adjustments and voids are to correct errors (procedure codes, participant I.D., dates, etc.) on previous claims.
2. Providers may also resubmit a denied claim.
3. Send hard copy adjustments to the DHS Fiscal Agent. For electronic filing, follow required procedures for adjusting or voiding a claim.

E. Pricing and Payment

All Medicaid waiver services are paid on an established rate schedule approved by CMS and DHS-MQD.

The Medicaid waiver payments are considered payment in full. No other costs can be billed to the participant or family except for Cost Share.

F. Editing Process

The claims system edits the claim in one process.

If the claim fails an edit or an audit, an error record is created. All failed claims are found in the Denied Claims section of the Remittance Advice. A description of the edit code is listed on the Processing Notes page of the Remittance Advice. Refer to the [Hawai'i Medicaid Provider Manual](#) for information on the [Remittance Advice](#).

G. Overpayments and Recoveries

Overpayments are recovered by the DOH-DDD for Medicaid waiver services through the DHS fiscal agent.

1. Overpayments discovered by the Provider must be reported immediately to the DOH-DDD.
2. If an overpayment is identified in a post payment review, the Provider will receive notification of the reason for the overpayment, the amount of the overpayment, and the action to be taken by the DOH-DDD.
3. The DOH-DDD reserves the right to adjust future claims for the overpayment or demand a refund from the Provider within 60 days.
4. If submitting a refund to the DOH-DDD for services, the Provider should contact the DHS Fiscal Agent for instructions.

H. Fiscal Appeals

Upon receiving notice of the denial of a written request to submit a claim, a Medicaid I/DD Waiver Provider can request from DHS a Fair Hearing in accordance with Title 11, Chapter 1, HAR.

Upon receiving notice of an overpayment, the Provider may choose to submit a written appeal request within 30 days from the date of the notification letter in accordance with HAR §17-1736-33. The following should be included with the written appeal:

1. All documents including the relevant Individualized Service Plan (ISP) and timesheets; and
2. Other written evidence that the Provider would like considered at the hearing.

Providers should submit written appeal requests, along with all documents to:

Administrative Appeals Office
Department of Human Services
P.O. Box 339
Honolulu, Hawai'i 96809

I. Remittance Advices

Each Remittance Advice is divided into five sections: 1) paid claims, 2) adjusted claims, 3) denied claims, 4) voided claims, and 5) claims in process. The last page of the Remittance Advice includes processing notes. Refer to the Hawai'i Medicaid Provider Manual for a listing of the codes.

J. Payment Schedule

1. Checks are generally mailed one week after processing the claim.
2. Providers may also choose to receive payment via electronic funds transfer (EFT). Contact the DHS Fiscal Agent for information on establishing EFT.
3. For any checks that are considered stale (dated beyond 180 days of check date) or lost, the Provider should contact the DHS Fiscal Agent for instructions for re-issue.

2.8 FISCAL ACCOUNTABILITY

A. Requirements

Providers must ensure that claims are made for services that have been rendered to eligible waiver participants, authorized in the ISP, and provided by qualified workers. Payment for waiver services is based on compliance with billing protocols. The following is required as proof of delivery of services:

1. Monthly verification of Medicaid eligibility of participants through DHS Med-QUEST phone or website;
2. All invoices are verified as correct;

3. Payment for services must only be made when the identical service is not authorized through the Medicaid State Plan, from start date of service provision by a Provider and must not include reimbursement for any Medicaid I/DD Waiver services while a participant is suspended from the Medicaid I/DD Waiver;
4. Claims are consistent with DOH-DDD prior authorizations and ISP and/or Action Plan for services under the Medicaid I/DD Waiver;
5. Reimbursement for services must not be provided prior to admission to the Medicaid I/DD Waiver; and
6. All claims must be traceable to documented and verified service delivery which includes, but are not limited to the following:
 - a. Participant name,
 - b. Date(s) of service,
 - c. Type of service (including staff to participant ratios),
 - d. Duration of delivery (time in and time out),
 - e. Name of direct support worker providing services, and
 - f. Name and signature of supervisor.

B. Independent Audits

Every Provider that receives \$750,000 or more in Medicaid funds during a year is required by the CMS-approved Medicaid I/DD Waiver, effective July 1, 2017, to perform an independent financial audit by a Certified Public Accountant (CPA) and submit the audit to the State for review. An independent financial audit means the audit is completed by a qualified professional that is not employed directly by the Provider.

1. Timelines:
 - a. By October 31 annually, Providers are required to self-identify that they are subject to the waiver requirement for independent audit described above and submit to DOH-DDD the following information: name of the firm or individual completing the audit,

contact information, and date the audit is expected to be submitted to DOH-DDD.

- b. By May 31 (five months after the end of the calendar year), the Provider must submit its audit to DOH-DDD. Any request for an extension of this date must be submitted in writing with justification for the extension request to DOH-DDD prior to the due date of May 31.
2. If inconsistencies are noted, the State will request additional information. The Provider will have 15 business days to submit the additional documentation.
 3. Failure to submit required independent audits by the due date will result in sanctions up to termination of the Medicaid Waiver Provider Agreement.

2.9 MONITORING PROVIDER AGENCIES

A. DOH-DDD Responsibilities

The DOH-DDD is responsible for monitoring compliance with the Waiver Standards Manual. The purpose of monitoring is to ensure that Providers of Medicaid I/DD Waiver services adhere to requirements of the 1915(c) waiver approved by CMS and the Waiver Standards Manual.

1. Program Monitoring
 - a. Notification of Scheduling and Sample
 - (1) DOH-DDD issues scheduling letters to Providers thirty (30) calendar days before the monitoring date. The scheduling letter includes the review date, review period and the required documentation for monitoring.
 - (2) The sample is determined by randomly selecting from a list of the total number of waiver participants served by each Provider.
 - b. Location and Approach

DOH-DDD determines the most efficient and effective manner to monitor Providers, which may include an on-site visit to complete record reviews at the Provider's main office; visits and observations of direct service delivery at the waiver participants'

location; surveys and interviews; and/or record reviews completed at DOH-DDD offices.

c. Frequency of Review

Monitoring will be conducted on an annual basis or more frequently as determined by DOH-DDD. The program monitoring period requires one year of program records. The program monitoring period will include a full twelve (12) month period that ends one (1) month prior to the monitoring date. For example, for a monitoring visit on January 24, 2017, records from January 2016 through December 2016 will be evaluated.

d. Required Documentation for Monitoring

- (1) Individualized Service Plan (ISP) and Individual Plan (IP)
- (2) Methods, plans and approaches (detailed strategies),
- (3) Evidence of DSW training,
- (4) Quarterly reports,
- (5) On-site supervision,
- (6) Adverse Event Reporting and internal quality assurance activities,
- (7) Behavior support plans (if applicable),
- (8) Contact logs,
- (9) Validation documents for staff qualifications, and
- (10) A copy of agency's current general liability insurance certificate and automobile insurance certificate covering your organization.

e. Findings

- (1) Results from the monitoring visit are issued to the Provider agency within thirty (30) calendar days after the final date of the review.
- (2) Findings, including the remediation required by Provider agencies through corrective action plans, are reported on the QA/I Provider Monitoring Tool (see Appendix 8A).

The monitoring tool is used as a data source for waiver performance measures. DHS-MQD tracks and reports these waiver performance measures to CMS.

2. Validation of Provider Staff Qualifications

The validation process begins at least one month prior to the program monitoring in order to give sufficient time to review staff qualification documents prior to the on-site monitoring visit. Provider qualification requirements are specified in Section 2.2 General Staff Requirements and service-specific qualifications are described in Section 3.

a. Notification of Scheduling and Sample

- (1) DOH-DDD issues a letter informing the Provider of the start of the fiscal year validation process. The Provider must submit a consolidated list of all employees providing waiver services within thirty (30) calendar days.
- (2) Once the consolidated employee list is received, DOH-DDD randomly selects a sample of direct support workers. The sample size for DSWs is a minimum of twenty (20) employees or ten percent (whichever is greater). The sample size for service supervisors and registered nurses is 100%.

b. Location and Approach

- (1) DOH-DDD notifies the Provider of the names of employees selected for the sample.
- (2) If the validation is completed at DOH-DDD offices, the Provider completes the spreadsheet and submits copies of all required documents within thirty (30) calendar days.
- (2) If the validation is completed during a monitoring site visit at the Provider's offices, the Provider will make all records available in an organized manner for DOH-DDD reviewers.

c. Frequency of Review

Validation of staff qualification requirements is conducted on an annual basis.

d. Required Documentation for Validation Review

The Provider must prepare all required documents for the sample. Required documentation is listed in Appendix 7A, Spreadsheet for Validation of New and Current Provider Staff.

e. Findings

Based on findings, DOH-DDD issues a letter to the Provider.

- (1) If all staff were validated, a letter indicating 100% compliance is sent to the Provider.
- (2) If documents were missing or incomplete, a letter documenting the outstanding validation issues is sent to the Provider. The Provider must respond within the timeline specified in the letter. Providers shall not permit any employee that is not in compliance with validation/certification requirements to work directly with waiver participants, unless under continuous line-of-sight supervision by a properly validated or certified staff. Continuous line-of-sight means the staff must be within eyesight and never left unattended with a participant until cleared to work by meeting all staff qualification requirements.
- (3) Findings, including the remediation required by Provider agencies through corrective action plans, are reported on the Staff Validation Tool. The tool is used as a data source for waiver performance measures. DHS-MQD tracks and reports these waiver performance measures to CMS.

3. Fiscal Monitoring

Fiscal records covering the fiscal audit period require three consecutive months of records. The fiscal audit period will begin 14 months prior and end 12 months prior to the monitoring date. For example, if the monitoring date is January 20, 2017, records for November 2015, December 2015 and January 2016 will be evaluated. The following are required documents for fiscal monitoring:

- a. Valid ISPs must cover the entire fiscal audit period. More than one ISP may be needed for a participant.
- b. Billing and Claims—timesheets, attendance sheets, and all other supporting documentation necessary to justify the service provided. It is necessary to fully disclose the type and extent of all services provided, which includes, but is not limited to the following:

- (1) participant name,
- (2) date(s) of service provided,
- (3) time of service provided (time in and time out),
- (4) name of direct support worker,
- (5) type and level of service, and
- (6) staff to participant ratio.

4. Special Monitoring Visits

Unannounced or short-notice visits may occur when the DOH-DDD monitoring team visits without providing the Provider agency with the typical two-day notice as required for annual monitoring Quality Assurance/Improvement reviews. Special monitoring visits are determined by a need identified by DOH-DDD, including but not limited to:

- a. issue(s) identified due to actions or inactions by a Provider;
- b. at the direction of the DD Division Administrator;
- c. in conjunction with Case Management Branch (CMB) if issues are related to Provider performance;
- d. new Providers to review for compliance with the Home and Community Based Settings final rule and Waiver Standards within the first year after enrolling as a Provider; and
- e. follow-up(s) on outstanding or recurrent areas requiring Corrective Action Plans.

B. Provider Responsibilities

Providers must prepare for monitoring visits by ensuring all records are readily available, current and organized.

1. Corrective Action Plan

When deficiencies identified on the monitoring tool are found, the DOH-DDD monitoring staff will issue the Provider a quality improvement action statement(s), through the monitoring report, to address the issues.

- a. The Provider will submit a corrective action plan (CAP) within 28 calendar days. DOH-DDD may specify immediate remediation with a due date that is earlier than 28 calendar days.
- b. The CAP must specify the action(s) to be taken, the responsible staff to implement and/or oversee the actions and timeline for remediation to be completed.
- c. Completion of the remediation in accordance with the Provider's CAP will be validated at the subsequent monitoring visit.
- d. If the Provider does not submit a CAP or if the Provider's CAP submission is not accepted, DOH-DDD will send follow-up correspondence and provide technical assistance.
- e. Failure by the Provider to submit a CAP that is accepted by DOH-DDD within timelines may result in sanctions imposed by DOH-DDD and DHS-MQD.

2. Remediation for HCBS Final Rule on Community Integration

Through its process of validation and monitoring of Providers, DOH-DDD will ensure that settings meet HCBS final rule requirements by maximizing opportunities for participants to have access to the benefits of community living and opportunities to receive services in the most integrated setting.

- a. Setting requirements include but are not limited to the following:
 - (1) The setting is integrated in and supports access to the greater community;
 - (2) The setting provides opportunities to seek employment and work in competitive integrated settings if Discovery and Career Planning and Individual Employment Supports services are part of the Provider's service array;
 - (3) The setting provides opportunities to engage in community life, and control personal resources; and
 - (4) The setting ensures the participant receives services in the community to the same degree of access as individuals not receiving Medicaid I/DD Waiver.
- b. A Provider that does not meet setting requirements will be notified in the validation tool results notice and/or the Provider monitoring tool of the need for remediation. DOH-DDD will make recommendations for remediation to meet setting requirements and give timelines for completion.

2.10 ACCOUNTABILITY AND SANCTIONS

In the event the Provider has gone through remediation activities, and continues to demonstrate a pattern of non-compliance with Waiver Standards for two or more consecutive years, the DOH-DDD is responsible for developing a specific process for working with the Provider to improve quality and performance through an Accountability Plan.

Depending on the type and severity of non-compliance, DOH-DDD can impose sanctions.

A. Accountability Activities

Providers under an Accountability Plan may be required to take additional actions to demonstrate progress toward and maintenance of compliance with Standards. Actions may include, but not be limited to:

1. increased frequency of supervision and oversight by the Provider over its staff to ensure that staff are delivering waiver services in accordance with Standards;
2. mandatory written status reports by the Provider and submitted to DOH-DDD at regular intervals specified;
3. re-training of staff in topics identified by DOH-DDD; and/or
4. mandatory Practice Improvement Project that the Provider must implement as part of its quality assurance program.

B. Sanctions

The Provider may be subject to sanctions based on a determination by DOH-DDD in consultation with DHS-MQD. DOH-DDD will assess the safety and well-being of the participants and the Provider's ability to provide services per the ISP and IP. Sanctions may include, but are not limited to:

1. DOH-DDD will initiate action to ensure the health, safety and well-being of the participants.
2. Heightened monitoring by DOH-DDD including a larger sample and/or more frequent scheduled or unannounced monitoring visits.
3. Suspension to admit new participants for services.

4. Termination of the Medicaid Provider Agreement. This sanction must be approved in advance by DHS-MQD and the letter of termination will be issued by DHS-MQD.

C. Appeal to DHS's Decision

In the event the Provider Agreement is terminated, the Provider may appeal the DHS-MQD decision following the procedures outlines in HAR, chapter 17-1736.





**SECTION 3:
SERVICE-SPECIFIC
PERFORMANCE STANDARDS**

These service standards will be used until the participant's ISP held in fiscal year 2018 (between July 1, 2017 and June 30, 2018). Once the ISP for the participant is held, use Standards B Service-Specific Performance Standards.

PHASE-IN FOR CHANGES TO SERVICES

The phase-in of the changes to services will occur during a three-year period.

Year 1 is state fiscal year 2018 (July 1, 2017 through June 30, 2018)

Year 2 is state fiscal year 2019 (July 1, 2018 through June 30, 2019)

Year 3 is state fiscal year 2020 (July 1, 2019 through June 30, 2020)

Participants have been grouped into cohorts to complete the Supports Intensity Scale (SIS) assessment. The SIS will be used to assign participants to a level of need and a corresponding rate tier for certain services. Adoption of the SIS will provide a more comprehensive assessment of individual needs and increase consistency across participants to ensure participants with similar needs are assigned to the appropriate level and have access to similar services. Participants will be reassessed with the SIS approximately every three years.

***Cohort 1** includes participants who live in a licensed or certified home. These participants will receive a SIS assessment prior to their ISP in Year 1 (July 1, 2017 through June 30, 2018).*

***Cohort 2** includes participants who live in a family home or their own home and who receive ADH services. These participants will receive a SIS assessment prior to their ISP in Year 2 (July 1, 2018 through June 30, 2019).*

***Cohort 3** includes all remaining participants. These participants will receive a SIS assessment prior to their ISP in Year 3 (July 1, 2019 through June 30, 2020).*

Two useful documents to understand the changes and timing of the phase-in are located in Appendix 14 and are also available on the DDD website at <http://health.hawaii.gov/ddd/>. These documents are:

- Highlights of Policy Changes Related to the I/DD Waiver Amendment and Rate Study
- Phase-In Timing for New Rates, by Services and ‘Cohort’

SECTION 3.1

ADULT DAY HEALTH (ADH)

FULL-DAY/HALF-DAY with CENTER-BASED/COMMUNITY BASED SERVICES (ENDS BY JUNE 30, 2018)

Waiver Standards Manual Version A reflects authorizations for ADH before the participant's ISP occurring on in Year 1 (between July 1, 2017 and June 30, 2018). After the participant's ISP in Year 1, use Waiver Standards Manual Version B.

Phase-in for new 15-minute billing codes: All ADH authorizations approved with the participant's ISP in Year 1 (between July 1, 2017 and June 30, 2018) will utilize 15-minute billing codes. Standards A reflects only the use of half-day and full-day ADH services that were in effect before July 1, 2017. The half-day/full-day authorizations will phase-out after the participants' next ISP in Year 1. During Year 1, ADH Providers will have some participants authorized for half-day/full-day billing codes (Standards A) and other participants moving to 15-minute billing codes (Standards B) throughout the year as ISPs occur. By June 30, 2018, all participants will have had their ISP and will be authorized to transition to 15-minute billing codes (Standards B).

Phase-in for Community Learning Services-Group (CLS-G): All ADH authorizations approved with the participant's ISP in Year 1 (between July 1, 2017 and June 30, 2018) will separate ADH services provided at the center from services provided in the community. Center-based services will continue to be authorized as ADH. Community-based services will be authorized as Community Learning Services-Group. This change is reflected in Standards B.

Phase- in for rate tiers that correspond to the SIS-based levels: Participants will be assigned to one of seven levels based on their SIS assessment. These levels will determine the rate tier for which the participant will be authorized. Individuals in SIS-based levels 1 and 2 will be assigned to rate tier 1, those in levels 3 and 4 will be assigned to rate tier 2, and those in levels 5, 6, and 7 will be assigned to rate tier 3. The timing of SIS assessments are based on a participant's 'cohort'.

Cohort 1 includes participants who live in a licensed or certified home. These participants will receive a SIS assessment prior to their ISP in Year 1 (July 1, 2017 through June 30, 2018). ADH authorizations with a start date in Year 1 will reflect the rate tier that corresponds to their SIS-based level.

Cohort 2 includes participants who live in a family home or their own home and who receive ADH services. In Year 1, the current ADH level will determine the rate tier (e.g., a participant with ADH Level 2 will be authorized in Year 1 for ADH tier 2) because the participant will not receive a SIS assessment until Year 2. These participants will receive a SIS assessment prior to their ISP in Year 2 (July 1, 2018 through June 30, 2019). ADH authorizations with a start date in Year 2 will reflect the rate tier that corresponds to their SIS-based level.

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| <p>SERVICE DESCRIPTION</p> | <p>Services generally furnished as specified in the Individualized Service Plan (ISP), in non-institutional, center-based and community-based settings, encompassing both health and social services needed to ensure the optimal functioning of the participant. The desired outcomes include measurable improvements in individual independence, increased participation in the community and other skill building that leads to increased community integration.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Activities include training in:</p> <ol style="list-style-type: none"> 1) activities of daily living (ADLs); 2) instrumental activities of daily living (IADLs); 3) communication; 4) social skills and interpersonal relationships; 5) choice making; 6) problem-solving; 7) teaching responsibility and teamwork; 8) mobility training to develop skills necessary to use public transportation for community integration; 9) other areas of training identified in the ISP, such as increasing community exploration that aids in the familiarity with and the use of community resources; and 10) training in acquiring, performing and becoming embedded in social valued roles. <p>Participants of retirement age (age 60 and older unless specified in the ISP with justification for someone younger than that age) may receive retirement supports to assist them in meaningful activities in their community, including altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior related activities in their communities.</p> <p>Each participant must complete an Interest Inventory (see Appendix 9A) when ADH services are initially authorized or for ongoing ADH services, at least a month prior to their ISP meeting. The Interest Inventory will be used to guide activities chosen by the participant to identify his or her social valued roles.</p> |
| <p>TRANSPORTATION</p> | <p>Transportation between the individual’s place of residence and the ADH setting will be provided as a component part of ADH services.</p> <p>Until the participant’s ISP during Year 1 that authorized the new service, Community Learning Services-Group, the ADH</p> |

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| | <p>Provider may also provide transportation to community settings during ADH attendance. The time spent transporting to community settings during ADH program times is billable. After the participant’s ISP in Year 1 when CLS-G is authorized, the ADH Provider cannot bill for transportation to community settings using the ADH billing code (Standards B).</p> <p>Transporting the participants to and from their home and waiting with a participant to be picked up shall not be included in the calculation of billable ADH service delivery time. Staff and other costs associated with transporting participants to and from their home, the time spent waiting for participants to be dropped off, and the time spent waiting with participants to be picked up are included in the ADH rate.</p> |
| <p>LEVELS OF SERVICE</p> | <p><i>For authorizations approved prior to July 1, 2017, the current use of levels of ADH services will continue. By June 30, 2018, ADH levels will not be in use. See Waiver Standards Manual B for tiers.</i></p> <p>There are three levels of ADH services, based on the participant’s need for staffing supports during a typical day and as specified in the ISP. The level of ADH must correlate to the staff to participant ratio needs and guidelines as follows:</p> <p>ADH LEVEL 1 ADH Level 1 may include participants who benefit from support to contribute, participate, and become valued community members while developing a wide range of relationships. ADH Level 1 does not include plans with nurse-delegated tasks or formal behavioral supports.</p> <p>ADH LEVEL 2 ADH Level 2 may include participants who require a smaller staff to participant ratio than ADH Level 1 and/or the ISP specifies the delivery of nurse-delegated tasks and/or behavioral supports.</p> <ol style="list-style-type: none"> 1) Increased support needs because of the participant’s need for instruction within a smaller group or because of participant’s inability to self-preserve, dependence on a device for mobility (i.e. wheelchair) and assistance with transfers and positioning; |

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| | <p>2) Behavioral supports including simple behavioral interventions but may not need intensive behavioral interventions such as a formal Behavior Support Plan (BSP) per Functional Behavior Assessment (FBA) or participants with ICAP scores of -34 to -70; or</p> <p>3) Health needs requiring nurse-delegated tasks as described in Section 1.7, E.</p> <p>ADH LEVEL 3 ADH Level 3 may include participants who can benefit from being with a group but may need periodic 1:1 intervention and participants with, but not limited to, the following medical or behavioral needs:</p> <ol style="list-style-type: none"> 1) Unstable respiratory status requiring continuous nursing assessment and care skills. This includes oxygen, suctioning, updraft treatments, chest percussion and proper positioning. The participant may have a tracheotomy and/or a history of respiratory failure; 2) Administration of multiple medications and respective assessment of response status; 3) Insulin-dependent diabetes and/or with fragile diabetes with unstable blood sugars; 4) Congestive heart failure, arrhythmia or a history of cardiac failure; 5) Nasogastric (NG) and gastrostomy tube feedings with history of aspiration and complicating factors such as tube medication administration, stoma site assessment, or frequent dressing changes; or 6) ICAP maladaptive scores from -34 and above and requires intense interventions to address significant challenging behaviors that pose a danger to self, others, and/or property. Baseline data on target behaviors, a Functional Behavior Analysis, and a current Positive Behavior Support Plan are required. |
| LIMITS | Limit on amount of ADH is determined through the ISP and authorized by the DOH-DDD Case Manager. |
| ACTIVITIES NOT ALLOWED | ADH must not duplicate services provided as Discovery and Career Planning or Individual Employment Supports. ADH excludes: <ol style="list-style-type: none"> 1) any time spent by the participant working for pay, including contracts, enclaves, groups or individual employment, regardless of the wage paid. Paid work |

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| | <p>requiring job supports is included in Individual Employment Supports; or</p> <p>2) supporting participants who independently perform activities that benefit the Provider or its staff, such as performing services that would otherwise require the Provider or its staff to pay for that service, such as landscaping, yard work, painting and housecleaning. This includes “volunteering” at the ADH center site. Volunteer or internship experiences are included in Discovery & Career Planning.</p> <p>NOTE: This does not include routine chores and activities that participants engage in to maintain their common areas, practice responsibility and teamwork.</p> <p>A Provider shall not bill for ADH services that occur at the same time (same 15-minute period) as another face-to-face service, including Personal Assistance/ Habilitation (PAB), Skilled Nursing, Respite, Discovery & Career Planning and Individual Employment Supports-Job Coaching.</p> <p>NOTE: ADH can be billed for the same 15-minute period with Individual Employment Support – Job Development because job development is not always a face-to-face service.</p> <p>Services must not duplicate services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations.</p> <p>Personal care/assistance may be a component part of ADH services as necessary to meet the needs of a participant but may not comprise the entirety of the service.</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Effective July 1, 2017, the ratios for ADH services change for all participants.</p> <p>The recommended staffing ratios during center-based ADH services are:</p> <p>Level 1: one (1) staff to six (6) participants Level 2: one (1) staff to four (4) participants Level 3: one (1) staff to three (3) participants</p> |

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| | <p>For monitoring conducted by DOH-DDD, the ADH Provider must maintain documentation that the staff to participant ratio is no more than 1:6 during center-based ADH services unless otherwise specified in the participant’s ISP.</p> <p>Effective July 1, 2017, the recommended staffing ratios during community-based ADH services are: Level 1: one (1) staff to three (3) participants Level 2: one (1) staff to two (2) participants Level 3: two (2) staff to three (3) participants</p> <p>For monitoring conducted by DOH-DDD, the ADH Provider must maintain documentation that the staff to participant ratio is no more than 1:3 during community-based ADH services unless otherwise specified in the participant’s ISP.</p> <p><i>NOTE: With the participant’s ISP in Year 1 (between June 1, 2017 and June 30, 2018), community-based ADH will end and be replaced by Community Learning Services – Group (CLS-G).</i></p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Direct Support Worker (DSW) (Column B)</p> <p>Registered Behavior Technician (RBT) (Column B)</p> <p>Licensed Practical Nurse (LPN) (Column F)</p> | <p><i>NOTE: For authorizations approved prior to July 1, 2017, the current use of levels of ADH services and the corresponding provider staff qualifications will continue until the participant’s ISP in Year 1 (July 1, 2017 through June 30, 2018). By June 30, 2018, ADH levels will not be in use and provider staff qualifications will change. See Waiver Standards Manual B for tiers, provider staff qualifications and service supervision qualifications.</i></p> <p>ADH LEVEL 1: DSW that meets General Standards.</p> <p>ADH LEVEL 2 (FOR NURSE-DELEGATED ACTIVITIES): DSW that meets General Standards and completion of specialized face-to-face training on the specific tasks to be performed. Training must be provided by the Registered Nurse (RN) delegating the task(s).</p> <p>ADH LEVEL 2 (OTHER SUPPORTS, NO NURSE-DELEGATED ACTIVITIES): 1) DSW that meets General Standards and completes face-to-face training to implement the Individual Plan based on the ISP, including positive behavior support approaches, if applicable.</p> |

2) If the ADH Level 2 service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA),

a) the DSW must complete:

- specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and
- training in the implementation of the BSP.

b) if the worker is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.

Training(s) for meeting the requirements of 2a) and 2b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.

c) for both DSW or RBT that are implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*.

ADH LEVEL 3 (INTENSIVE SUPPORT NEEDS - BEHAVIORAL):

In addition to meeting General Standards,

a) the DSW must complete:

- specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and
- training in the implementation of the BSP; or

b) if the worker is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.

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| | <p>Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.</p> <p>c) for both DSW or RBT that are implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 <i>Positive Behavior Supports</i> and #2.02 <i>Restrictive Interventions</i>.</p> <p>ADH LEVEL 3 (INTENSIVE SUPPORT NEEDS – MEDICAL):</p> <ol style="list-style-type: none"> 1) Licensed Practical Nurse (LPN) in accordance with Hawai'i state law; or 2) DSW that meets General Standards and completion of specialized face-to-face training on the specific tasks to be performed. Training must be provided by the Registered Nurse (RN) delegating the task(s). |
| <p>SUPERVISION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Service Supervisor (Column A)</p> <p>Registered Nurse (Column E)</p> | <p><i>NOTE: For authorizations approved prior to July 1, 2017, the current use of levels of ADH services and the corresponding service supervisor qualifications will continue until the participant's ISP during Year 1 (between July 1, 2017 and June 30, 2018). By June 30, 2018, ADH levels will not be in use. See Waiver Standards Manual B for tiers.</i></p> <p>ADH LEVEL 1:</p> <p>Service supervisor that meets all General Standards. No additional qualification standards required.</p> <p>ADH LEVEL 2 (FOR NURSE-DELEGATED ACTIVITIES):</p> <p>Registered Nurse (RN) in accordance with Hawai'i state law who is delegating the task(s).</p> <p>ADH LEVEL 2 (OTHER SUPPORTS, NO NURSE-DELEGATED ACTIVITIES):</p> <ol style="list-style-type: none"> 1) Service supervisor that meets General Standards and possesses specialized training, if applicable, in positive behavior supports. |

2) If the ADH Level 2 services includes implementation of a formal BSP based on a FBA, in addition to General Standards,

a) the service supervisor must also complete:

- specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and
- face-to-face training in the implementation of the BSP; or

b) the service supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/service supervisor must complete face-to-face training in the implementation of the BSP.

Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.

c) whether the service supervisor is qualified under a) or b), the service supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*.

It is recommended that the service supervisor for a participant's plan that includes BSP interventions obtain RBT certification. Note that the RBT does not permit the supervisor to oversee the BSP; however, the RBT training enables the service supervisor to have a standard base of knowledge.

ADH LEVEL 3 (INTENSIVE SUPPORT NEEDS - BEHAVIORAL):

The service supervisor meets General Standards and:

a) the service supervisor must also complete:

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| | <ul style="list-style-type: none"> • specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and • face-to-face training in the implementation of the BSP; or <p>b) the service supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/service supervisor must complete face-to-face training in the implementation of the BSP.</p> <p>Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.</p> <p>c) whether the service supervisor is qualified under a) or b), the service supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 <i>Positive Behavior Supports</i> and #2.02 <i>Restrictive Interventions</i>.</p> <p>It is recommended that the service supervisor for a participant's plan that includes BSP interventions obtain RBT certification. Note that the RBT does not permit the supervisor to oversee the BSP; however, the RBT training enables the service supervisor to have a standard base of knowledge.</p> <p>ADH LEVEL 3 (INTENSIVE SUPPORT NEEDS – MEDICAL):</p> <p>Registered Nurse (RN) in accordance with Hawai'i state law who is delegating the task(s).</p> |
| AUTHORIZATION | <p>The participant's ISP may include a combination of Adult Day Health, Discovery & Career Planning, and Individual Employment Supports. <i>At the participant's ISP in Year 1 (between July 1, 2017 and June 30, 2018), Community Learning Services - Group will be authorized for community-based activities delivered by the ADH provider (See Standards B).</i></p> |

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| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <ol style="list-style-type: none"> 1) ADH providers must maintain documentation for each participant’s Interest Inventory (see Appendix 9A), including the date the Inventory was completed; how the interests were identified; the social valued role(s) chosen by the participant; how the identified social valued role(s) promote positive recognition; frequency of community engagement with individuals who do not have disabilities and who are not paid staff; and how the activity relates to the participant’s interests. The Interest Inventory must be updated at least annually or more frequently as new interests are identified. 2) The IP for ADH must have measureable and observable goals based on the ISP and/or Action Plan that are clearly defined and able to be implemented by the DSW. 3) When additional training is required by Provider Qualifications and Supervision Standards, the Provider must maintain documentation of all face-to-face training(s) of the BSP conducted by the licensed professional or qualified designee for the DSW, RBT, and service supervisor(s). Documentation must be available for review by DOH-DDD upon request. 4) When additional training is required by Provider Qualifications and Supervision Standards, the Provider must maintain documentation for the DSW, RBT, and service supervisor(s) of completion of comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 for <i>Restrictive Interventions</i>. |
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OPERATIONAL GUIDELINES:

Additional tools and resources for ADH are located in Appendix 9B.

HOURS OF OPERATION

Note: all ADH services will change to 15 minute units in fiscal year 2018 (July 1, 2017 – June 30, 2018) based on the participant’s ISP date:

For service authorizations prior to July 1, 2017, the ADH provider must continue to use the half-day/full-day billing requirements.

As specified in the ISP, a participant may receive ADH services on a full-day or half-day basis.

1. Full-day ADH services are provided for six (6) hours per day on a regularly scheduled basis for one (1) or more days per week;
2. Half-day ADH services are provided for at least three (3) but less than six (6) hours of service per day on a regularly scheduled basis for one (1) or more days per week.
3. ADH services of fewer than three (3) hours in a day cannot be billed.

Full-day or half-day ADH services that were authorized prior to July 1, 2017 using the daily billing codes will not be amended. ADH services authorized at the participant's ISP on and after July 1, 2017 will be authorized using the 15-minute billing codes.

Further guidance on limits for ADH services and coordination with Community Learning Services-Group is located in Waiver Standards Manual Version B.

AVAILABILITY OF SERVICE SUPERVISOR:

The provider must have the qualified supervisor immediately accessible and available for participants with medical needs, as necessary:

1. Immediately accessible is defined as having phone communication and protocol in place for ADH Level 2 and 3 (Nurse-Delegated).
2. Immediately available is defined as an RN being designated as standby or on call for the applicable Level 2 and Level 3 ADH service;
3. In the event the participant is off-site, a crisis contingency plan must be in place for any behavioral or medical/health needs of participants.

FREQUENCY OF SUPERVISION:

On-site supervision must be conducted monthly or more frequently as identified in the ISP and/or Action Plan.

LOCATION OF SERVICES:

Individuals participate in structured age-relevant activities in a variety of settings other than their private residence. If the ADH program is center-based, ADH services must not limit participants to activities only provided at the center or to activities away from the center that are not chosen by the individual. ADH services provide supports for participants to explore and engage in their communities, pursue activities and build relationships with members of their communities who share common interests and friendships and who are not paid to provide supports.

The provider must assure that the ADH site:

1. is clean, ventilated, and equipped with proper lighting, addresses physical safety and has adequate space for the participants served;
2. is equipped with fire extinguishers that are inspected and certified annually by a licensed sales or service representative;
3. has smoke alarms that are inspected annually;
4. has a fire safety inspection conducted annually by the fire marshal or designated county fire official for each site; or the request for an annual fire safety inspection must be

- documented including the efforts made by the ADH provider to secure the annual fire inspection;
5. conducts semi-annual fire drills at random times and documents fire drill outcomes, problems, and corrective actions;
 6. provides safe and secure storage of materials with appropriate labels for:
 - a. hazardous materials such as toxic substances and cleaning supplies;
 - b. medication; and
 - c. sharp containers and the disposal of sharp material;
 7. provides a secure space for each participant to keep personal items;
 8. addresses requirements for compliance with the CMS HCBS final rule on community integration.

INTERFACE WITH TRAINING AND CONSULTATION:

Training and Consultation (T&C) – Behavior Analysis: For participants who have a formal behavior support plan (BSP) based on functional behavior assessment (FBA) that is implemented during the provider’s combined authorization of ADH and CLS-G service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with ADH because the qualified T&C professional will train ADH staff implementing the BSP.

T&C – Registered Nurse (T&C-RN): For participants who require nurse-delegated tasks to be completed during the provider’s combined authorization of ADH and CLS-G service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with ADH because the qualified T&C professional will train ADH staff doing nurse-delegated tasks.

The provider must work closely with the T&C provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.

NOTE: T&C does not replace the ADH service supervisor’s responsibilities.

MEALS:

Effective July 1, 2017, meals are not required to be provided by the ADH program. Participants may bring their lunch from home or the ADH program will work with participants, families and caregivers who want to purchase meals for a reasonable cost. Providers shall not require the participant to purchase lunch as a condition of participation in the ADH.

REQUIREMENTS FOR HCBS FINAL RULE ON COMMUNITY INTEGRATION:

For ADH providers that were operating ADH programs prior to March 2014, the setting(s) must be in compliance or working toward compliance as part of the *My Choice My Way* state transition plan. For settings not fully compliant, the provider must complete a corrective action plan (CAP) based on the validation completed by DOH-DDD and DHS-MQD. Upon approval of the CAP by DOH-DDD, the provider will implement the activities needed to achieve compliance with the *My Choice My Way* plan. Monitoring visits conducted by DOH-DDD will review the provider’s progress toward reaching the milestones approved in the CAP. All settings must be in full compliance no later than December 31, 2021.

Any ADH providers approved after July 1, 2016 must be in full compliance with the HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings.. DOH-DDD will complete a site visit prior to approving the service by the new provider and at least one unannounced visit during the first year of operation to ensure compliance is maintained.

If an existing provider opens a new setting (location) on or after July 1, 2016, it must meet and be able to maintain all requirements of the HCBS final rule prior to the delivery of waiver services. There is no transition period for a new setting opened by an existing provider. DOH-DDD will complete a site visit prior to approving the service in the new location.



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| SERVICE DESCRIPTION | <p>Assistive technology includes items, devices, pieces of equipment, or product systems, whether acquired commercially, modified or customized, that are used to increase, maintain, or improve functional capabilities of participants.</p> <p>The assistive technology must be for the use of the participant and necessary as specified in the ISP to assist the participant in achieving identified measurable goals, must have high potential to increase autonomy and reduce the need for physical assistance, and must be the most cost effective option.</p> <p>All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai'i state law. An order is valid for one year from the date it was signed.</p> |
| REIMBURSABLE ACTIVITIES | <p>Assistive technology includes:</p> <ol style="list-style-type: none"> 1) assisting the participant to select, purchase, lease, or acquire assistive technology devices; 2) designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; and 3) coordinating with the DOH-DDD Case Manager to obtain any necessary therapies, interventions, or services with assistive technology devices. |
| TRANSPORTATION | Not included in this service |
| LEVELS OF SERVICE | Not applicable for this service |
| LIMITS | <p>Commercially-available technology such as tablets and software applications are available only for the purposes of communication.</p> <p>Replacement of AT may be made when an assessment determines that it is more cost-effective to replace rather than repair the item and must not occur more frequently than once a year for low-technology AT or once every two years for customized, adapted or higher-technology AT. Low-technology AT means a commercially available item or device that can be used by the participant “off the shelf” and/or items that cost less than \$500.00. Higher-technology AT means an item or a device that may require customizing or adapting after purchase to meet the participant’s unique needs and/or costs more than \$500.00.</p> |

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| <p>ACTIVITIES NOT ALLOWED</p> | <p>The purchase, training and upkeep of service animals are excluded. Internet service, laptops, personal computers and cell phones are excluded.</p> <p>Assistive Technology purchased through the waiver is not intended to replace devices and services under the State Plan. Assistive Technology that can be covered under the State Plan are provided through the QUEST Integration health plans, including Early Periodic Screening Diagnosis and Treatment (EPSDT) or through another program such as the Department of Education or Division of Vocational Rehabilitation.</p> <p>Assessment and training are excluded from this service and are covered under Training and Consultation (T&C).</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Not applicable for this service.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Vendor (Column H)</p> | <p>Assistive Technology can be provided by either of the following:</p> <ol style="list-style-type: none"> 1) Waiver Provider approved by DOH-DDD to deliver AT. 2) Vendor that meets applicable state licensure, registration, and certification requirements (be authorized by the manufacturer to sell, install, and/or repair equipment if applicable and ensure that all items meet applicable standards for manufacture, design, and installation). |
| <p>SUPERVISION STANDARDS</p> | <p>No additional supervision required once the AT is in use by the participant and training has been completed.</p> |
| <p>AUTHORIZATION</p> | <p>The Case Manager with approval of Unit Supervisor and Section Supervisor authorizes the AT.</p> |
| <p>ENDING SERVICE AUTHORIZATION</p> | <p>This is a one-time purchase and the service ends once the participant has received the AT and training has been completed.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <p>Documentation is maintained in the file of each participant that the AT is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the AT would have been covered but the plan rules were not followed, the AT must not be purchased using waiver funds.</p> |

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| | Documentation is maintained in the participant’s file of the date the AT is received, the date(s) that the participant and others have been trained in its use, and signature(s) of the participant/family affirming that the AT meets the participant’s needs. |
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OPERATIONAL GUIDELINES:

LOCATION OF SERVICES: Assistive Technology will be used by the participant in locations that are customary to the participant.

INTERFACE WITH TRAINING AND CONSULTATION:

Training and Consultation (T&C) – OT, PT, Speech or Environmental Accessibility Adaptation Clinician: The assessment of the need for Assistive Technology is completed by a qualified T&C professional. Assessments for Assistive Technology cannot be bundled with an assessment for Specialized Medical Equipment or Environmental Accessibility Adaptations, which must be authorized separately by the DOH-DDD CM. The participant must be offered a choice of providers and can select a different qualified provider for the assessment and/or training needed for the Assistive Technology. The T&C professional must not have any conflict of interest with any vendor or business that provides the Assistive Technology.

The AT provider must work closely with the T&C provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.

PROCESS FOR PURCHASING ASSISTIVE TECHNOLOGY:

1. CM receives the request for AT.
2. CM refers to T&C provider for assessment.
3. Assessment is completed by a qualified T&C professional to justify the need.
4. CM verifies that AT is not available through other sources, including another program or funding source such as DOE, DVR, QUEST Integration, EPSDT, or other insurance.
5. CM identifies a provider agency or vendor authorized to provide Assistive Technology.
6. T&C professional that completed the assessment submits written attestation that there is no conflict of interest with the provider of the Assistive Technology device.
7. DOH-DDD follows the State of Hawai‘i procurement rules.
8. Provider agency or vendor purchases the device for participant and ensures it is delivered to the home.
9. T&C professional trains the participant and family, caregivers and/or staff on the use of the device.

SECTION 3.3

CHORE

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| <p>SERVICE DESCRIPTION</p> | <p>Services to maintain the home as a clean, sanitary and safe environment in order to ensure the participant’s health and welfare.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>This service includes heavy household chores such as</p> <ol style="list-style-type: none"> 1) washing floors, windows and walls, 2) tacking down loose rugs and tiles, and 3) moving heavy items of furniture, in order to provide safe access and egress. <p>This service also includes more routine or regular services such as meal preparation and routine household care for the participant only.</p> <p>Chore services may be provided without the participant present at the time of service delivery.</p> |
| <p>TRANSPORTATION</p> | <p>Not included in this service</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable for this service</p> |
| <p>LIMITS</p> | <p>These services are available to participants living in their own place of residence who need Chore services and are without natural (non-paid) supports or who are living with family but the members of the household are physically unable to perform the chores.</p> <p>Routine or regular services are provided for the participant only.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>Chore services must not be authorized for participants who live independently or with family where either the participant or family in the family home are able to perform this service.</p> <p>Chore services must not be provided in licensed or certified care settings.</p> <p>Chore services provided in the family home must not include house maintenance such as yard work, house painting, and minor repairs. For participants living independently in their own home, such basic maintenance chore services may be considered on a case-by-case basis.</p> <p>Chore services must not be provided to minor children Chore services must not be provided by the participant’s spouse.</p> |

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| | Chore services does not include meal preparation and routine household care for other members of the household. |
| STAFF TO PARTICIPANT RATIO | If more than one participant live in the same home and are receiving Chore, the number of authorized units will be divided between the participants. For example, if four hours of Chore are authorized for two participants living together, Chore would be authorized for two hours for each participant, totaling four hours of Chore in the home. |
| PROVIDER QUALIFICATION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) DSW – Agency (Column B) | The Direct Support Worker (DSW) must meet General Standards. |
| PROVIDER QUALIFICATION STANDARDS FOR CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) DSW – Consumer-Directed Employee (Column D) | The DSW who is a consumer-directed employee must meet General Standards. |
| SUPERVISION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) Service Supervisor - Agency (Column A) | The Service supervisor must meets General Standards. |
| SUPERVISION STANDARDS FOR CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) | For consumer-directed Chore, the employer supervises the employee(s). |

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| Employer – Consumer-Directed | |
| AUTHORIZATION | The CM authorizes Chore in the ISP. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | Documentation must indicate that no other party is capable of and responsible for providing chore services, including the participant, anyone else financially providing for the participant. |

OPERATIONAL GUIDELINES:

LOCATION OF SERVICES:

Chore services must be provided in the participant’s own home or home of family member where the participant resides.

FREQUENCY OF SUPERVISION:

1. On-site supervision of services being delivered to participant must be conducted quarterly or more frequently if indicated in the ISP and/or Action Plan.
2. On-site supervision of Chore services must consist of verification of service completion and participant satisfaction as documented in the quarterly report to the DOH-DDD Case Manager.

SECTION 3.4

DISCOVERY & CAREER PLANNING (DCP)

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| <p>SERVICE DESCRIPTION</p> | <p>Discovery & Career Planning (DCP) combines elements of traditional prevocational services with career planning in order to provide supports that the participant may use to develop skills and interests toward becoming employed for the first time or at different stages of the participant’s work career to develop skills and interests for advancement or a change in the participant’s career plan.</p> <p>DCP is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on an individual's strengths, abilities and interests.</p> <p>This service is designed to assist participants to:</p> <ol style="list-style-type: none"> 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities. <p>The outcome of DCP services is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated employment or be self-employed.</p> <p>The provision of DCP is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.</p> <p>DCP does not duplicate services provided by the Division of Vocational Rehabilitation.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>All DCP activities billed are for face-to-face contact between the participant and provider.</p> <p>Discovery and Career Planning services are time-limited activities that include the following:</p> <ul style="list-style-type: none"> exploring employment goals and interest to identify a career direction; community-based formal or informal situational assessments; task analysis activities; |

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| | <p>mobility training to be able to use fixed route and/or paratransit public transportation as independently as possible;</p> <p>skills training/ mentoring, work trials, apprenticeships, internships, and volunteer experiences;</p> <p>training in communication with supervisors, co-workers and customers; generally accepted workplace conduct and attire; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and other skills as identified through the person-centered planning process;</p> <p>broad career exploration and self-discovery resulting in targeted employment opportunities including activities such as job shadowing, information interviews and other integrated worksite based opportunities;</p> <p>interviewing, video resumes and other job-seeking activities;</p> <p>transitioning the participant into employment supports for individualized competitive integrated employment or self-employment from:</p> <ul style="list-style-type: none"> a) volunteer work, apprenticeships, internships or work trials; b) from a job that pays less than minimum wage; and c) from a more segregated setting or group employment situation; <p>10) financial literacy (including benefits counseling and planning), budgeting, credit, debt, savings, donating and investing;</p> <p>11) when assisting a participant who is already employed, activities to support the participant in exploring other careers or opportunities; and</p> <p>12) transporting the participant to and from DCP experiences is billable under DCP.</p> |
| TRANSPORTATION | <p>Transportation to and from activities will be provided or arranged by the provider and is included in the rate paid for the service.</p> <p>The provider must use the mode of transportation that achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate.</p> |
| LEVELS OF SERVICE | Not applicable for this service |
| LIMITS | Personal care/assistance may be a component of DCP services, but does not comprise the entirety of the service. |

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| | <p>Discovery & Career Planning (DCP) services are limited to a maximum of 24 months of cumulative DCP with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-employed. A month of DCP means a calendar month in which one or more units of DCP is provided.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>DCP are not intended to teach the participant task specific skills to perform a particular job. This is provided through Individual Employment Supports.</p> <p>DCP services must not be provided at the same time (same hour) as another face-to-face service, such as Personal Assistance/ Habilitation (PAB), Adult Day Health (ADH), Individual Employment Supports – Job Coaching or Respite.</p> <p>Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations.</p> <p>DCP excludes:</p> <ol style="list-style-type: none"> 1) providing vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered workshops and contract work at less than minimum wage; 2) payments that are passed through to users of DCP, including payments of wages or stipends for internships or work experience; 3) paying employers incentives to encourage or subsidize the employer’s participation in internships or apprenticeships; 4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay (“volunteering”) that benefit the waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed, such as landscaping, painting, or housecleaning; 5) supporting any activities that involve payment of sub-minimum wage; and 6) offering services in settings that do not meet the criteria included in the service definition. |

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| <p>STAFF TO PARTICIPANT RATIO</p> | <p>The ratio is one (1) DCP staff to one (1) participant.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Employment Specialist (Column C)</p> <p>Employment Technician (Column B)</p> <p>Benefits Counselor: (Column G)</p> | <p>Providers of employment services must have at least one Employment Specialist or Service Supervisor who is a Certified Employment Service Professional by June 30, 2020.</p> <p>Employment Specialist must meet General Standards and have the knowledge and competency to deliver quality employment services to assist job seekers with I/DD in acquiring competitive integrated employment.</p> <p>An Employment Specialist also acting as a Service Supervisor must have a Bachelor’s Degree.</p> <p>Employment specialist will have specialized training and demonstrated competency in the all of the following areas:</p> <ul style="list-style-type: none"> a) Application of core values and principle in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/ career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, work impact on benefits, accommodation plan, and transition to work models. c) Community research and job development: knowledge to prepare marketing approaches and materials for job developer and job seeker (brochures, resumes, profiles and materials, planning job seeker involvement and decision making, assistance with disclosure and accommodations requests, networking, development of skills for outreach and interactions with employers to explore their needs, as well as conducting community research including labor market information, range of employers in the area and information on specific employers or industries. d) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, ongoing supports and funding, access to resources needed for long-term employment, opportunity for career advancement, transportation planning, ensuring work is well integrated into life activities and supports. <p>Employment Specialists are required to complete specialized training in implementing the DCP pathway within the first</p> |

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| | <p>two years of hire. Specialized training may be completed either by completing an Association of Community Rehabilitation Educators (ACRE) certified Customized Employment curricula, or completing training through the DOH-DDD Discovery Community of Practice.</p> <p>Employment Technician must meet General Standards and have the knowledge and competency to provide quality employment services to job seekers with I/DD in maintaining competitive integrated employment.</p> <p>Employment Technician will have specialized training and demonstrated competency in the following areas:</p> <ul style="list-style-type: none"> a) Application of core values and principle in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/ career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, work impact on benefits, accommodation plan, and transition to work models. c) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, ongoing supports and funding, access to resources needed for long-term employment, opportunity for career advancement. <p>Employment Technicians are required to complete specialized training in implementing the DCP pathway within the first two years of hire. Specialized training may be completed either by completing an ACRE certified Customized Employment curricula, or completing training through the DOH-DDD Discovery Community of Practice.</p> <p>Benefits Counselor must meet General Standards and complete and maintain certification provided by an accredited university and have documentation on file with the DOH-DDD Community Resources Branch to be added to the Benefits Counselor Registry. The Benefits Counselor may be either an employee of the Provider or an independent contractor of the Provider.</p> |
| <p>SUPERVISION STANDARDS</p> | <p>The service supervisor must meet General Standards and must complete a customized employment overview that</p> |

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| <p>(These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Services Supervisor (Column A)</p> | <p>includes the Discovery and Career Planning Pathway, job development, systematic instruction, job coaching, and benefits planning within the first two years of providing employment services.</p> |
| <p>AUTHORIZATION</p> | <p>The participant’s Individualized Service Plan (ISP) will include employment-related goals and the DCP activities designed to support the employment goals.</p> <p>Participation in DCP is not a pre-requisite for receiving Individual Employment Supports. The participant’s ISP may include a combination of DCP and other non-residential waiver services. When used as a wrap-around support for participants who work part-time, DCP must be coordinated with any Individual Employment Services or any other non-residential supports the participant is receiving to reinforce participation in competitive integrated employment as a priority life activity.</p> <p>An extension of the authorization may be made for a second 24-month interval if the participant lost his or her job or has experienced a major gap in employment due to health or other issues.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards, in Section 2.4.B)</p> | <p>The Discovery Process should document these steps in order:</p> <p>Profile I should be completed during the first quarter after authorization of the DCP goal (the 1st through 3rd months after authorization).</p> <p>Profile II should be completed during the second quarter (the 4th through 6th months after authorization).</p> <p>Profile III should be completed during the third quarter (the 7th through 9th months after authorization).</p> <p>The Discovery Action Meeting should be held during the fourth quarter (the 10th through 12th months after authorization) with a Job Development Plan being completed as a result of the accumulated data and results from the Discovery Action Meeting.</p> <p>If any of the steps in the Discovery Process are not completed within the recommended time interval, the Provider must</p> |

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| | <p>document the reasons(s) for the delay, barriers to completing, and action steps to address the barriers.</p> <p>Progress toward these milestones must be reviewed at regular intervals as specified in the ISP.</p> |
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OPERATIONAL GUIDELINES:

HOURS OF OPERATION:

DCP providers must consider the needs of participants when scheduling DCP activities to ensure all aspects of the participant’s life are observed, which may include weekend and evening activities.

AVAILABILITY OF SERVICE SUPERVISOR:

The Service Supervisor must be available by phone when DCP activities are being performed in the community.

FREQUENCY OF SUPERVISION:

The frequency is specified in the ISP.

LOCATION OF SERVICES:

DCP services are primarily provided in community-based settings. Home visits may be required to fully assess the participant’s interests and skills; however, the participant’s residence is not a primary location for DCP services.

MEALS:

This service does not include the cost of meals.

REQUIREMENTS FOR HCBS FINAL RULE ON COMMUNITY INTEGRATION:

For DCP (formerly pre-vocational) providers that were operating programs prior to March 2014, the setting(s) must be in compliance or working toward compliance as part of the *My Choice My Way* state transition plan. For settings not fully compliant, the provider must complete a corrective action plan (CAP) based on the validation completed by DOH-DDD and DHS-MQD. Upon approval of the CAP by DOH-DDD, the provider will implement the activities needed to achieve compliance with the *My Choice My Way* plan. Monitoring visits conducted by DOH-DDD will review the provider’s progress toward reaching the milestones approved in the CAP. All settings must be in full compliance no later than December 31, 2021.

Any DCP providers approved after July 1, 2016 must be in full compliance with the HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings. DOH-DDD will complete a site visit prior to approving the service by the new provider and at least one unannounced visit during the first year of operation to ensure compliance is maintained.

If an existing provider opens a new setting (location) on or after July 1, 2016, it must meet and be able to maintain all requirements of the HCBS final rule prior to the delivery of waiver

services. There is no transition period for a new setting opened by an existing provider. DOH-DDD will complete a site visit prior to approving the service in the new location.

DISCOVERY PATHWAY:

Tools are located in Appendix 10A, Discovery & Career Pathway.

BENEFITS PLANNING/COUNSELING:

Benefits planning/counseling services are an important part of career decision making for participants with I/DD who receive Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), and other entitlements. Benefits counselors are skilled in helping participants determine the impact of earning income on their benefits and are knowledgeable about many work incentives that may be available.

1. All Providers approved by DOH-DDD to deliver DCP services must supply the participant with a list of certified benefits counselors and assists them with scheduling a Benefits Counseling session with the provider of their choice.
2. Each provider must provide instructions on how to obtain a Benefits Planning Query (BPQY) from Social Security prior to the scheduled Benefits Counseling appointment.
3. The Benefits Counselor will complete a Benefits Counseling Profile and a Personalized Benefits Plan (see Appendix 10B).

DEFINITIONS:

BENEFIT COUNSELING is a service that promotes work preparation by examining current disability benefits and assisting the individual and family to understand the impact of increased income on those benefits.

FINANCIAL LITERACY is practical financial knowledge to save, budget, avoid debt, spend wisely, invest, donate, and manage other aspects of financial decision-making to enhance an individual's quality of life.

SECTION 3.5

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

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| <p>SERVICE DESCRIPTION</p> | <p>Those physical adaptations that are permanently installed in the participant’s home (owned or rented by the participant or family with whom the participant resides), required by the participant’s ISP, and necessary to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home.</p> <p>The EAA must be ordered by a physician or other health practitioner with prescriptive authority under Hawai‘i law. The order must be dated within one year of the request.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>EAA include the installation of ramps and grab bars; widening of doorways; modification of bathroom facilities; environmental control devices that replace the need for physical assistance and increase the participant's ability to live independently, such as automatic door openers; and the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant and directly related to the participant’s developmental disability.</p> <p>Adaptations are for homes owned by the participant and/or their legal guardian or family with documentation provided to demonstrate ownership. Adaptations may be completed on a rental property where the property owner has agreed in writing to the adaptation and will not require that the property be restored to the previous floorplan or condition.</p> <p>All adaptations must be made utilizing the most cost effective materials and supplies. The environmental modification must incorporate reasonable and necessary construction standards. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, water/sewer, foundation, smoke detector systems, roof, free of pest damage) must be in compliance with any applicable local codes.</p> |
| <p>TRANSPORTATION</p> | <p>Not included in this service</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable for this service</p> |
| <p>LIMITS</p> | <p>Adaptations must be of direct medical or remedial benefit and not be considered experimental.</p> <p>"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to</p> |

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| | <p>the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement.</p> <p>"Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.</p> <p>Limit of \$55,000 per request which includes a maximum of \$45,000 for the modification and a maximum of \$10,000 for the engineering or architectural drawings and permits required by the city or county where the home is located.</p> <p>Requests for modifications are limited to once in the life expectancy of the modification as follows: Grab bars – 5 years Environmental Control Devices (automatic door opener) – 5 years Exterior ramp – 7 years. Egress is limited to one exterior door. Bathroom modification – 15 years Widen doors and hallways – 15 years Other modifications – determined on a case-by-case basis A participant may request more than one modification within a five (5) calendar year period but the requests must be medically necessary to address different needs, such as a ramp for access to the building and a roll-in shower for bathing.</p> <p>Exceptions to these time limits may be made for health and safety of the participant, e.g., participant condition changes and needs a modification in order to remain in the community or the participant must move from a rented setting. Participants are always afforded the ability to request that DOH-DDD review the participant’s situation if a modification is needed prior to the life expectancy of the modification period.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>Excluded are:</p> <ol style="list-style-type: none"> 1) those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant [carpeting, roof repair, sidewalks, driveways, garages, central air conditioning, hot tubs, whirlpool tubs, swimming pools, landscaping, pest control, and general home repairs and maintenance]; |

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| | <ol style="list-style-type: none"> 2) cosmetic improvements or upgrades that exceed the most cost-effective materials in the specifications to meet the needs; 3) additional square footage to the home’s living area or space [building an extension or addition at, above or below grade on the existing structure of living area; converting garage, shed, carport space, porch, lanai or other non-living space such as attic or area with sloped ceiling that does not meet minimum ceiling height requirements; building an ohana or accessory dwelling unit]; 4) adaptations, modifications, improvements or repairs to the existing home where long-term residency of the participant cannot be assured. Long-term residency must be defined as five (5) consecutive years; 5) adaptations, modifications, improvements or repairs to licensed or certified care homes; 6) duplicate adaptations, modifications or improvements regardless of the payment source; 7) new residential construction (e.g., homes or apartment buildings), even if the new dwelling is designed to be accessible by and/or accommodate the needs of individuals with disabilities; and 8) adaptations, modifications, improvements or repairs exclusively required to meet local building codes. <p>Assessment and training are excluded from this service and are covered under Training and Consultation (T&C).</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Not applicable for this service.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Building Contractor (Column H)</p> <p>Vendor for Permitting (Column H)</p> | <p>Qualified vendor for construction: Independent Contractor with current and valid license through the State of Hawai‘i Department of Commerce & Consumer Affairs as General Contractor and has a State General Excise Tax License. The contractor must provide services in accordance with applicable state, county and city building codes. The contractor must be authorized as a Medicaid provider for EAA once awarded the contract through the State’s procurement system.</p> <p>Qualified vendor for drawings and permit application: DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement, with at least two years of experience in</p> |

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| | developing the drawings and completing the permitting process for environmental accessibility adaptation projects. |
| SUPERVISION STANDARDS | No additional supervision required once EAA is in use by the participant and training has been completed. |
| AUTHORIZATION | Case Manager with approval of Unit Supervisor authorizes the EAA services for drawings and permitting not to exceed \$10,000 limit. Case Manager with approval of Unit Supervisor and Fiscal Office authorizes the EAA service for construction to complete the EAA not to exceed \$45,000 limit once successfully awarded through HIePRO. |
| ENDING SERVICE AUTHORIZATION | This is a one-time purchase and the service ends once the participant's environmental accessibility adaptation has been completed and the participant/family and T&C provider have completed training and signed off on the EAA. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | Documentation is maintained in the file of each participant that the EAA is received, the participant and others have been trained in its use, and the T&C provider and participant/family have signed off that the service meets the participant's needs. |

OPERATIONAL GUIDELINES:

LOCATION OF SERVICES:

This service may only be delivered in the participant's owned or rented home or family home where the participant resides and where the participant is expected to reside for at least five (5) years following the completion of the EAA.

INTERFACE WITH TRAINING AND CONSULTATION:

Training and Consultation (T&C) – Environmental Accessibility Adaptation Clinician: The assessment of the need for the EAA is completed by a qualified T&C professional. Assessments for EAA cannot be bundled with an assessment for Specialized Medical Equipment or Assistive Technology, which must be authorized separately by the DOH-DDD CM. The participant must be offered a choice of providers and can select a different qualified provider for the assessment and/or training needed for the EAA. The T&C professional must not have any conflict of interest with any vendor or business that provides the EAA.

The provider must work closely with the T&C provider to ensure that any staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.

PROCESS FOR OBTAINING ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS:

1. The process begins with the person-centered planning discussion and recommendations in the ISP. The DOH-DDD Case Manager (CM) completes an EAA checklist to identify need for a referral for assessment.
2. CM makes a referral for a Training & Consultation (T&C) provider with experience in completing EAA assessments, generally an occupational therapist or physical therapist.
3. The T&C provider completes the assessment with recommendations and submits to the CM.
4. The assessment and recommendations are reviewed by a team of DOH-DDD staff. The review determines if all the necessary information has been provided for justification of medical need or if additional information is required to develop the scope of work.
5. DOH-DDD develops the scope of work and posts on the State of Hawai'i procurement website HIePRO for builders to submit bids. Vendor is authorized to complete permitting while bid process is underway.
6. DOH-DDD reviews the bids and an award is made.
7. The builder that received the award will work with DOH-DDD to enroll as a Medicaid provider in order to bill the Medicaid fiscal agent at the successful completion of the project.
8. Once the work is completed, the T&C provider that completed the initial assessment will accompany the CM to the participant's home for the purpose of training the family and participant, assessing to ensure the EAA meets the participant's needs and obtains signatures from participant/family and clinician that the adaptation meets the individual's needs.

SECTION 3.6

INDIVIDUAL EMPLOYMENT SUPPORTS (IES)

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| <p>SERVICE DESCRIPTION</p> | <p>Individual Employment Supports (IES) are based on the belief that all individuals with intellectual and developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community, but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. Individual Employment Supports are designed to maximize the participant’s skills, talents, abilities and interests.</p> <p>The goal of Individual Employment Supports is employment in a competitive integrated work setting. This is defined as a work place in the community or self-employment, where the participant receives at least minimum wage or the prevailing rate for that work, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individuals to the same extent that individuals employed in comparable positions would interact. Services may be ongoing based on the support needs of the participant and must increase individual independence and reduce level of service need.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Individual Employment Supports are activities needed to obtain and maintain an individual job in competitive or customized employment or self-employment, including home-based self-employment. Individual Employment Supports consists of Job Development and Job Coaching.</p> <p>IES activities may include:</p> <ol style="list-style-type: none"> 1) ongoing job coaching services to include on-the-job work skills training and systematic instruction required to perform the job with fading of supports as the participant becomes more confident and competent in the job to the extent possible; 2) person-centered employment planning; 3) job development, carving, or customization; 4) negotiations with prospective employers; 5) assistance for self-employment, including <ol style="list-style-type: none"> a) assist in identifying potential business opportunities; b) assist in the development of a business plan, including potential sources of business financing and other assistance needed to develop and launch a business; |

- c) identification of supports needed in order for the participant to operate the business; and
 - d) ongoing assistance, counseling and guidance once the business has been launched;
- 6) worksite visits as needed by the individual or employer to assess for new needs and to proactively support the participant to address issues that arise (typically at the worksite unless the individual requests visits outside the worksite or worksite visits are deemed too disruptive by the employer);
 - 7) ongoing evaluation of the individual's job performance except for supervisory activities rendered as a normal part of the business setting; training related to acclimating to or acceptance in the workplace environment, such as effective communication with co-workers and supervisors and when and where to take breaks and lunch;
 - 8) individualized problem-solving/advising with the participant about issues that could affect maintaining employment;
 - 9) training in skills to communicate disability-related work support and accommodation needs;
 - 10) assessing the need for basic job aids, facilitating referral through the participant's Case Manager for assistive technology assessment and acquisition of assistive technology from Division of Vocational Rehabilitation;
 - 11) facilitating referral through the Case Manager to a Discovery & Career Planning provider for financial literacy, money management and budgeting;
 - 12) providing information and training, as appropriate, for employers related to disability awareness, use of tax credits and other incentives, individual disability-specific training, and use of basic job aids and accommodations (may or may not be delivered with the participant present);
 - 13) training in arranging and using transportation, such as fixed route public transportation or paratransit services to get to and from the participant's place of employment; and
 - 14) career advancement services.

When Individual Employment Supports are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and

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| | training required by the participant receiving waiver services as a result of his or her disabilities. |
| TRANSPORTATION | Transportation to and from the supported employment activities must be arranged by the participant with assistance by the Provider. |
| LEVELS OF SERVICE | Not applicable for this service |
| LIMITS | <p>Services are limited to a maximum of 40 hours per week.</p> <p>Personal care/assistance may be a component of Individual Employment Supports but does not comprise the entirety of the service. If ongoing personal assistance is needed, the DOH-DDD Case Manager may authorize Personal Assistance/Habilitation (PAB) services at the workplace. <i>NOTE: This will change to using Community Learning Service – Individual after the participant’s ISP in Year 1 (between July 1, 2017 and June 30, 2018).</i></p> <p>Individual Employment Supports (with the exception of job development, negotiations with prospective employers or meetings and phone calls where the participant may not be present, such as discussions with the supervisor or family) may not be provided at the same time (same hour) as another face-to-face service, such as Personal Assistance/Habilitation (PAB), Adult Day Health, Community Learning Service, Discovery & Career Planning, or Respite.</p> <p>Job Development activities must be related to the participant’s job gal. Job Development activities are limited to four (4) hours per week up to three (3) months.</p> |
| ACTIVITIES NOT ALLOWED | <p>Individual Employment Supports exclude:</p> <ol style="list-style-type: none"> 1) supporting the participant to perform work that benefits the waiver provider, regardless of wage paid, including paid employment in an enterprise owned by the provider of Individual Employment Supports or a relative of that provider; 2) paying incentives, subsidies or unrelated vocational training expenses such as the following: <ul style="list-style-type: none"> • incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment arrangement; • payments that are passed through to participants receiving Individual Employment Supports; |

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| | <ul style="list-style-type: none"> • payments for training that is not directly related to the participant’s Individual Employment Supports; <ol style="list-style-type: none"> 3) paying expenses with starting up or operating a business; 4) continuing the service for the sole purpose of providing transportation to and from the place of employment once the participant no longer needs job coaching; and 5) paying for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business. <p>Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations.</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>The staff to participant ratio for all face-to-face IES is 1:1.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Employment Specialist (Column C)</p> <p>Job Coach (Column B)</p> | <p>Providers of employment services must have at least one Employment Specialist or Service Supervisor who is a Certified Employment Service Professional by June 30, 2020.</p> <p>Employment Specialist must meet General Standards and have the knowledge and competency to deliver quality employment services to assist job seekers with I/DD in acquiring competitive integrated employment.</p> <p>An Employment Specialist also acting as a Service Supervisor must have a Bachelor’s Degree.</p> <p>Employment specialist will have specialized training and demonstrated competency in the all of the following areas:</p> <ol style="list-style-type: none"> a) Application of core values and principle in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/ career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, work impact on benefits, accommodation plan, and transition to work models. |

- c) Community research and job development: knowledge to prepare marketing approaches and materials for job developer and job seeker (brochures, resumes, profiles and materials), planning job seeker involvement and decision making, assistance with disclosure and accommodations requests, networking, development of skills for outreach and interactions with employers to explore their needs, as well as conducting community research including labor market information, range of employers in the area and information on specific employers or industries.
- d) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, ongoing supports and funding, access to resources needed for long-term employment, opportunity for career advancement, transportation planning, ensuring work is well integrated into life activities and supports.

Employment Specialists are required to complete specialized training in implementing the DCP pathway within the first two years of hire. Specialized training may be completed either by completing an Association of Community Rehabilitation Educators (ACRE) certified Customized Employment curricula, or completing training through the DOH-DDD Discovery Community of Practice.

Job Coach must meet General Standards and have the knowledge and competency to provide quality employment services to job seekers with I/DD in maintaining competitive integrated employment.

The Job Coach will have specialized training and demonstrated competency in the following areas:

- a) Application of core values and principle in delivery of employment services: rights, history, legislation, best practice and professionalism.
- b) Workplace and related supports: implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, opportunity for career advancement, and tasks associated with best practices in how to deliver IES.

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| | Job Coaches are required to complete training in Customized Employment or other ACRE certified curricula within the first two years of providing job-coaching services. |
| SUPERVISION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) | The service supervisor must meet General Standards and must complete a customized employment overview that includes the Discovery and Career Planning Pathway, job development, systematic instruction, job coaching, and benefits planning within the first two years of providing employment services. |
| AUTHORIZATION | Individual Employment Supports are provided in accordance with the participant's Individualized Service Plan (ISP) and developed through a detailed person-centered planning process, which includes annual assessment of employment goals. The participant's ISP may include a combination of Adult Day Health, Discovery & Career Planning, and Individual Employment Supports. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | <p>Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those programs beyond any program limitations.</p> <p>The provider must report to DOH-DDD on a quarterly basis the following information for each participant receiving IES: their name, whether they are receiving job development or job coaching or both, hours working per week, rate of pay, place of employment or self-employment, employment start date, employment end date (if applicable), and average number of hours of support provided per week by job developer and/or job coach.</p> <p>Job Development services must document why the business was chosen for the participant.</p> |

OPERATIONAL GUIDELINES:

HOURS OF OPERATION:

Hours of service are flexible, based on needs of participants' jobs and shifts.

AVAILABILITY OF SERVICE SUPERVISOR:

The service supervisor must be available by phone during the hours when IES services are being directly provided to the participant.

FREQUENCY OF SUPERVISION:

The frequency of supervision is specified in the ISP.

LOCATION OF SERVICES:

IES job development and job coaching are provided in the community at settings where members of the general public work and visit or at the participant's microenterprise location.

MICRO-ENTERPRISE DEVELOPMENT:

Micro-enterprise development activities include:

1. aiding the participant in identifying potential business opportunities;
2. assisting in the development of a business plan, including potential sources of business financial and other assistance in developing and launching a business; and
3. identifying the supports that are necessary in order for the participant to operate the business.

A participant who is pursuing micro-enterprise must complete a business plan that addresses the following:

1. outline for the micro-enterprise opportunity;
2. feasibility of micro-enterprise opportunity (address who will be responsible for work activities, tax/license, paperwork, financial management, materials acquisition, inventory, etc.);
3. identify funding sources for start-up and operating business expenses; and
4. identify natural supports necessary to operate the business

REQUIREMENTS FOR HCBS FINAL RULE ON COMMUNITY INTEGRATION:

Individual Employment Services are expected to be provided in competitive, fully integrated settings where others without disabilities are employed, unless self-employed. If any workers are employed by the IES agency, the employment arrangement will be validated by DOH-DDD and DHS-MQD to determine whether a transition plan will be implemented to support the participant to seek competitive integrated employment elsewhere.

For IES providers that were operating IES programs prior to March 2014, the setting(s) must be in compliance or working toward compliance as part of the *My Choice My Way* state transition plan. For settings not fully compliant, the provider must complete a corrective action plan (CAP) based on the validation completed by DOH-DDD and DHS-MQD. Upon approval of the CAP by DOH-DDD, the provider will implement the activities needed to achieve compliance with the *My Choice My Way* plan. Monitoring visits conducted by DOH-DDD will review the provider's progress toward reaching the milestones approved in the CAP. All settings must be in full compliance no later than December 31, 2021.

Any IES providers approved after July 1, 2016 must be in full compliance with the HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings. DOH-DDD will complete a site visit prior to approving the service by the new provider and at least one unannounced visit during the first year of operation to ensure compliance is maintained.

If an existing provider moves to a new location on or after July 1, 2016, it must meet and be able to maintain all requirements of the HCBS final rule prior to the delivery of waiver services.

There is no transition period for a new setting opened by an existing provider. DOH-DDD will complete a site visit prior to approving the service in the new location.



SECTION 3.7

NON-MEDICAL TRANSPORTATION

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| <p>SERVICE DESCRIPTION</p> | <p>Service offered to enable participants to gain access to waiver services and other (non-waiver) community services, activities and resources, and support community living as specified in the ISP.</p> <p>Whenever possible, family, neighbors, friends, or community agencies that can provide transportation without charge should be utilized. This service may be consumer-directed.</p> <p>Non-Medical Transportation services under the waiver are offered in accordance with the participant’s ISP.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>The service may be used by a participant who lives in a rural or other area where public transportation is limited or non-existent or if the participant requires door-to-door transportation because he/she is unable to reasonably access the bus-stop or other public pick-up location.</p> <p>Transportation services may be delivered on a per-trip or per-mile basis.</p> <p>Transportation services enable participants to gain access to community resources and activities specified in the ISP such as:</p> <ol style="list-style-type: none"> 1) Community events or activities of the participant’s choosing; 2) Work for up to the first ninety (90) days of employment; 3) Volunteer sites; 4) Homes of relatives or friends; 5) Civic organizations or social clubs; and 6) Public meetings or other civic activities. |
| <p>TRANSPORTATION</p> | <p>This service covers transportation. Refer to service description, reimbursable activities, limits and activities not allowed for the specific information about this service.</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable for this service.</p> |
| <p>LIMITS</p> | <p>Transportation services must be limited to intra-island, ground transportation.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>This service must not be used to provide or replace medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable) delivered through the QUEST Integration health plans.</p> |

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| | <p>Non-Medical Transportation Services may not duplicate transportation that is part of another waiver service:</p> <ul style="list-style-type: none"> • for the purpose of transporting the participant to and from an Adult Day Health (ADH) center; • for the purpose of community activities that occur during ADH hours or during Personal Assistance/Habilitation (PAB) services in the community (Agency or Consumer-Directed); • for the purpose of Discovery & Career Planning exploration activities in the community <p>Non-Medical Transportation Services may not duplicate transportation to a setting that is the responsibility of another agency, such as the Department of Education or Division of Vocational Rehabilitation.</p> <p>The legally responsible person (parent of minor child or spouse) or the legal guardian or the designated representative cannot be a paid provider through consumer-directed arrangements.</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Not applicable for this service.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW – Agency (Column B)</p> <p>Vendor (Column H)</p> | <p>The Direct Support Worker (DSW) or Vendor must meet General Standards and must possess:</p> <ol style="list-style-type: none"> 1) Valid Hawai'i driver's license; 2) Public Utilities Commission (P.U.C.) license as appropriate; 3) Current automobile insurance (meets or exceeds minimum requirements under Hawai'i State law). |
| <p>PROVIDER QUALIFICATION STANDARDS FOR CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW – Consumer-Directed Employee (Column D)</p> | <p>The consumer-directed employee or Vendor must meet General Standards and must possess:</p> <ol style="list-style-type: none"> 1) Valid Hawai'i driver's license; 2) Public Utilities Commission (P.U.C.) license as appropriate; 3) Current automobile insurance (meets or exceeds minimum requirements under Hawai'i State law). |

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| Vendor (Column H) | |
| SUPERVISION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) Service Supervisor – Agency (Column A) | The service supervisor (Agency) must meet General Standards. |
| SUPERVISION STANDARDS FOR CONSUMER-DIRECTED Employer – Consumer-Directed | The employer supervises the consumer-directed employee(s). |
| AUTHORIZATION | The Case Manager authorizes this service in the ISP. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) Agency | <p>The Provider must maintain a written transportation log which must include, but not be limited to, the following:</p> <ul style="list-style-type: none"> a) participant name; b) date(s) of service; c) start time and end time of trip(s); d) location(s) where the participant begins travel and each destination point (point to point, not round trip); and e) total miles traveled if delivered on a per-mile basis. <p>The Provider must maintain a file, as appropriate, that contains documentation of:</p> <ul style="list-style-type: none"> a) licensure with the Public Utilities Commission (PUC) to provide transportation services; b) City and County and Department of Transportation motor vehicle safety requirements; and c) all other applicable licensing requirements for drivers and vehicles that provide transportation services for participants. <p>Make copies of the transportation log available to the participant, the participant’s legal or designated representative, and/or the Case Manager, as requested.</p> |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | <p>The Consumer-Directed Employer must maintain a written transportation log, which must include, but not be limited to, the following:</p> <ul style="list-style-type: none"> a) participant name; |

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| Consumer-Directed | <ul style="list-style-type: none"> b) date(s) of service; c) start time and end time of trip(s); d) location(s) where the participant begins travel and each destination point (point to point, not round trip); e) total miles traveled if transportation is delivered on a per-mile basis; and f) the name of the DSW or vendor providing the service. |
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OPERATIONAL GUIDELINES:

POLICIES AND PROCEDURES:

Provider agencies must develop contract provider emergency protocols and contingency plans that ensure the health and safety of participants.

For Consumer-Directed Services, the employer must develop a written plan explaining desired emergency protocol and contingency plans.

AVAILABILITY OF SERVICE SUPERVISOR:

The service supervisor is available by phone when this service is delivered.

FREQUENCY OF SUPERVISION:

Frequency is specified in the ISP.

SECTION 3.8 PERSONAL ASSISTANCE/HABILITATION (PAB)

*If the participant is in **Cohort 1** (participants who live in a licensed or certified residential setting), PAB services will phase out as Residential Habilitation phases in based on the participant’s ISP date between July 1, 2017 and June 30, 2018.*

*If a participant is in **Cohort 2** (participants who live in a family home or their own home and who receive ADH services), PAB services will transition to the new fee schedule without tiers based on the participant’s ISP date between July 1, 2018 and June 30, 2019.*

*If a participant is in **Cohort 3** (participants who live in a family home or their own home and do not receive ADH services), PAB services will transition to the new fee schedule without tiers based on the participant’s ISP date between July 1, 2019 and June 30, 2020.*

NOTE: Consumer-directed PAB services will phase in during Year 1 based on the participant’s ISP date between July 1, 2017 and June 30, 2018.

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| SERVICE DESCRIPTION | A range of assistance or training to enable participants to assist with the acquisition, retention or improvement in skills related to living in the community. |
| REIMBURSABLE ACTIVITIES | <p>PAB services are identified through the person-centered planning process and included in the ISP to address measurable outcomes related to the participant’s skills in the following areas:</p> <ol style="list-style-type: none"> 1) Increase independence with eating, dressing, personal hygiene; 2) Build natural supports; 3) Be self-sufficient (taking care of one’s self and one’s needs to live in own home); 4) Engage in opportunities which identify and expand personal interests which promote independence; and 5) Build skills in self-advocacy. <p>These supports may include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, social and leisure skill development. Services may also include training to increase independence as well as developing natural supports and relationships.</p> <p>This may take the form of hands-on assistance (actually performing a task for the person), training, or multi-step instructional cueing, as a part of a plan to prompt the participant to perform a task.</p> |

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| | <p>PAB may include assistance and/or training in the performance of Activities of Daily Living (ADL) skills, e.g., bathing, dressing, toileting, transferring, maintaining continence, and Instrumental Activities of Daily Living (IADLs) that are more complex life activities, e.g., personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management.</p> <p>Such assistance also may include active supervision (readiness to intervene as necessary when there is greater than a 50% likelihood that assistance will be required during the supervision episode).</p> <p>Personal assistance/habilitation (PAB) services may be provided on an episodic or on a continuing basis.</p> |
| TRANSPORTATION | <p>Transportation to and from the participant’s home or site designated for start of service provision for PAB activities is included.</p> <p>Transportation is not reimbursable for staff travel to and from the participant’s home or the site designated for start of service provision.</p> |
| LEVELS OF SERVICE | <p>PAB services include: PAB Level 1 PAB Level 2 PAB Level 3</p> <p>The PAB Level is determined by the DOH-DDD CM based on an ICAP behavioral score and health needs identified within the ISP.</p> <p>PAB LEVEL 1: Participants are in need of training and/or assistance with activities included in this service and do not require nurse delegated tasks or formal behavior analysis services.</p> <p>PAB LEVEL 2 (NURSE-DELEGATED TASKS OR OTHER SUPPORT NEEDS):</p> <ul style="list-style-type: none"> a) ICAP Maladaptive scores for participants are -23 and higher; or b) Participants requiring tasks that have been delegated by an RN as specified (see Section 1.7 D for nurse delegation) |

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| | <p>PAB LEVEL 3 (INTENSIVE SUPPORTS - BEHAVIORAL):</p> <ul style="list-style-type: none"> a) ICAP Maladaptive scores for participants fall within the -34 to -70 range and include participants with behaviors that cause harm to self, others, and/or property; and b) PAB Level 3 services is provided in conjunction with a FBA and/or in accordance with a BSP plan and must include outcome-based measurable data. |
| <p>LIMITS</p> | <p>Out-of-State PAB services cannot exceed fourteen (14) calendar days in a fiscal year (July 1 through June 30) for one staff to accompany the participant. An exception process is in place for situations that could arise during travel that would require additional authorization of hours. Out-of-state PAB is approved for the same number of hours as the current authorization.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>Services may not be provided out of the country.</p> <p>For participants under age 21, PAB may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration (QI) health plans.</p> <p>PAB services may not be delivered during the school day or educational hours as defined in the Individualized Education Plan (IEP) for a student (age 3 to 20) who is attending school, such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide PAB services during the times when the participant would otherwise be attending school. These limits do not apply once an adult has graduated or exited school.</p> <p>PAB services may not be used to help a student complete school homework assignments.</p> <p>PAB services may not be used for the sole purpose of child care while parents work outside the home.</p> <p>PAB services may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor.</p> <p>PAB services may not be provided to a participant by their spouse.</p> |

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| | <p>An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide PAB.</p> <p>PAB must not be provided at the same time (in the same hour of the day) as Respite, Adult Day Health, Discovery and Career Planning or Individual Employment Supports.</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>The staff to participant ratio for all PAB services is 1:1. Exceptions to the 1:1 staff to participant ratio are made on a case-by-case basis and will be based on needs identified in the ISP and/or Action Plan.</p> <ol style="list-style-type: none"> 1) More than 1:1 direct support worker coverage may include two (2), three (3) or four (4) direct support workers providing services to one (1) participant. 2) For instances where one (1) direct support worker provides services to two (2) or three (3) participants, PAB services must be prorated when the staff to participant ratio is less than 1:1. |
| <p>PROVIDER QUALIFICATION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW - Agency: (Column B)</p> <p>RBT - Agency: (Column B)</p> | <p>If the DSW providing PAB Level 1 or PAB Level 2 services is a family member of the participant, some General Standards requirements are mandatory and some are recommended.</p> <ol style="list-style-type: none"> 1) Mandatory: <ol style="list-style-type: none"> a) Criminal History check according to the Standards set forth by the DHS; b) Adult Protective Services (APS) and/or Child Welfare Services (CWS) checks according to the Standards set forth by the DHS; c) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer, as stated in the Standards, prior to the service delivery and in the event of any changes to the ISP; 2) Recommended: <ol style="list-style-type: none"> a) TB clearance; b) First Aid training; and c) Cardiopulmonary Resuscitation (CPR) training. <p>PAB Level 1: The Direct Support Worker (DSW) meets General Standards.</p> <p>PAB Level 2 (FOR NURSE-DELEGATED ACTIVITIES):</p> |

The DSW meets General Standards and completes specialized face-to-face training on the specific tasks to be performed. Training must be provided by the Registered Nurse (RN) delegating the task(s).

PAB Level 2 (OTHER SUPPORTS, NO NURSE-DELEGATED ACTIVITIES):

- 1) The DSW meets General Standards and completes face-to-face training to implement the Individual Plan based on the ISP, including positive behavior support approaches, if applicable.
- 2) If the PAB Level 2 service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the worker meets General Standards and:
 - a) the DSW must complete:
 - specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and
 - training in the implementation of the BSP.
 - b) if the worker is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.

Training(s) for meeting the requirements of 2a) and 2b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.

- c) for either a DSW or RBT implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*.

PAB Level 3 (INTENSIVE SUPPORT NEEDS - BEHAVIORAL):

The qualified worker meets General Standards and::

- a) the DSW must complete:

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| | <ul style="list-style-type: none"> • specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and • training in the implementation of the BSP. <p>b) if the worker is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.</p> <p>Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.</p> <p>c) for either DSW or RBT that are implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 <i>Positive Behavior Supports</i> and #2.02 <i>Restrictive Interventions</i>.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS FOR CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW – Consumer-Directed Employee (Column D)</p> | <p>The DSW-CD must complete:</p> <ol style="list-style-type: none"> 1) Mandatory: <ul style="list-style-type: none"> a) Criminal History name check; and b) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer prior to the service delivery and in the event of any changes to the ISP; 2) Recommended: <ul style="list-style-type: none"> a) national criminal history checks, APS and/or CWS checks according to the Standards set forth by the DHS; b) TB clearance; c) First Aid training; and d) CPR training. |
| <p>SUPERVISION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Service Supervisor</p> | <p>PAB LEVEL 1: The service supervisor must meet General Standards only. No additional qualification standards required.</p> <p>PAB LEVEL 2 (FOR NURSE-DELEGATED ACTIVITIES): Registered Nurse (RN) in accordance with Hawai‘i state law who is delegating the task(s).</p> |

(Column A)

Registered Nurse
(Column E)

PAB LEVEL 2 (OTHER SUPPORTS, NO NURSE-DELEGATED ACTIVITIES):

- 1) The service supervisor must meet General Standards and possess specialized training, if applicable, in positive behavior supports.
- 2) If the PAB Level 2 services includes implementation of a formal BSP based on a FBA, in addition to General Standards,
 - a) the service supervisor must also complete:
 - specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and
 - face-to-face training in the implementation of the BSP; or
 - b) the service supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/service supervisor must complete face-to-face training in the implementation of the BSP.

Training(s) for meeting the requirements of 2a) and 2b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.
 - c) whether the service supervisor is qualified under a) or b), the service supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*.

It is recommended that the service supervisor for a participant's plan that includes BSP interventions obtain RBT certification. Note that the RBT does not permit the supervisor to oversee the BSP; however, the RBT training enables the service supervisor to have a standard base of knowledge.

PAB LEVEL 3 (INTENSIVE SUPPORT NEEDS - BEHAVIORAL):

The service supervisor meets General Standards and:

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| | <p>a) the service supervisor must also complete:</p> <ul style="list-style-type: none"> • specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; and • face-to-face training in the implementation of the BSP; or <p>b) the service supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/service supervisor must complete face-to-face training in the implementation of the BSP.</p> <p>Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai'i state law.</p> <p>c) whether the service supervisor is qualified under a) or b), the service supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 <i>Positive Behavior Supports</i> and #2.02 <i>Restrictive Interventions</i>.</p> <p>It is recommended that the service supervisor for a participant's plan that includes BSP interventions obtain RBT certification. Note that the RBT does not permit the supervisor to oversee the BSP; however, the RBT training enables the service supervisor to have a standard base of knowledge.</p> |
| <p>SERVICE SUPERVISION REQUIREMENTS FOR CONSUMER-DIRECTED</p> <p>Consumer-Directed Employer</p> | <p>PAB LEVEL 1: Employer supervises the employee(s).</p> <p>PAB LEVEL 2 (NURSE-DELEGATED): Employer supervises the employee(s). Participant receives Skilled Nursing to oversee nurse-delegated tasks performed by employee(s).</p> <p>PAB LEVEL 2 (OTHER SUPPORTS, NO NURSE-DELEGATED TASKS): Employer supervises the employee(s). Participant may receive Training & Consultation services to oversee implementation of the BSP, if applicable.</p> |

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| AUTHORIZATION | <p>PAB is authorized by the Case Manager based on the ISP. Level is determined by the ICAP score.</p> <p>PAB Level 2 is allowable on an hourly basis for twenty-four (24) hours for participants with an ICAP score for maladaptive behavior of -46 to -70 and who require intervention on a twenty-four (24) hour basis or for participants with need for medical intervention on a twenty-four (24) hour basis.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <ol style="list-style-type: none"> 1) For staff providing PAB Level 2 or PAB Level 3 services to participants with formal BSPs based on FBA, the Provider must maintain documentation of all face-to-face training(s) completed by the licensed professional or qualified designee for DSW, RBT, and service supervisor(s). Documentation must be available for review by DOH-DDD upon request. 2) For workers and service supervisors for PAB Level 2 or PAB Level 3 services to participants with formal BSPs based on FBA, the Provider must maintain documentation of completion of comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 for Restrictive Interventions. Documentation must be available for review by DOH-DDD upon request. |

OPERATIONAL GUIDELINES:

HOURS OF OPERATION:

PAB services are available based on the participant’s needs as identified through the person-centered planning process and documented in the Individualized Service Plan (ISP).

AVAILABILITY OF SERVICE SUPERVISOR:

The service supervisor must be available by phone during the hours PAB is provided.

FREQUENCY OF SUPERVISION:

1. On-site supervision by a service supervisor for PAB Level 1 and PAB Level 2 must be conducted monthly or more frequently as indicated in the ISP and/or Action Plan. The service supervisor must conduct an on-site supervision visit on each shift that has PAB workers assigned on a monthly basis or more frequently as indicated in the ISP and/or Action Plan.
2. On-site supervision for PAB Level 3 must be conducted as specified in the ISP and/or Action Plan.
3. On-site supervision for PAB Level 3 services must be conducted at the frequency specified in the ISP and/or Action Plan.

LOCATION OF SERVICES:

PAB services are provided in a licensed or certified homes (Domiciliary Home, Adult Residential Care Home, Extended Adult Residential Care Home, Therapeutic Living Program and DOH-DDD Adult Foster Home), family home and outside of the residential setting within the community.

SERVICE PROVISION BY FAMILY MEMBERS AS DIRECT SUPPORT WORKERS:

1. Service provision by family members should not replace “usual non-paid activities and customary” efforts that are typically taught by family members to their children.
2. The family member will provide services in accordance with the Standards.
3. The family member will only provide services to the participant for approved services as stated in the ISP and/or Action Plan.

CMS COMMUNITY INTEGRATION FINAL RULE REQUIREMENTS:

PAB services must be delivered in compliance with the final rule in homes and community settings.

MEALS:

Not included in this service.

SECTION 3.9

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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| <p>SERVICE DESCRIPTION</p> | <p>PERS is a system that enables waiver participants to maintain safety in the community and secure help in an emergency. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals.</p> <p>As part of the system, a participant may also wear a portable “help” button to allow for mobility.</p> <p>The response center may also provide daily reminder calls to participants or respond to other environmentally triggered alarms, e.g., motion detectors, etc., in the household.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Service includes a one-time installation fee for new systems and on-going monitoring of the system.</p> <p>PERS providers must:</p> <ol style="list-style-type: none"> a) demonstrate and instruct the participant and family in the use of PERS; b) monitor the PERS by conducting monthly testing of the system; c) act immediately to repair or replace equipment in the event of a malfunction; d) provide trained professionals to operate the PERS response center; and <p>3) have procedures in place for handling electrical power outages and telephone system problems.</p> |
| <p>TRANSPORTATION</p> | <p>Not included in this service.</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable to this service.</p> |
| <p>LIMITS</p> | <p>This service is available for participants living in their own home or family home.</p> <p>The installation fee is limited to the rate determined by DHS-MQD and DOH-DDD. Monthly monitoring must not exceed 12 months in the year.</p> <p>PERS is not permitted in licensed or certified homes unless there is a plan to move to a more independent living setting within six (6) months and the device is essential to the transition plan as outlined in the ISP.</p> <p>Availability of service may be dependent on the service area of the electronic device.</p> |

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| ACTIVITIES NOT ALLOWED | Cost of the phone landline is excluded. |
| STAFF TO PARTICIPANT RATIO | Not applicable for this service. |
| PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) Agency/Vendor (Column H) | Service is provided by a DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement. Agency/vendor must have the infrastructure and a minimum of two years of experience performing this specialized service. |
| SUPERVISION STANDARDS | No additional supervision required once PERS is in use by the participant and training has been completed. |
| AUTHORIZATION | Case Manager with approval of Unit Supervisor and Section Supervisor authorizes the PERS service. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | Documentation is maintained in the file of each participant receiving this service that the PERS is received, the participant and others have been trained in its use, and the participant/family have signed off that the service meets the participant's needs. |

OPERATIONAL GUIDELINES:

HOURS OF OPERATION:

PERS service must be operational 24 hours a day, 7 days a week.

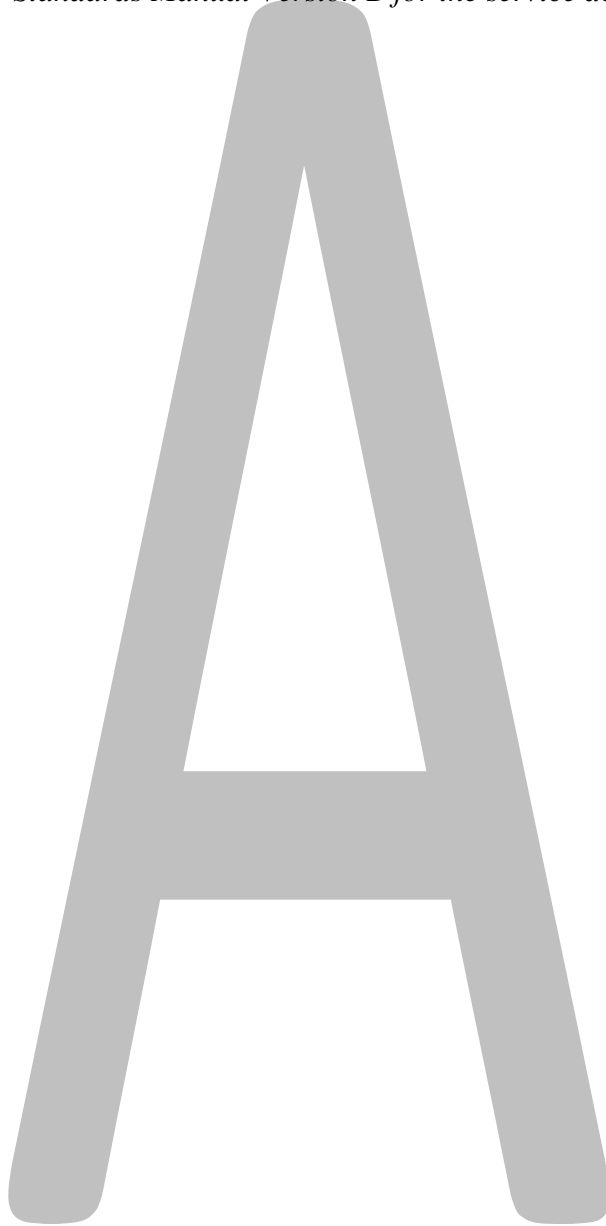
LOCATION OF SERVICES:

PERS is installed in the participant's own home or family home where the participant resides. Installation in a licensed or certified home is permitted with transition plan to move within six months.

SECTION 3.10

RESIDENTIAL HABILITATION (ResHab)

This service will phase-in based on the participant's ISP date between July 1, 2017 and June 30, 2018. When ResHab services are authorized at the ISP, PAB services in the home will end. Refer to Waiver Standards Manual Version B for the service description.



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| SERVICE DESCRIPTION | <p>The goal of Respite services is to support family relationships to sustain the participant living in the family home.</p> <p>Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide uncompensated care for the participant for at least a portion of the day.</p> |
| REIMBURSABLE ACTIVITIES | <p>Respite services may include the supervision or provision of assistance to meet participant needs in the following areas:</p> <ol style="list-style-type: none"> 1) Routine health needs such as nurse delegated tasks; 2) Activities of Daily Living (bathing, toileting etc.); 3) Meal preparation |
| TRANSPORTATION | Not included in this service. |
| LEVELS OF SERVICE | Not applicable to this service |
| LIMITS | <p>Multiple episodes of respite may occur during the year. However, a single episode of respite is limited to 14 consecutive days. The DOH-DDD will perform further authorization on a case-by-case basis.</p> <p>Respite services are provided hourly up to eleven (11) hours.</p> <p>Respite services requiring more than eleven (11) hours of service per day is billed at the daily rate.</p> |
| ACTIVITIES NOT ALLOWED | <p>Respite is not available in long-term care facilities.</p> <p>Respite services must not be available to participants who reside in licensed or certified settings.</p> <p>Respite cannot be used during times when the person providing care is being paid to deliver another waiver service, such as PAB or CLS. It is limited to providing for relief during times when the person is not being paid to provide care to the participant.</p> <p>Respite services provided on an hourly basis are not delivered during the same time (same hour) that the following face-to-face services are delivered: Personal Assistance/Habilitation (PAB), Adult Day Health (ADH), Discovery and Career Planning, or Individual Employment Supports – Job Coaching.</p> |

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| | <p>Respite may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor.</p> <p>Respite may not be provided to a participant by their spouse.</p> <p>An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide Respite.</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>The staff to participant ratio must be 1:1.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW – Agency (Column B)</p> | <p>The Direct Support Worker (DSW) must meet General Standards. The agency must ensure that DSWs have written information on:</p> <ul style="list-style-type: none"> a) basic health and safety needs and care affecting the participant; b) emergency and personal information; and c) medical history as outlined in the ISP. <p>Additional training requirements apply if the worker will perform nurse-delegated tasks. The DSW must complete specialized face-to-face training on the specific tasks to be performed. Training must be provided by the Registered Nurse (RN) delegating the task(s);</p> |
| <p>PROVIDER QUALIFICATION STANDARDS CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW – Consumer-Directed (Column D)</p> | <p>The consumer-directed employee must be a Direct Support Worker (DSW) who completes the mandatory qualifications:</p> <ul style="list-style-type: none"> 1) <u>Mandatory</u>: <ul style="list-style-type: none"> a) Criminal History name check; and b) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer prior to the service delivery and in the event of any changes to the ISP, including required training and skills verification for nurse delegated tasks. 2) <u>Recommended</u>: In addition, it is recommended that the consumer-directed employee complete the recommended qualifications: <ul style="list-style-type: none"> a) national criminal history checks, Adult Protective Services (APS) and/or Child Welfare Services (CWS) checks according to the Standards set forth by the DHS; b) TB clearance; c) First Aid training; and |

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| | d) Cardiopulmonary Resuscitation (CPR) training. |
| <p>SUPERVISION STANDARDS FOR PROVIDER AGENCY (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Service Supervisor (Column A)</p> | <p>The service supervisor must meet General Standards.</p> |
| <p>SUPERVISION STANDARDS FOR CONSUMER-DIRECTED (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Consumer-Directed Employer</p> | <p>The consumer-directed employer supervises the employee(s).</p> <p>The employer must ensure that all employees performing nurse-delegated tasks have successfully completed all required training and skills verification.</p> |
| <p>AUTHORIZATION</p> | <p>The Case Manager authorizes Respite as specified in the ISP.</p> <p>For participants who require nursing assessment and observation, and whose families are in need of relief, Skilled Nursing services may be authorized instead of Respite services after review by DOH-DDD and must be documented in the ISP and/or Action Plan.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> <p>Agency</p> | <p>Respite services rendered by the Provider must follow General Standards for documentation.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> <p>Consumer-Directed</p> | <p>Consumer-directed Respite must document the provision of Respite services, including:</p> <ol style="list-style-type: none"> 1) participant name; 2) date(s) of service; 3) duration of service delivery (i.e., start time and end time) and intervals that the participant was asleep (i.e., time from when the participant falls asleep until s/he awakens, including if the participant is awake periodically during the night); and 4) sign-in sheets for training completed by consumer-directed employees in performing nurse-delegated tasks. |

OPERATIONAL GUIDELINES:

AVAILABILITY OF SERVICE SUPERVISOR:

Frequency is specified in the ISP and/or Action Plan.

FREQUENCY OF SUPERVISION:

Frequency of supervision within the Respite period at intervals stated in the ISP and/or Action Plan.

LOCATION OF SERVICES:

Services must be provided in a residential or community setting that ensures the health and safety of the participant, including

1. participant's own home;
2. private residence of a respite care worker;
3. DD Domiciliary Home;
4. DD Adult Foster Home;
5. Adult Residential Care Home; or
6. Expanded Adult Residential Care Home.

MEALS:

Meals are not included in the cost of this service.

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| SERVICE DESCRIPTION | <p>Skilled nursing services include services listed in the ISP that are within the scope of the State’s Nurse Practice Act and require the education, assessment, judgment and intervention of a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN. The RN and LPN are licensed to practice in the State of Hawai‘i.</p> <p>Skilled Nursing Services include the provision of nursing assessment, treatments and observation consistent with an order by a practitioner with prescriptive authority in accordance with Hawai‘i state law and specified in the ISP in the participant's record.</p> <p>Skilled Nursing services are provided on an intermittent, part-time and time-limited basis. “Intermittent and part-time” is defined as occurring at irregular intervals, sporadic, and not continuous.</p> |
| REIMBURSABLE ACTIVITIES | <p>Skilled Nursing services must fall within the scope of the State’s Nurse Practice Act and be provided by an RN or an LPN under the supervision of an RN.</p> <p>Skilled Nursing activities, as ordered by a practitioner with prescriptive authority in accordance with Hawai‘i state law. Please refer to examples of non-delegable nursing tasks in Table 1.7-1, Nurse Delegation.</p> |
| TRANSPORTATION | Not included in this service. |
| LEVELS OF SERVICE | Not applicable for this service. |
| LIMITS | Personal care/assistance may be provided when incidental to the delivery of Skilled Nursing as necessary to meet the needs of a participant but may not comprise the entirety of the service. |
| ACTIVITIES NOT ALLOWED | <p>Skilled Nursing Services under the waiver may not replace the services available under the State Plan. Medically necessary skilled nursing services that are covered under the State Plan are provided by the QUEST Integration (QI) health plans. For participants under age 21, Skilled Nursing Services may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration health plans.</p> <p>Skilled Nursing Services must not be used in place of PAB services where the participant’s needs could be met with a trained PAB worker performing nurse-delegated tasks in accordance with HRS §457-7.5 but the agency has not hired and trained a worker. An exception may</p> |

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| | be requested through the DOH-DDD in an emergency situation for time-limited coverage while the agency hires and trains a PAB worker. |
| STAFF TO PARTICIPANT RATIO | <ol style="list-style-type: none"> 1) The staff to participant ratio is 1:1. 2) Exceptions on staff to participant ratio are made on a case-by-case basis by DOH-DDD and will be based on needs identified in the ISP and/or Action Plan. <ol style="list-style-type: none"> a) Less than 1:1 nurse coverage can include one (1) nurse providing services to more than one (1) participant. b) At a maximum, one (1) nurse may provide services to two (2) participants. |
| PROVIDER QUALIFICATIONS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) RN (Column E) LPN (Column F) | Registered Nurse (RN) in accordance with Hawai'i state law. Licensed Practical Nurse (LPN) in accordance with Hawai'i state law and working under the supervision of a Registered Nurse. |
| SUPERVISION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) RN (Column E) | On-site supervision of LPNs providing Skilled Nursing services must be furnished by an RN in accordance with Hawai'i state law. |
| AUTHORIZATION | Initial authorization of skilled nursing assessment is done by the unit nurse and specified in the ISP. Level of service and continued authorization is reviewed by DOH-DDD at a frequency determined by DOH-DDD and specified in the ISP. DOH-DDD actively review participants when skilled nursing hours are not intermittent, time-limited and/or part-time. For participants who require the assessment, judgment, and skilled interventions of a nurse, and whose families need relief, Skilled Nursing services can be authorized instead of Respite services after review by DOH-DDD and must be documented in the ISP and/or Action Plan. |
| ENDING AUTHORIZATION | DOH-DDD will assess through the DOH-DDD review process whether these participants still meet criteria for and can benefit from the waiver |

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| | or whether intense medical needs requiring more continuous nursing care make them more appropriate for QUEST Integration (QI) services from the health plans. |
| DOCUMENTATION STANDARDS | The nurse provides detailed notes of interventions, judgments and assessments and makes documentation available at the frequency specified in the ISP for the DOH-DDD Case Manager and upon request, review by DOH-DDD. |

OPERATIONAL GUIDELINES:

AVAILABILITY OF SERVICE SUPERVISOR:

The Registered Nurse (RN) supervisor must be immediately accessible and available for participants during Skilled Nursing hours:

1. Immediately accessible is defined as having phone communication and protocol in place;
2. Immediately available is defined as staff being designated as standby or on-call; and
3. A crisis contingency plan must be in place for the behavioral or medical health needs of the participant.

FREQUENCY OF SUPERVISION:

On-site supervision by an RN must be conducted monthly or more frequently as indicated in the ISP and/or Action Plan. The RN supervisor must observe and document the observation of the LPN delivering the service as part of the supervision visit.

LOCATION OF SERVICES:

Services must be provided in a residential or community setting that ensures the health and safety of the participants.

1. Residential settings include:
 - a. participant's own home or family home;
 - b. Licensed and certified settings.
2. Community settings include, but are not limited to:
 - a. Community recreational sites;
 - b. Public settings.

SECTION 3.13 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SMES)

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| <p>SERVICE DESCRIPTION</p> | <p>Specialized Medical Equipment and Supplies includes devices, controls, or appliances, specified in the service plan, which enable participants to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live.</p> <p>All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai'i state law. An order is valid one year from the date it was signed.</p> <p>All items must meet applicable standards of manufacture, design and installation.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Specialized medical equipment and supplies include:</p> <ol style="list-style-type: none"> 1) devices, controls, appliances, equipment and supplies, specified in the ISP that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; 2) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; 3) such other durable and non-durable medical equipment not available under the State Plan that are necessary to address participant functional limitations; and 4) necessary medical supplies. |
| <p>TRANSPORTATION</p> | <p>Not included in this service.</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable for this service.</p> |
| <p>LIMITS</p> | <p>There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need.</p> <p>Nutritional diet supplements, such as Ensure and Pediasure, are only covered by the waiver if the participant is able to eat by mouth (no feeding tube) and is at risk for weight loss that will adversely impact the participant's health. Prior to authorization, the plan includes a request from a medical provider and measurable weight goals and a follow-up plan.</p> <p>Additional diapers, pads and gloves over the amount covered by the State Plan may be covered by the waiver only on a temporary or intermittent basis. Temporary is defined as a period of three months or less. Intermittent is defined as occurring at irregular intervals, sporadic and not continuous.</p> |

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| <p>ACTIVITIES NOT ALLOWED</p> | <p>Specialized Medical Equipment and Supplies under the waiver may not replace the medical equipment and supplies covered by other insurances or under the State Plan through the QI health plans, including EPSDT medically necessary equipment and supplies for waiver participants under age 21.</p> <p>All applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies must be followed. This service may not be used to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using network providers that participate with that program and adhering to prior authorization requirements of that program.</p> <p>Specialized Medical Equipment and Supplies exclude those items that are not of direct medical or remedial benefit to the participant or are considered to be experimental.</p> <p>“Direct medical or remedial” benefit is a prescribed specialized treatment and its associated equipment or supply that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement.</p> <p>"Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.</p> <p>Eye glasses, hearing aids, and dentures are not covered.</p> <p>Assessment and training are excluded from this service and are covered under Training and Consultation (T&C).</p> |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Not applicable for this service.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Agency/Vendor (Column H)</p> | <p>The SMES provider must meet applicable State licensure, registration, and certification requirements (e.g. PROVIDER must be authorized by the manufacturer to sell supplies).</p> <p>DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement Agency</p> <p>Medical Supply Company</p> |

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| SUPERVISION STANDARDS | No additional supervision required once equipment or supply is in use by the participant and training has been completed. |
| AUTHORIZATION | Case Manager with approval of Unit Supervisor and Section Supervisor authorizes the service. |
| ENDING SERVICE AUTHORIZATION | This is a one-time purchase and the service ends once the participant has received the specialized medical equipment or supplies and training has been completed. |
| DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B) | <p>Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the equipment or supplies would have been covered but the plan rules were not followed, the equipment or supplies must not be purchased using waiver funds.</p> <p>Documentation is maintained in the file of each participant receiving this service that the equipment or supplies are received, the participant and others have been trained in its use, and the participant/family have signed off that the service meets the participant's needs.</p> |

OPERATIONAL GUIDELINES:

LOCATION OF SERVICES: Specialized Medical Equipment and Supplies (SMES) will be used by the participant in locations that are customary to the participant.

INTERFACE WITH TRAINING AND CONSULTATION:

Training and Consultation (T&C) – OT, PT, Speech or Environmental Accessibility Adaptation Clinician: The assessment of the need for SMES is completed by a qualified T&C professional. Assessments for SMES cannot be bundled with an assessment for Assistive Technology or Environmental Accessibility Adaptations, which must be authorized separately by the DOH-DDD CM. The participant must be offered a choice of providers and can select a different qualified provider for the assessment and/or training needed for the SMES. The T&C professional must not have any conflict of interest with any vendor or business that provides the SMES.

The provider must work closely with the T&C provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.

PROCESS FOR PURCHASING SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SMES):

1. CM receives the request for SMES.
2. CM refers to the T&C provider for assessment.
3. Assessment is completed by a qualified T&C professional to justify the need.
4. CM verifies that the SMES is not available through other sources, including DOE, DVR, QUEST Integration, EPSDT, or other insurance.
5. CM identifies a provider agency or vendor authorized to provide SMES.
6. T&C professional who completed the assessment submits written attestation that there is no conflict of interest with the provider of the SMES.
7. DOH-DDD follows the State of Hawai'i procurement rules.
8. Provider agency or vendor purchases the SMES on behalf of the participant and ensures it is delivered to the home.
9. T&C professional trains the participant and family, caregivers and/or staff on the use of the SMES.

SECTION 3.14 TRAINING & CONSULTATION (T&C)

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| <p>SERVICE DESCRIPTION</p> | <p>Training & Consultation services assist unpaid caregivers, paid service supervisors and/or paid support staff in implementing the goals and outcomes developed from the person-centered planning process and included in the Individualized Service Plan (ISP). Unpaid caregivers are defined as any person, family member, neighbor, friend, or co-worker who provide care, training, guidance, or support to a waiver participant without financial gain or payment.</p> <p>The goals and outcomes are necessary to improve the participant’s independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, occupational therapy, physical therapy, speech and language pathology, and behavior analysis.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>The service may include evaluation and assessment; the development of recommendations for person-centered goals and outcomes; initial and/or ongoing training and/or technical assistance to implement the goals and outcomes; and monitoring of the participant, caregivers and providers in the implementation of the goals and monitoring the implementation and outcomes.</p> <p>Training includes instruction about treatment regimens and other services included in the ISP and/or Action Plan, use of equipment specified in the service plan, and included updates as necessary to safely maintain the participant at home or in the community. All training must be identified and included in the ISP and/or Action Plan.</p> <p>When a participant has a BSP developed through another source (e.g., Department of Education, QUEST Integration, and private insurance), T&C may be authorized to develop a BSP to address behaviors that occur in settings where DOH-DDD services are provided. The author of the BSP must ensure consistency amongst and across the services the participant receives by consulting with the authors of the other BSPs and their treatment teams and utilizing similar interventions in settings where DOH-DDD services are provided, where appropriate. This T&C must include training in implementing the BSP strategies and approaches during waiver service hours, as well as providing periodic monitoring of the BSP to ensure consistency.</p> |

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| | <p>Training and consultation is not intended to provide direct services beyond the time required for the face-to-face evaluation and assessment, and if applicable, providing training, observing/monitoring the implementation of the goals and revising/updating outcomes as appropriate. T&C also includes attendance at ISP meetings if applicable and documentation/report writing.</p> |
| TRANSPORTATION | Not included in this service. |
| LEVELS OF SERVICE | Not applicable. |
| LIMITS | <p>Training and Consultation is time limited, intermittent, and consultative. Time-limited means the service is authorized for a specified time period in the ISP. Intermittent means that the service is delivered at intervals specified by the ISP that generally will be a block of time to complete assessments and training or at ongoing intervals such as ongoing monitoring. Consultative means the T&C provider delivers services in a manner that trains and builds capacity of the workers, family and natural supports who provide the day-to-day supports to the participant.</p> |
| ACTIVITIES NOT ALLOWED | <p>T&C services will not duplicate services provided through another source, including Applied Behavior Analysis (ABA) services covered by a participant's commercial insurance or, if the participant is under 21 years of age, through the Early Periodic Screening Diagnostic and Treatment (EPSDT) services under the Medicaid QUEST Integration Health Plan.</p> <p>This service does not supplant any service that is the responsibility of the Medicaid State Plan under the QUEST Integration health plans, another agency or other insurance.</p> <p>T&C services must not duplicate other services under the Medicaid I/DD Waiver, i.e., may not take the place of the provider's supervision of direct support workers as required to be performed by service supervisors.</p> <p>T&C services must not be provided to children aged three (3) to twenty (20) years of age as part of, or related to, any educational entitlement services.</p> |
| STAFF TO PARTICIPANT RATIO | Not applicable for this service. |
| PROVIDER QUALIFICATION STANDARDS | <p>In addition to General Standards, the T&C provider must be a licensed professional in accordance with Hawai'i state law and possess the experience necessary to deliver the appropriate service within the scope of their practice.</p> <p>1) Behavior Analysis: HAR Chapter 465D</p> |

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| <p>(These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> | <p>Qualified designees must be explicitly listed in the exemptions of their respective licensure law, supervised by a licensed professional, and can only perform duties as permitted by Hawai‘i state law.</p> <ol style="list-style-type: none"> 2) Dietician: HRS Chapter 448B; 3) Occupational Therapist: HRS §457G; 4) Physical Therapist: HRS Chapter 461J; 5) Psychologist: HRS Chapter 465; 6) Speech Language Pathologist: HRS Chapter 468E. <p>All Providers of T&C services must meet the requirements of their respective licensing board. All providers of T&C services must maintain licensing and continuing education documentation. This documentation must be available for review by DOH-DDD upon request.</p> |
| <p>SUPERVISION STANDARDS</p> | <p>Not applicable.</p> |
| <p>AUTHORIZATION</p> | <p>T&C Authorizations are specified for each type of service. Requests for additional T&C hours must be submitted to DOH-DDD in writing for review, with documentation indicating what the previously approved hours were used for and what the additional hours are needed for, prior to delivering services exceeding the CM authorization.</p> <p><u>Behavior Analysis:</u></p> <p><u>Initial evaluation phase:</u> The DOH-DDD Case Management Branch Section Supervisor, in consultation with the Case Manager, may authorize up to five (5) hours of T&C for a qualified provider to make a determination based on data of the need for a formal request for the prior authorization phase.</p> <p><u>Prior authorization phase:</u> The Case Manager will submit the written data and justification provided by the qualified provider following the initial evaluation phase to the DOH-DDD Clinical Interdisciplinary Team (CIT) for a decision to approve additional T&C hours for the purpose of completing the Functional Behavior Assessment (FBA), developing a Behavior Support Plan (BSP), and training in implementing the BSP.</p> <p><u>Monitoring phase:</u> The CMB Section Supervisor may authorize ongoing monitoring of the implementation of the BSP, retraining, collection and review of relevant data, and</p> |

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| | <p>updating the BSP as needed. The amount of authorized hours for monitoring will be determined by DOH-DDD as part of the prior authorization decision. The monitoring phase requires re-authorization by DOH-DDD every six (6) months for the first year after completion of the initial training on the BSP or at intervals to be determined by DOH-DDD.</p> <p>Hours authorized for T&C monitoring must not be used by the author of the BSP to complete tasks or other duties that are the responsibility of the DOH-DDD provider’s service supervisor.</p> <p>A request for additional hours per month and/or an extension of the ongoing monthly monitoring by the author of the BSP must be requested through DOH-DDD, which may authorize additional hours following a review of data and/or documentation which demonstrates the need for increased hours.</p> <p><u>Clinical Assessments</u> (Dietary, OT, PT, Psychology, and Speech): DOH-DDD Case Manager, in consultation with Unit Supervisor, authorizes up to four (4) hours to assess, and to develop a written report and recommendations.</p> <p><u>Environmental Accessibility Adaptations Assessments:</u> DOH-DDD Case Manager, in consultation with Unit Supervisor, authorizes up to 20 hours to assess, and to develop a written report and recommendations/specifications for modifications. CM may authorize up to five (5) additional hours after the project is completed to re-assess, train and sign-off that the modification meets the participant’s needs. Any requests to exceed the authorizations must be submitted in writing from the T&C provider with justification of the need for additional hours due to complexity of the project as well as documentation indicating what the previously approved hours were used for. The written justification and request are submitted to the Case Manager and will be reviewed by the CM Unit Supervisor and CMB Section Supervisor.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <p>Documentation of services must include evaluation, assessment, consultation notes, reports or written plans. All documentation must be available for review by DOH-DDD upon request.</p> <p><u>Behavior Analysis:</u></p> |

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| | <ol style="list-style-type: none"> 1) Refer to Timelines for Completing T&C – Behavior Analysis Activities (Policy #2.01). 2) Any requests for additional hours of T&C must be submitted in writing and provide a detailed description of how the additional hours will be used each month to improve the implementation of the BSP and/or collection of data. 3) If a restrictive intervention is proposed for use in a BSP, the intervention must be the least restrictive method to address the challenging behavior (Policy #2.01 and #2.02). The restrictive intervention must only be used to prevent imminent risk of harm to the participant or others and should be removed once the imminent risk is no longer present. 4) The licensed professional must document the ongoing supervision for qualified designees. <p><u>OT/PT/Speech/Dietary/Psychology:</u></p> <ol style="list-style-type: none"> 1) Complete comprehensive assessment that identifies, at a minimum, strengths, abilities, interests, needs, and recommendations. 2) Any requests for additional hours of T&C must be submitted in writing and provide a detailed description of how the additional hours will be used, justification for need that exceeded the approved number of hours. 3) Written assessment must be submitted to DOH-DDD Case Manager within 14 days after referral is accepted by the provider unless an extension is requested in writing and granted by the DOH-DDD CM. 4) Assessments for Environmental Accessibility Adaptations may take several weeks to complete depending on family and participant availability, complexity of project and other variables. The timeline for completing the assessment is determined on an individual basis by the DOH-DDD in consultation with the T&C provider. |
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OPERATIONAL GUIDELINES:

TIMELINES FOR COMPLETING T&C – BEHAVIOR ANALYSIS ACTIVITIES:

1. The CM must initiate contact with a T&C provider within five (5) business days of receiving written authorization from the CIT.

2. Once the FBA is completed, a BSP must be developed and written within fourteen (14) business days and must include the date the BSP report was completed as well as the name of the author and his/her credentials. A final copy of the BSP report must be forwarded by the author to the DOH-DDD CM within two (2) business days of the date of completion indicated on the BSP report. See Policy #2.02, Restrictive Interventions, for additional BSP requirements.
3. Training must be initiated by the author of the BSP within seven (7) business days of the completion date indicated on the BSP. Training must include face-to-face instruction of the interventions and data collection methods included in the BSP for all individual's in the participant's circle of support who will implement the BSP.
4. Any variance from these timelines must be requested in writing and must be granted by the DOH-DDD CM.

REPORTS TO CASE MANAGEMENT:

For Behavior Analysis T&C, documentation of challenging behavior(s), including the effectiveness of the recommendations and/or interventions indicated in the BSP, must be reported by the provider to the DOH-DDD CM every quarter or more frequently, as documented in the ISP.

LOCATION OF SERVICES: This service may be delivered in the participant's home or in the community as described in the ISP.

SECTION 3.15

VEHICULAR MODIFICATIONS

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| <p>SERVICE DESCRIPTION</p> | <p>Adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified in the ISP as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.</p> <p>The approved amount is based on modifications to a full-sized van or standard size automobile.</p> <p>All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai'i state law. An order is valid one year from the date it was signed.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Modifications include adaptations to the vehicle to enable the participant to safely enter/exit the vehicle, as well as passive vehicle restraint devices such as wheelchair tie-downs.</p> <p>The cost of assessment and training in use of the modification is included in the service.</p> |
| <p>TRANSPORTATION</p> | <p>Not included in this service.</p> |
| <p>LEVELS OF SERVICE</p> | <p>Not applicable for this service.</p> |
| <p>LIMITS</p> | <p>Modifications are limited to \$36,000 per request, one request every 7 years, including if received under a previous waiver.</p> |
| <p>ACTIVITIES NOT ALLOWED</p> | <p>The following are specifically excluded:</p> <ol style="list-style-type: none"> 1) adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual; 2) purchase or lease of a vehicle; 3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification; 4) modifications to vehicles that are older than five (5) years or that have more than 50,000 miles; 5) modifications to vehicles with frame or flood damage that have been determined from inspection to be ineligible for modification; and 6) modifications that are for the convenience of the caregiver/driver and are not used by the participant, such as automatic door openers and automatic starters. |
| <p>STAFF TO PARTICIPANT RATIO</p> | <p>Not applicable for this service.</p> |
| <p>PROVIDER QUALIFICATION STANDARDS</p> | <p>Vendor with Medicaid Provider Agreement, a minimum of two years of experience performing vehicle modifications</p> |

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| <p>(These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Vendor (Column H)</p> | <p>a) Meet applicable State licensure, registration, and certification requirements (be authorized by the manufacturer to sell, install, and/or repair equipment); and</p> <p>b) Ensure that all items meet applicable standards for manufacture, design, and installation.</p> |
| <p>SUPERVISION STANDARDS</p> | <p>Training in the use of the Vehicular Modification is completed by the T&C authorized provider. The vendor that modified the vehicle must be on-site during the training as part of the Vehicular Modification service.</p> <p>No additional supervision required once the Vehicular Modification is in use by the participant and training has been completed.</p> |
| <p>AUTHORIZATION</p> | <p>Case Manager with approval of Unit Supervisor and Section Supervisor authorizes the Training & Consultation (T&C) services for assessment and follow-up training.</p> <p>Case Manager with approval of Unit Supervisor and Section Supervisor authorizes the Vehicular Modification service.</p> |
| <p>ENDING SERVICE AUTHORIZATION</p> | <p>This is a one-time purchase and the service ends once the participant has received the Vehicular Modification and training has been completed.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <p>Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under §110 of the Rehabilitation Act of 1973 or covered by other insurance. If the Vehicular Modification would have been covered but the plan rules were not followed, the device must not be purchased using waiver funds.</p> <p>Documentation is maintained in the participant's file the date the Vehicular Modification is received, date(s) and names of the participant, family and/or staff who were trained in its use, and the participant/family sign-off that the service meets the participant's needs.</p> |

OPERATIONAL GUIDELINES:

Process for Obtaining a Vehicular Modification:

1. CM receives the request for a Vehicular Modification from the participant and/or family.

2. CM refers to the Vehicular Modification provider for an assessment of the participant's needs and recommend medically necessary modifications to the family vehicle.
3. CM verifies that SMES is not available through other sources, including DVR or other insurance.
4. Specifications for the modification are developed and posted on the State of Hawai'i Procurement website (HIePRO) by DOH-DDD.
5. Once the bid is awarded, the Case Manager enters the award amount in the calculator and authorizes the service.
6. The Vehicular Modification provider will complete the work.
7. Upon completion, the Vehicular Modification provider, participant, family and/or staff will meet to ensure training is completed and sign-off that the modification meets the participant's need.
8. The Vehicular Modification provider will bill for the authorized amount in the calculator, which is the amount of the bid award from HIePRO.

SECTION 3.16.A WAIVER EMERGENCY SERVICES: CRISIS MOBILE OUTREACH (CMO)

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| <p>SERVICE DESCRIPTION</p> | <p>Crisis Mobile Outreach (CMO) services include the initial call requesting outreach and the immediate, face-to-face, on-site crisis support to participants and families experiencing an active crisis which is impacting the participant's ability to function within their family, living situation, and/or community environments.</p> <p>Active crisis includes situations in which the DOH-DDD participant exhibits behaviors of such intensity, duration, and frequency that it endangers his/her safety or the safety of others. Without CMO services, these participants may experience hardship due to placement disruption and incarceration and/or the utilization of hospital services. The CMO must be deployed to provide immediate face-to-face, on-site response and supports when the Provider has triaged the call and determined an active crisis exists.</p> <p>CMO is available to waiver participants of any age.</p> <p>The Provider must accept all referrals from DOH-DDD.</p> <p>Services are based on the ISP and/or Action Plan from the DOH-DDD Case Manager, if available.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>The outreach service must be face-to-face with the participant for at least a portion of the visit.</p> <p>The provider must provide Crisis Mobile Outreach services that include, but are not limited to, the following interventions to deescalate crisis situations:</p> <ol style="list-style-type: none"> 1) Telephone consultation through Crisis Telephone Hotline (CTH) with the family, caregiver, or program staff for advice on how best to manage the situation and that results in mobilization. 2) Staff being mobilized must receive information from Crisis Telephone Hotline (CTH) and prepare for mobilization. 3) Travel to and from location. 4) Initial risk assessment. 5) Build rapport. 6) Assess for language interpreter. 7) Assess for need for medical or psychiatric consults. 8) Coordinate with other agencies, such as police or emergency personnel. |

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| | <p>9) Conduct an overall assessment of the participant, situation and environment.</p> <p>10) Create a plan for services to implement with the participant and circle of supports.</p> <p>11) Provide support, problem solving, and conflict resolution, or recommend interventions in a brief therapy, solution focused therapeutic style.</p> <p>12) Provide a personalized plan moving forward, which could include a safety plan, appropriate information, referral and a contact number for future consultation and follow-up.</p> <p>Review Positive Behavior Plan (PBS) to determine effectiveness and, if appropriate, recommend necessary follow-up action as the result of the Emergency Outreach.</p> <p>1) Consult with supervisor to provide a referral to the licensed setting for Out-of-Home Stabilization (OHS) services [formerly called the Crisis Shelter] if necessary.</p> <p>2) Provide information, assessment and observations to help support intake process into the OHS setting;</p> <p>3) Complete arrangements, including transportation, for more intensive services, such as OHS or hospitalization, in the event the CMO services are not sufficient to stabilize;</p> <p>4) Provide additional staffing if needed to stabilize situation and/or transport participant to the licensed setting for OHS services, hospital, or other location.</p> |
| TRANSPORTATION | Transportation to and from the participant's location is reimbursable. |
| LEVELS OF SERVICE | Not applicable. There is only one level of service. |
| LIMITS | <p>There are no limits to the number of times a participant receives CMO; however, frequent use of this service requires additional follow-up to address the underlying issues causing use of CMO.</p> <p>Short-term time-limited (up to two hours) follow-up monitoring of the participant and situation for stability immediately after the crisis.</p> |
| ACTIVITIES NOT ALLOWED | This service must not be billed if there was no face-to-face activity with the participant. |
| STAFF TO PARTICIPANT RATIO | The CMO service supervisor determines the number of CMO staff to deploy based upon the participant's needs and the situation. |

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| <p>PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>DSW (Column B)</p> | <p>In addition to General Standards, staff providing services to participants and their circles of support must have a bachelor’s degree, at minimum, in social services, psychology, human development, family sciences, or other related degree, and at least one-and-a-half (1.5) years of experience working with people with I/DD and/or behavioral crisis.</p> <p>CMO staff must also possess Specialized Training as specified in Operational Guidelines below.</p> |
| <p>SUPERVISION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1)</p> <p>Service Supervisor (Column A)</p> | <p>In addition to General Standards, service supervisors must have all of the following qualifications:</p> <ol style="list-style-type: none"> 1) A master’s degree, at minimum, in psychology, social work, or related field; 2) Possess a valid license to practice in the State of Hawai‘i as a licensed clinical social worker (“LCSW”), licensed mental health counselor (“LMHC”), licensed marriage and family therapist (“LMFT”), licensed psychologist (“LP”), or registered nurse (“RN”); and 3) At least three (3) years of experience working with people in crisis and/or people with I/DD with acute behaviors. |
| <p>AUTHORIZATION</p> | <p>CMO referrals are authorized through the Crisis Telephone Hotline (CTH) screening process. Any referral to a level of care beyond the licensed setting for OHS services, such as hospitalization for medical or psychological reasons must be authorized by a CMO supervisor and medical consultation staff.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <p>Documentation requirements. Required documentation for each dispatched CMO must include, but is not limited to, the following:</p> <ol style="list-style-type: none"> 1) Name(s) of all people involved in the crisis situation, including participant; 2) Date and time that referral was received from CTH; 3) Dates and times that CMO was dispatched and arrived at location, with total number of minutes from dispatch to arrival; 4) Location and address where the crisis occurred and outreach is provided; 5) Nature of the crisis; 6) Name of staff who provided services; 7) Assessment of risk and the results of that assessment; including level of staffing if person is removed from setting; |

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| | 8) Overall assessment of the participant and situation; 9) Services provided; 10) Outcomes; 11) Details of plan of care; and 12) Details concerning OHS referral, if needed 13) Documentation of reason for exceeding 45-minute response requirement per the Operational Guidelines below, if applicable. |
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OPERATIONAL GUIDELINES:

The Provider must design and facilitate a standardized script/protocol to:

1. Follow a standard protocol for assessment, and it must include, but not be limited to, the following information:
 - a. Name(s) of all people involved in the crisis situation, including the participant;
 - b. Address and description of current living situation;
 - c. Cultural and language considerations;
 - d. Risk of harm to self or others;
 - e. Abuse and neglect;
 - f. Trauma;
 - g. Need for emergency services (police or ambulance);
 - h. Description of the crisis situation including people involved, source of stress, behaviors of concern, onset and duration of crisis;
 - i. Treatment history and if there is a current Behavior Support Plan (BSP), if BSP is currently being utilized;
 - j. Co-occurring mental health issues;
 - k. Medical issues and allergies;
 - l. Medications, type, regimen and current and historical compliance with medication regimen;
 - m. Ongoing needs;
 - n. Environmental stressors;
 - o. Life/transition stressors; and
 - p. Strengths and vulnerabilities of the participant.
2. Arrive at the participant’s location within forty-five (45) minutes of dispatch. Exceptions are made for the counties of Hawai‘i, Maui, and Kauai due to geographic remoteness and for City and County of Honolulu (island of Oahu) due to traffic delays caused by unforeseen circumstances. All exceptions for time exceeding 45-minute requirement must be documented in progress notes and submitted to DOH-DDD with quarterly reports of performance.
3. If a referral to a licensed setting for OHS services is necessary, utilize a protocol to discern the need based on current risk of harm, the ability to de-escalate the situation in person and the potential for future risk of harm. All referrals for OHS services will, at a minimum, require notification of a supervisor with the option of supervisor approval as a protocol.

4. Follow up with the participant who was in crisis and/or family members or caregivers to assess if further assistance is needed within thirty-six (36) hours of initial face-to-face contact. “Stabilized in place” is defined as the participant has had no further crisis situations, police contact or hospital visits between CMO and follow-up call.
5. Contact DOH-DDD Case Manager to provide update and give a report by phone by the next business day of the occurrence with information from Crisis Telephone Hotline (CTH) staff by the next business day. Confirm from DOH-DDD Case Manager the participant’s waiver enrollment status.

HOURS OF OPERATION:

Crisis Mobile Outreach must be available 24 hours a day, seven (7) days a week, including holidays.

AVAILABILITY OF SERVICE SUPERVISOR:

A supervisor must be on call 24 hours a day, seven (7) days a week, in the event of clinically complex or psychiatric-related situations in need of consultation, and a supervisor must be available for on-call service, consultation, direction, and case debriefings.

FREQUENCY OF SUPERVISION:

1. Staff must meet with their supervisor individually no less than once a month, and must be a part of clinical team meetings held monthly.
2. Debriefings following the use of restrictive interventions must occur with the supervisor and staff involved within twenty-four (24) hours of the event.

LOCATION OF SERVICES:

CMO services must be delivered at the residential or community setting where the participant is located.

ON-CALL MEDICAL CONSULTATION:

On-call medical consultation staff must be a registered nurse, physician or psychiatrist with a valid license to practice in the State of Hawai‘i.

COORDINATION OF CARE:

CMO services must be coordinated with emergency services, police, and OHS and CTH as appropriate. The CMO Provider is responsible to contact the participant’s DOH-DDD Case Manager to provide information concerning the services provided and coordinate appropriate follow-up services within the next business day of occurrence.

SPECIALIZED TRAINING AND COMPETENCIES FOR WAIVER EMERGENCY SERVICES STAFF:

1. Prior to providing services, all staff must receive at least twenty-four (24) hours of orientation training which covers the following topics: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources.

2. The provider must provide documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the provider's training curriculum, and I/DD-specific situations experienced by crisis telephone stabilization workers. Training must promote evidence-based services and best practice procedures for urgent and emergent care situations.
3. Training for staff must include but not be limited to the following topics:
 - a. Person Centered Planning;
 - b. Familiarity with DOH-DDD and mental health service array and other community resources and services to provide guidance and referrals to callers;
 - c. Risk Assessment including suicide, homicide, and any other risk of harm to self or others;
 - d. Screening, assessment, and intervention/treatment planning;
 - e. Positive behavioral support;
 - f. Functional behavioral assessment and behavioral support plan functions and processes;
 - g. Behavioral crisis intervention system (Safety Care, Crisis Prevention Institute (CPI), the Mandt system);
 - h. Dual diagnosis (I/DD and mental health);
 - i. A familiarity with psychotropic medications, classifications and side effects;
 - j. Trauma informed care;
 - k. De-escalation techniques; and
 - l. Cultural and diversity awareness and sensitivity.
4. All Crisis staff must show competency in the following areas:
 - a. Following the guidelines of the Standards and their own organization;
 - b. Showing empathy, concern and caring for all participants receiving services;
 - c. Being able to direct and facilitate an effective interaction and avoid power struggles;
 - d. Working with supervisors and other team members to make decisions and provide services;
 - e. Offering choices versus directives;
 - f. Interacting with individuals with intellectual and developmental disabilities and communication deficits;
 - g. Ability to interact with people who are escalated, emotional, anxious, and angry;
 - h. Knowledge of how and when to utilize problem solving, alternative choices, and prescribing steps moving forward; and
 - i. Knowledge of how to recognize and act upon a life or death situation.

MANDATORY REPORTING:

1. Any suspected case of physical abuse, psychological abuse, sexual abuse, financial exploitation, caregiver neglect, or self-neglect of a participant who is a dependent adult must be reported by the provider to Adult Protective Services and to DOH-DDD Case Manager immediately upon discovery.
2. Any suspected case of child abuse or neglect of a participant who is under the age of eighteen (18) must be reported by the provider to Child Welfare Services, and to the DOH-DDD Case Manager immediately upon discovery.

QUALITY ASSURANCE REPORTING REQUIREMENTS:

1. The Provider must maintain data on:
 - a. Performance measures:

1. Location of the crisis;
 2. Types of interventions used to stabilize; and
 3. Disposition of CMO (out-of-home, emergency department, OHS, or specify other).
- b. Operational performance measures:
1. Staff turnover;
 2. Supervision occurring;
 3. Satisfactory agency record/documentation;
 4. Progress toward workforce development for Registered Behavior Technicians (RBTs); and
 5. Grievances.
2. Measurements to include, but not be limited to:
- a. Length of time required for Crisis Telephone Hotline (CTH) call to result in decision to dispatch CMO staff;
 - b. Length of time between dispatch and arrival of the CMO on-site;
 - c. Length of time from arrival to stabilization and completion of intervention;
 - d. Percentage of CMO staff who meet qualifications and competencies; and
 - e. Percentage of individuals who have had previous contact with Crisis Services within the last three (3) calendar months.
3. Data must be analyzed quarterly for trends and recommendations for improvement; and
4. Submit data analysis on CMO in a report to DOH-DDD on a quarterly basis.

SECTION 3.16.B WAIVER EMERGENCY SERVICES: OUT-OF-HOME STABILIZATION (OHS)

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| <p>SERVICE DESCRIPTION</p> | <p>Out-of-Home Stabilization (OHS) services [formerly called Crisis Shelter services] provide emergency out-of-home placement of adult participants in need of intensive intervention in order to avoid institutionalization or more restrictive placement and in order to return to the current or a new living situation once stable. OHS services are delivered at a licensed setting operated by the Provider.</p> <p>This is a short-term, temporary service. Transition and discharge planning must start from admission, looking at planning for successful community living.</p> <p>The Provider must comply with HAR, Title 11, Chapter 98, for Special Treatment Facilities to operate a Therapeutic Living Program where OHS services are delivered. The maximum home capacity is three (3) adults.</p> <p>The Provider must accept all DOH-DDD referrals based on bed availability.</p> |
| <p>REIMBURSABLE ACTIVITIES</p> | <p>Reimbursable activities include:</p> <ol style="list-style-type: none"> 1) Receive information and assessment from CMO to prepare for participant intake; 2) Provide DOH-DDD participant and circle of supports with information for questions and concerns they may have when entering the licensed setting to receive OHS services that include but are not limited to: <ol style="list-style-type: none"> a) Description of service; b) Rules of OHS services and the licensed setting; c) What to bring/what not to bring; and d) Visiting hours/contact information; 3) Build rapport and working relationship with participant and circle of supports; 4) Assess need for language interpreter, and medical or psychiatric consultation; 5) Upon admission the provider must develop an interim plan to address the participant’s need(s) for crisis stabilization and intervention; 6) Conduct an overall assessment of the participant, working collaboratively with the participant and circle of supports to gather information to learn about |

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| | <p>the participant and gain insight that may be helpful in discharge planning;</p> <p>7) Assess and coordinate if a higher level of care is needed for medical or psychological reasons, or if police is needed for criminal behavior. The provider must seek emergency hospitalization for a participant when deemed necessary and appropriate by provider's clinical staff to ensure the participant's safety and the safety of others.</p> <p>8) The provider must develop an Individual Plan (IP) in coordination with and approval from the DOH-DDD Case Manager or designee within seven (7) days of admission. The IP must be based on the Individualized Service Plan (ISP) from the DOH-DDD Case Manager and a service delivery approach that includes:</p> <ul style="list-style-type: none"> a) Person-centered aspects of the ISP and the participant's input, as appropriate; b) Discharge criteria that include an estimated length of stay; c) Training for families, caregivers, and providers for post-discharge community-based living and services, if indicated. <p>9) Based on assessment, connect participant with appropriate medical, psychiatric, waiver or other services as needed:</p> <ul style="list-style-type: none"> a) Psychiatric assessment, treatment, and/or consultation including psychotropic medication management and monitoring; b) Psychological assessment, treatment, and/or consultation c) Training and Consultation (T&C) for completion of a Functional Behavior Analysis (FBA) and development of a Positive Behavior Support Plan (BSP); d) Medical assessment, treatment, and/or consultation and medication administration, as necessary; <p>10) Deliver crisis stabilization and intervention services within a safe environment to calm and manage the participant;</p> <p>11) Provide medication management and administration. This must include prescriptive authority for medical staff while the participant is receiving OHS services at the licensed setting;</p> |
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| | <p>12) Provide support and family therapy, as appropriate, to circle of supports;</p> <p>13) Provide a personalized discharge-transition plan moving forward that includes the participant and circle of supports in the process. This may include a safety plan, appropriate information, referral and contact number for future consultation and follow up;</p> <p>14) Prepare and specify assignments, roles and responsibilities to implement the discharge-transition plan to support the participant in the residential environment he/she will be in upon discharge, so that crisis support will “fade” no later than 90 calendar days after implementation of the agreed upon plans;</p> <p>15) Provide training with circle of supports as a part of the transition process; and</p> <p>16) Provide follow-up services after discharge that may include support, further training, and consultation to DOH-DDD participant and circle of supports for 30 calendar days.</p> |
| TRANSPORTATION | <p>Transportation of the participant to and from the licensed setting for OHS services is included in the cost of this service. Transportation must be provided for inter-island air travel for a participant located on a neighbor island to the licensed setting for OHS services located on Oahu.</p> <p>Non-Medical Transportation to and from non-medical services and activities is included.</p> |
| LEVELS OF SERVICE | Not applicable. There is only one level of service. |
| LIMITS | This is a short term stabilization intervention that will not exceed 30 calendar days unless one additional 30-calendar day extension is authorized by DOH-DDD. If extenuating circumstances require that the participant remain in the licensed OHS setting beyond 60 days, DOH-DDD must authorize the extension. |
| ACTIVITIES NOT ALLOWED | <p>This service must not be billed on the date of admission to a hospital or for any days of hospitalization. Services may be billed on the date of discharge from the hospital when the participant returns and receives OHS services.</p> <p>Medical Transportation to and from medical appointments are provided through the participant’s Medicaid Health Plan and are excluded from this service.</p> |
| STAFF TO PARTICIPANT RATIO | 1) At minimum, two (2) direct care staff must be on duty per shift, with one (1) staff awake during overnight shifts. |

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| | <ol style="list-style-type: none"> 2) A ratio of not less than one (1) staff to two (2) participants must be maintained at all times. 3) The provider must ensure the provision of necessary additional personnel to meet the needs of the participant receiving services for emergencies including escorting and remaining with the participant at an emergency unit, or maintaining one to one (1:1) supervision of a participant. This may include increased staff within the first 72 hours to meet stabilization needs. |
| PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) DSW (Column B) | <p>In addition to General Standards, staff providing services to participants and their circles of support must have a bachelor’s degree, at minimum, in social services, psychology, human development, family sciences, or other related degree, and at least one-and-a-half (1.5) years of experience working with people with I/DD and/or behavioral crisis.</p> <p>OHS staff must also possess specialized training as specified in Operational Guidelines below.</p> |
| SUPERVISION STANDARDS (These are in addition to General Standards, See Page 51, Section 2.2, Table 2.2-1) Service Supervisor (Column A) | <p>In addition to General Standards, service supervisors must have all of the following qualifications:</p> <ol style="list-style-type: none"> 1) A master’s degree, at minimum, in psychology, social work, or related field; 2) Possess a valid license to practice in the State of Hawai‘i as a licensed clinical social worker (“LCSW”), licensed mental health counselor (“LMHC”), licensed marriage and family therapist (“LMFT”), licensed psychologist (“LP”), or registered nurse (“RN”); and 3) At least three (3) years of experience working with people in crisis and/or people with I/DD with acute behaviors. 4) The service supervisor must be certified to train staff in the provider’s crisis intervention system. 5) The service supervisor must be able demonstrate to proficiency the ability to train staff on the BSP, if applicable and following training from the licensed professional, or qualified designee, in accordance with Hawai‘i state law. |
| AUTHORIZATION | OHS referrals come from Crisis Mobile Outreach (CMO) after they have determined the participant to be appropriate |

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| | <p>for services. Referrals may also come directly from the DOH-DDD Case Manager.</p> <p>OHS services for calendar days one through three (1-3) must be authorized by the CMO supervisor in consultation with OHS supervisor (if different from the CMO supervisor) and medical staff.</p> <p>If the participant will require OHS services beyond three (3) calendar days, the provider must seek verbal prior authorization by speaking with a DOH-DDD Branch Chief or DOH-DDD Administrator by phone. Leaving a voice message or sending an email must not constitute a request for prior authorization. Written authorization will be sent by fax to the provider within one (1) business day of the verbal authorization.</p> <p>The initial period of authorization covers (4) four through 30 calendar days. A maximum of an additional 30 calendar days may be prior authorized by DOH-DDD upon the provider's written request for the extension to the DOH-DDD Branch Chief or DOH-DDD Administrator. If extenuating circumstances require that the participant remain in the licensed OHS setting beyond 60 days, the DOH-DDD Administrator or DOH-DDD Branch Chief must review the written request for extension and authorize on an individual basis.</p> |
| <p>DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)</p> | <ol style="list-style-type: none"> 1) Each shift staff will complete required documentation including, but not limited to, the following: <ol style="list-style-type: none"> a) Name of DOH-DDD participant; b) Name of the shift staff who provided services; c) Date and time of shift; d) Services provided; e) Description of activities and behaviors of DOH-DDD participant; f) BSP interventions used and efficacy of interventions; g) Insights and impressions of time spent with DOH-DDD participant; and h) Follow-up, consultation or coordination needed or facilitated. 2) A special incident report must be completed for any incidents of physical aggression, threats of harm to self, including self-injurious behavior, suicidal ideation or attempts, and/or property destruction that |

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| | <p>creates a health and safety issue. Special incident reports must include but not limited to:</p> <ul style="list-style-type: none"> a) Name(s) of all people involved in crisis situation, including the participant; b) Name of the staff who provided services; c) Date and time that incident occurred (start time and end time); d) Description of antecedents and behaviors of the participant; e) BSP interventions used and efficacy of interventions; f) Resolution or how incident ended; g) Observations of the participant after incident; h) Insights and impressions based on observation of the participant in crisis (what worked and what did not in supporting the participant and how to avoid future crisis); i) Documentation of supervisor debriefing with staff within 24 hours of incident in person or by phone. Debriefing will review information and insights from the incident and identify opportunities for improvement in service delivery; and j) In addition to this special incident report an Adverse Event Report Form may be required (see Appendix 5A). <p>3) If staff utilizes any chemical, physical, or mechanical restraints or emergency procedures as interventions to maintain health and safety of milieu, documentation must include, but not be limited to, the following:</p> <ul style="list-style-type: none"> a) Name(s) of all people involved in crisis situation, including the participant; b) Name of staff who facilitated the restrictive procedure; c) Lesser restrictive interventions that were attempted prior to use of restraint or emergency procedure; d) Date and time that restrictive procedure was initiated; e) Observations of the participant during the monitoring process as restrictive procedure is being facilitated; f) Time that restrictive procedure was terminated; g) Observations of the participant after restrictive procedure was terminated; and |
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| | <p>h) An AER is required per DOH-DDD’s P&P #3.07, <i>Adverse Event Report for People Receiving Developmental Disabilities Division Services</i> (see Appendix 5A).</p> <p>4) The provider must report a participant’s hospital admission as an adverse event and follow the procedures for Adverse Event Reporting by using the AER form (see Appendix 5B for instructions).</p> <p>5) Report on a quarterly basis (July, October, January and April) the provider’s progress toward workforce development for RBTs. Documentation will include:</p> <ul style="list-style-type: none"> a) the staff name b) date of hire c) status (staff has not started coursework; staff is completing 40 hours of coursework; staff has completed coursework and is performing competency work with Licensed Behavior Analyst; staff has taken the exam – did not pass; staff has passed the exam); and d) comments to explain status if needed. <p>DOH-DDD will provide a spreadsheet template with the categories for reporting.</p> |
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OPERATIONAL GUIDELINES:

The Provider must ensure that OHS services are:

1. provided in a safe and therapeutic milieu that supports and observes the participant at all times;
2. provided in an environment conducive to recovery which provides an opportunity for individuals to stabilize to baseline or better and learn skills to promote wellness and community living;
3. delivered in a manner that ensures the capacity to adjust settings and staffing to maintain a safe and therapeutic environment at all times;
4. coordinated with referrals and all necessary services and evaluations as needed;
5. delivered in accordance with DOH-DDD’s P&P #2.01 *Positive Behavior Supports*, #2.02 *Restrictive Interventions*, #2.03 *Behavior Support Review*, and #3.07 *Adverse Event Report for People Receiving Developmental Disabilities Division Services*; and

When required, the Provider must secure Training and Consultation (T&C) Behavior Analysis services for completion of a Functional Behavior Analysis (FBA) and development of a Positive Behavior Support Plan (BSP) plan by a qualified professional or designee in accordance with Hawai‘i state law. The Provider must seek prior authorization from DOH-DDD for T&C Behavior Analysis services. Ensure that OHS staff are trained and monitored by the T&C Behavior Analysis provider.

HOURS OF OPERATION:

OHS services must be available 24 hours a day, seven (7) days a week, including holidays.

AVAILABILITY OF SERVICE SUPERVISOR:

1. A supervisor must be on call 24 hours a day, seven (7) days a week, in the event of clinically complex or psychiatric-related situations in need of consultation, and a supervisor must be available for on-call service, consultation, direction, and case debriefings.
2. Provider staff must be under the supervision of a supervisor. A supervisor must be on the premises of the licensed setting at a minimum of eight (8) hours per business day (Monday – Friday). If the supervisor will be away from the premises for brief periods due to meetings or weekend supervision, the supervisor must be available by phone at all times.

FREQUENCY OF SUPERVISION:

1. Staff must meet with supervisor individually no less than once a month, and must be a part of clinical team meetings held monthly.
2. Debriefings following use of restrictive interventions must occur with the supervisor and staff involved within 24 hours of the event.

LOCATION OF SERVICES:

The Provider must operate a facility that meets all licensure requirements from Department of Health, Office of Health Care Assurance (DOH-OHCA) as a Special Treatment Facility (Title 11, Chapter 98, Hawai‘i Administrative Rules) to operate the Therapeutic Living Program where OHS services are delivered.

MEDICAL CONSULTATION:

1. A licensed medical professional must be on staff or on contract to establish the system of operation for administering or supervising medication and medical needs or requirements, monitoring the participant’s response to medications, and training staff to administer medication and proper protocols.
2. A licensed medical professional must be available 24 hours a day, seven (7) days a week. The licensed medical professional does not need to be on-site for that time period but must be on-call and accessible 24 hours a day, seven (7) days a week.

COORDINATION OF CARE:

OHS services must be coordinated with emergency medical services, as appropriate. The Provider must coordinate and notify the participant’s DOH-DDD Case Manager of any adverse events. The Provider must also coordinate with the family and circle of supports to be an active partner in treatment and transition.

SPECIALIZED TRAINING AND COMPETENCIES FOR WAIVER EMERGENCY SERVICES STAFF:

1. Prior to providing services, all staff must receive at least 24 hours of orientation training which covers the following topics: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources.
2. The Provider must provide documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the provider's training curriculum, and I/DD-specific situations. Training must promote evidence-based services and best practice procedures for urgent and emergent care situations.
3. Training for staff must include but not be limited to the following topics:
 - a. Person Centered Planning;
 - b. Familiarity with DOH-DDD and mental health service array and other community resources and services to provide guidance and referrals to callers;
 - c. Risk Assessment including suicide, homicide, and any other risk of harm to self or others;
 - d. Screening, assessment, and intervention/treatment planning;
 - e. Positive behavioral support;
 - f. Functional behavioral assessment and behavioral support plan functions and processes;
 - g. Behavioral crisis intervention system (Safety Care, Crisis Prevention Institute (CPI), the Mandt system);
 - h. Dual diagnosis (I/DD and mental health);
 - i. A familiarity with psychotropic medications, classifications and side effects;
 - j. Trauma informed care;
 - k. De-escalation techniques; and
 - l. Cultural and diversity awareness and sensitivity.
4. All staff must show competency in the following areas:
 - a. Following the guidelines of the Standards and their own organization;
 - b. Showing empathy, concern and caring for all participants receiving services;
 - c. Being able to direct and facilitate an effective interaction and avoid power struggles;
 - d. Working with supervisors and other team members to make decisions and provide services;
 - e. Offering choices versus directives;
 - f. Interacting with individuals with intellectual and developmental disabilities and communication deficits;
 - g. Ability to interact with people who are escalated, emotional, anxious, and angry;
 - h. Knowledge of how and when to utilize problem solving, alternative choices, and prescribing steps moving forward; and
 - i. Knowledge of how to recognize and act upon a life or death situation.

QUALITY ASSURANCE REPORTING REQUIREMENTS:

1. The Provider must maintain data on:
 - a. Performance measures
 - 1) Safety;

- 2) Decrease in behaviors of risk of harm; and
- 3) Discharges with successful placement;
- b. Restraints and restrictive procedures administered
- c. Operational performance measures
 - 1) Staff turnover;
 - 2) Supervision occurring;
 - 3) Satisfactory agency record/documentation; and
 - 4) Grievances;
2. The Provider must analyze data quarterly for trends and recommendations for improvement; and
3. The Provider must submit data analysis on OHS services in a report to DOH-DDD on a quarterly basis.

HOME AND COMMUNITY BASED SERVICES COMMUNITY INTEGRATION:

For OHS providers that served waiver participants in settings in the previous waiver renewal, the setting(s) must be in compliance or working toward compliance as part of the ***My Choice My Way*** state transition plan. This type of setting is a Therapeutic Living Program (TLP) licensed as a Special Treatment Facility.

Validation of the setting(s) may identify areas requiring remediation. In those situations, the provider agency must complete a corrective action plan (CAP) based on the validation completed by the licensing state agency.

Upon approval of the CAP by the licensing or certifying state agency, the provider agency will implement the activities needed to achieve compliance with the ***My Choice My Way*** plan. The licensing state agency will review the progress toward reaching the milestones approved in the CAP. All settings must be in full compliance no later than December 31, 2021.

Any newly licensed or certified setting where waiver participants will receive OHS services during this waiver renewal period must be in full compliance with the HCBS final rule and be able to demonstrate the provision of services in fully integrated community settings. Newly approved is defined as on or after July 1, 2016. There is no transition period for newly approved settings. The licensing or certifying state agency will complete a site visit prior to DOH-DDD approving the service.

As part of compliance with the HCBS final rule, any restrictions, limitations or modifications to access to the community must be approved in the Individualized Service Plan (ISP) through the person-centered planning process. Per CMS, “The modifications process must:

- be highly individualized,
- document that positive interventions had been used prior to the modifications,
- document that less-intrusive methods did not successfully meet the individual’s assessed needs,
- describe how the modification is directly proportionate to the specific assessed need,

- include regular data collection,
- have established time limits for periodic reviews,
- include informed consent, and
- be assured to not cause harm.

Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as “house rules” in any setting, regardless of the population served and must not be used for the convenience of staff.”

[HCBS FINAL REGULATIONS - QUESTIONS AND ANSWERS REGARDING HOME AND COMMUNITY](#)