

ADAD COC Meeting

June 19, 2020

9 am – 11 am

BHHSURG website (bhhsurg.hawaii.gov)

Agenda

- | | |
|-------------|------------------------------------------|
| 9:00-9:05 | Introduction |
| 9:05-9:15 | Hope Treatment Services |
| 9:15-9:25 | COOP Q & A |
| 9:25-9:40 | MQD 1179 – Puanani Crabbe-Parker |
| 9:45-10:00 | ADAD Survey Results: Eddie/Ami |
| 10:00-10:15 | CARES/ADAD Data Reporting and Initiative |
| 10:15-11:00 | WITS: Clinical and Fiscal. |

Next COC meeting: July 17, 2020



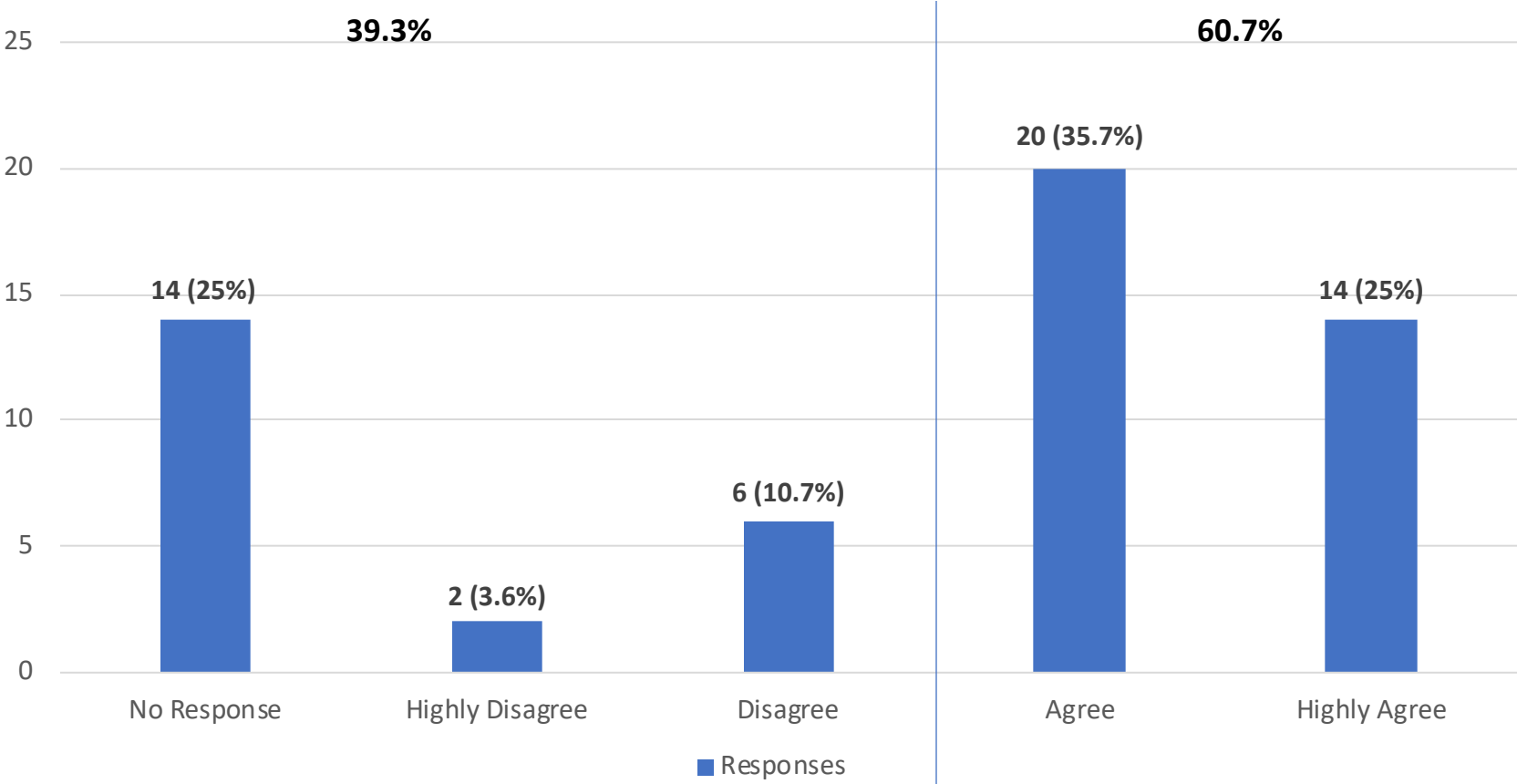
ADAD Quality Assurance Survey Results

(based on 42 responses out of 56
providers)

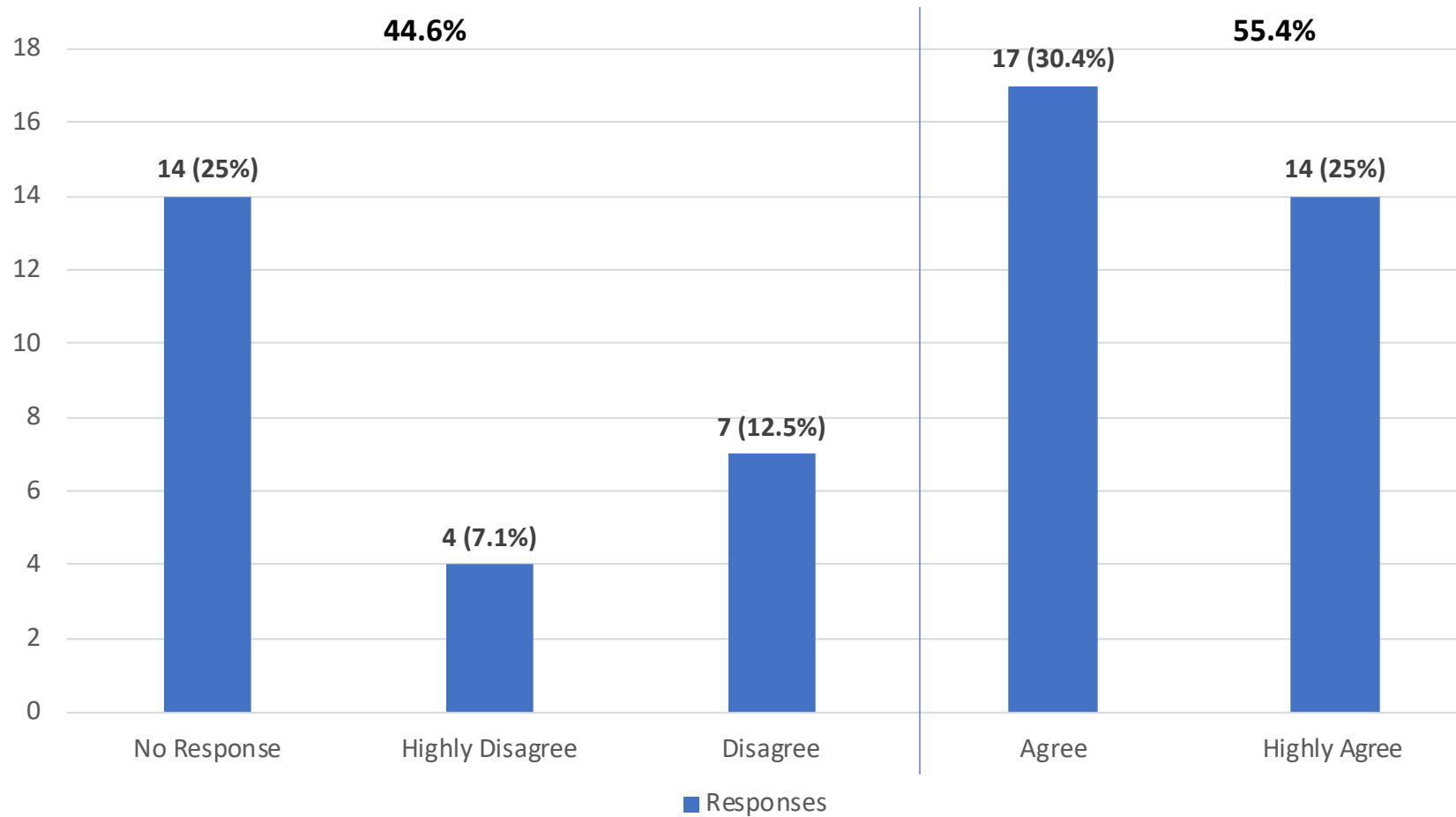
June 9, 2020

Contracts/Budgets

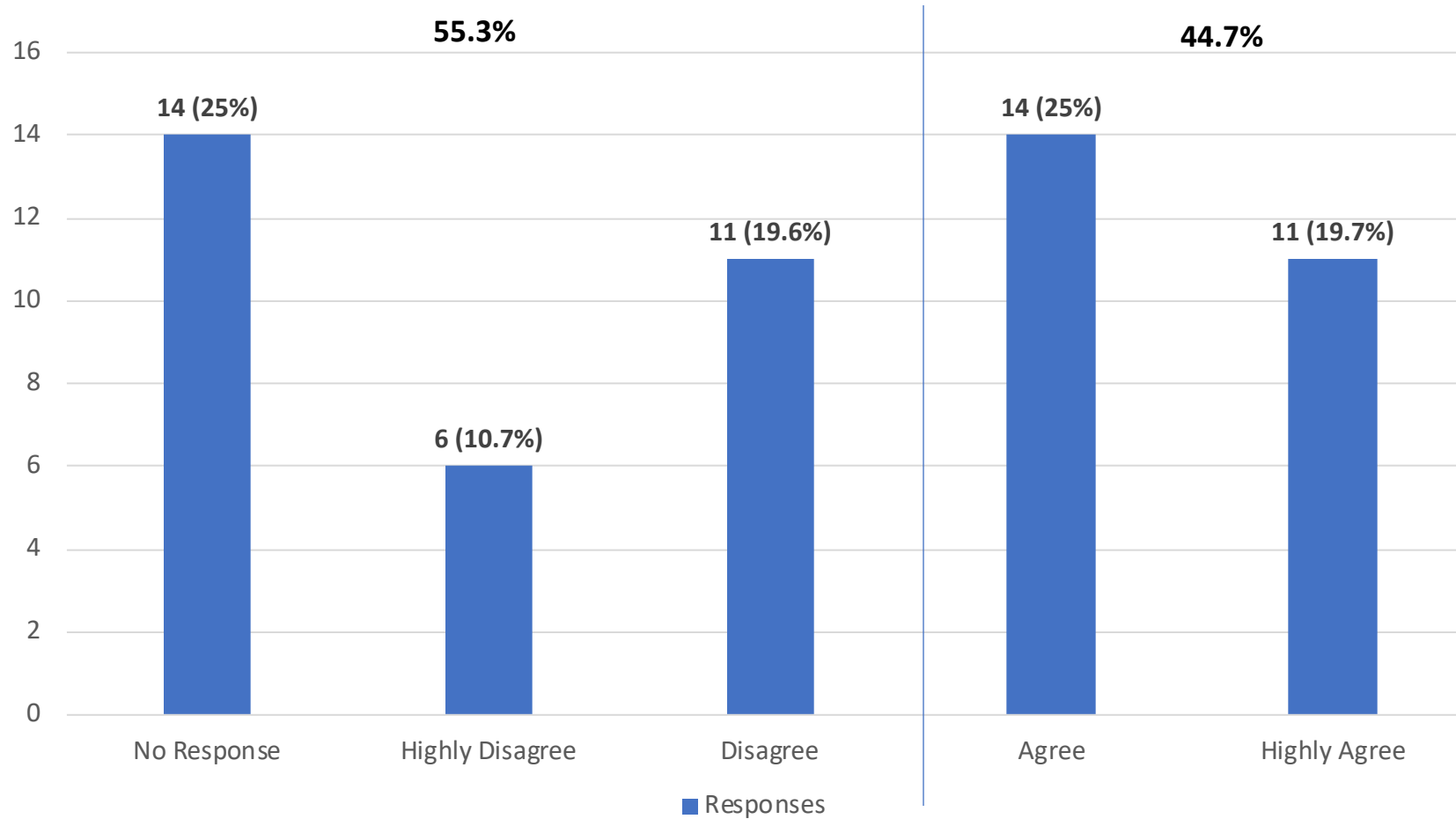
My contract is being managed by ADAD regularly and discussions about my contract are generally supportive and focused on quality improvement.



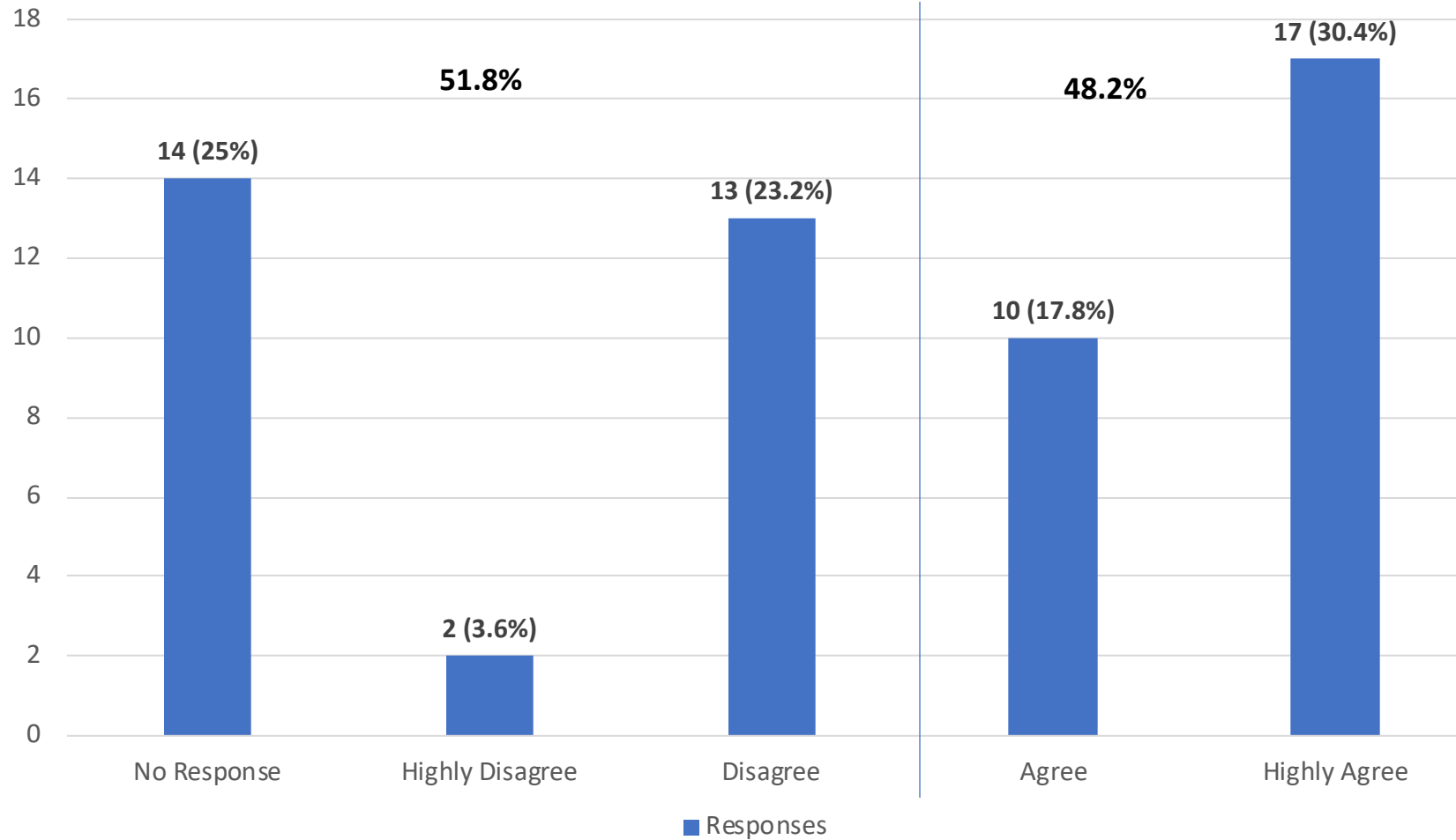
The utilization of my contract is being reviewed regularly by ADAD and ADAD communicates with me and updates me regularly



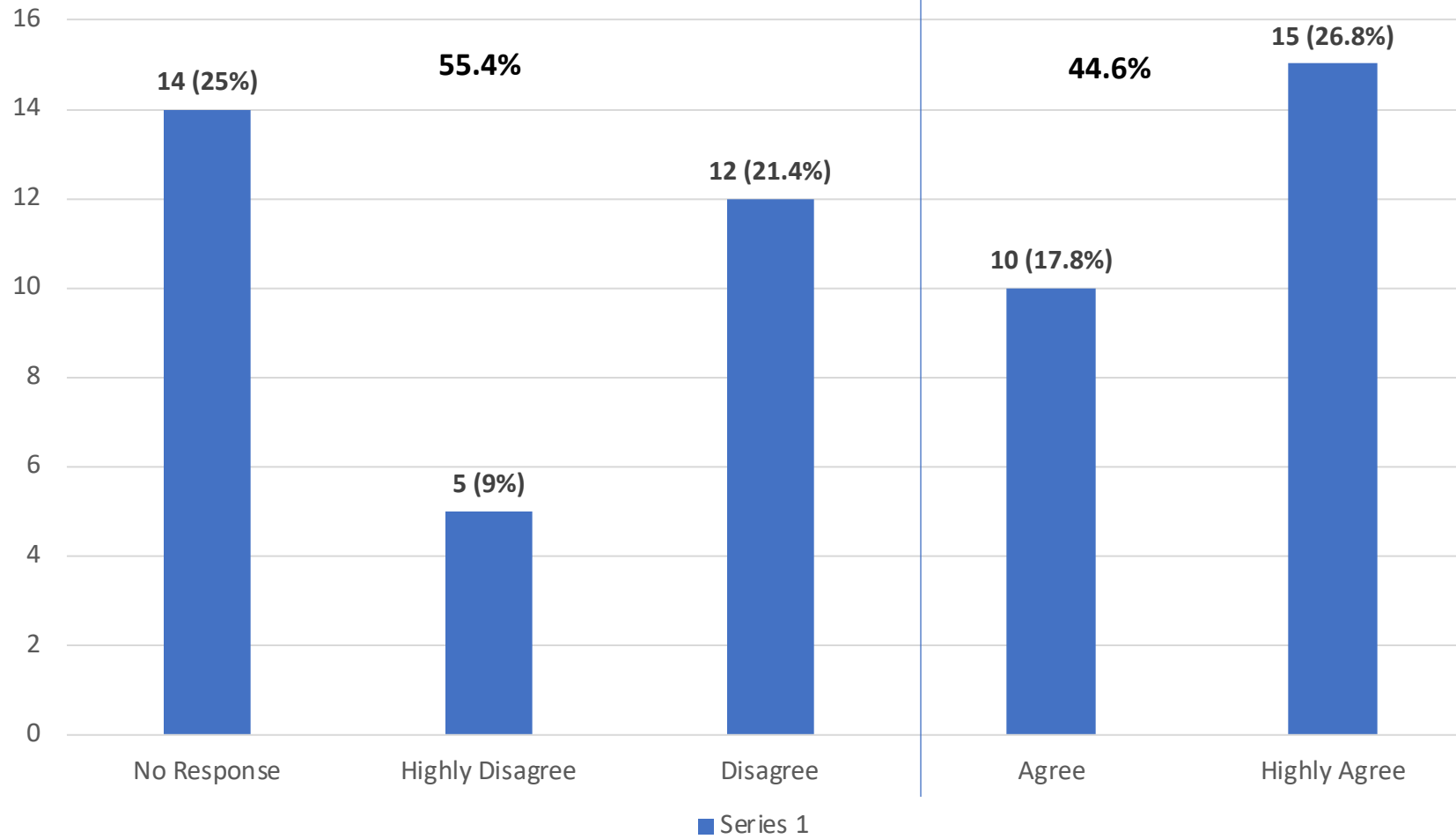
Trainings are available to help me understand contract and/or grant requirements as well as utilization management.



I feel that I can communicate openly with ADAD about challenges I am having with contract execution and utilization.

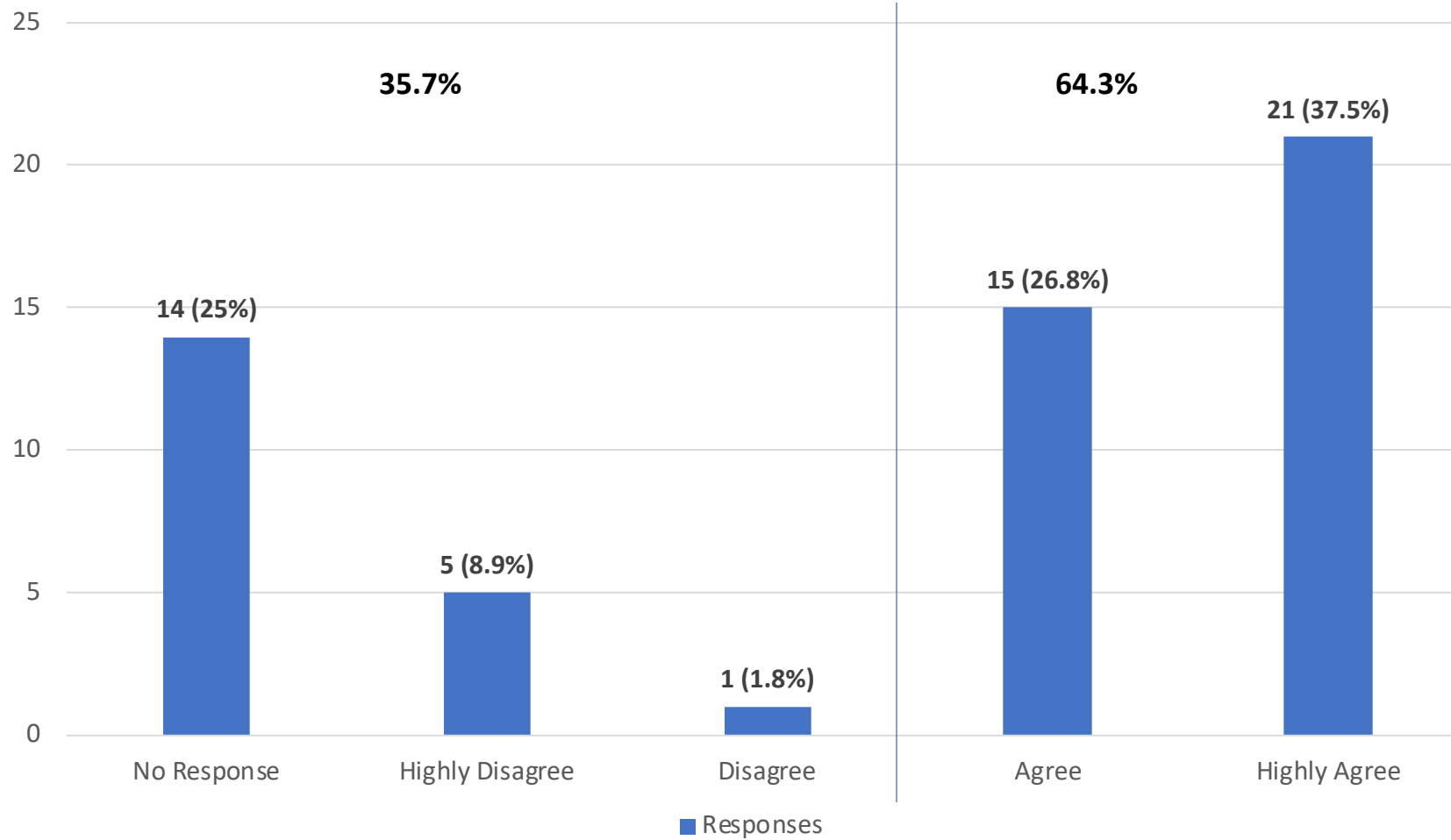


I feel I can provide feedback to ADAD about how they can be more supportive, and that ADAD will listen.

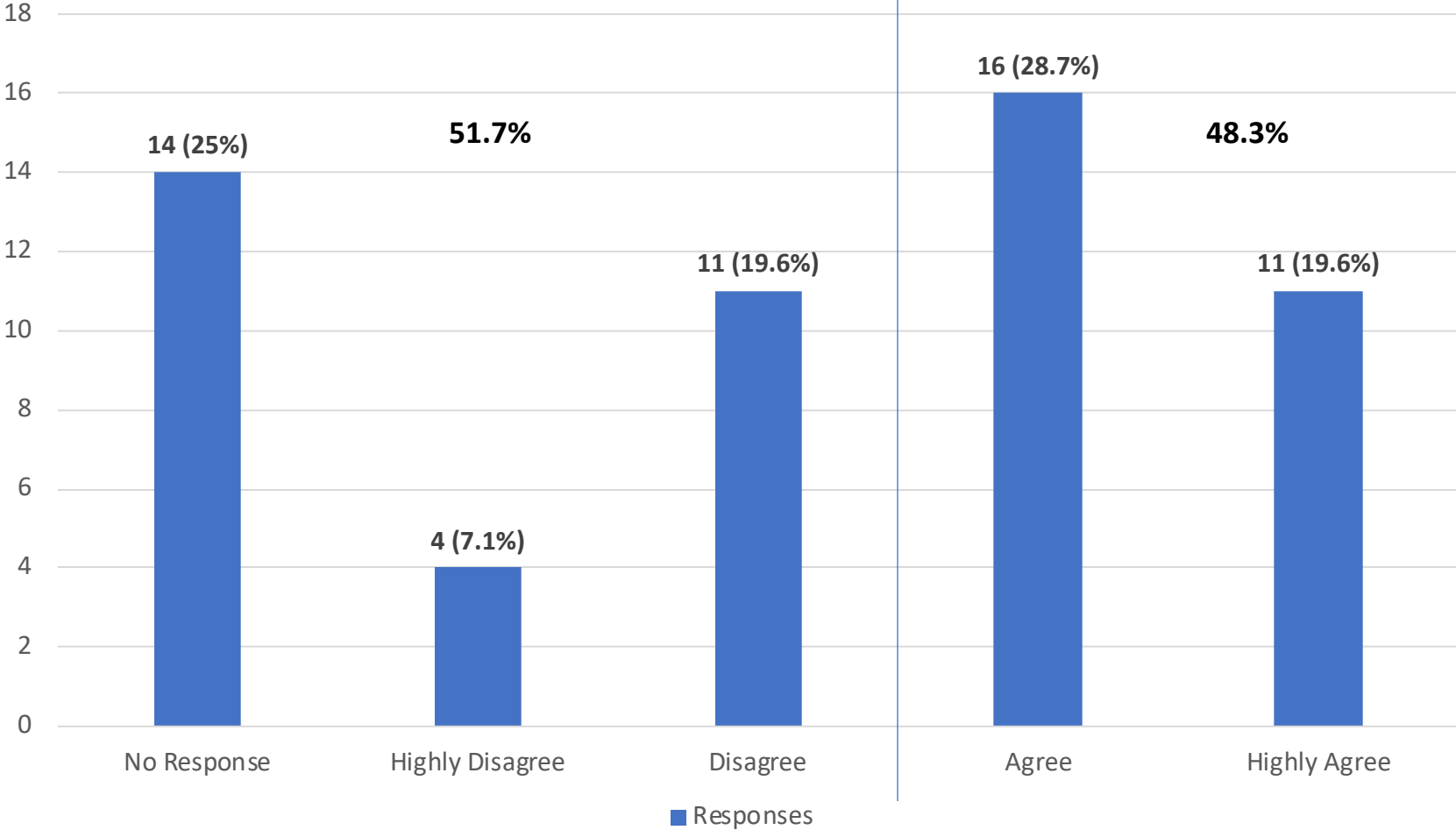


Provider & COC Meetings

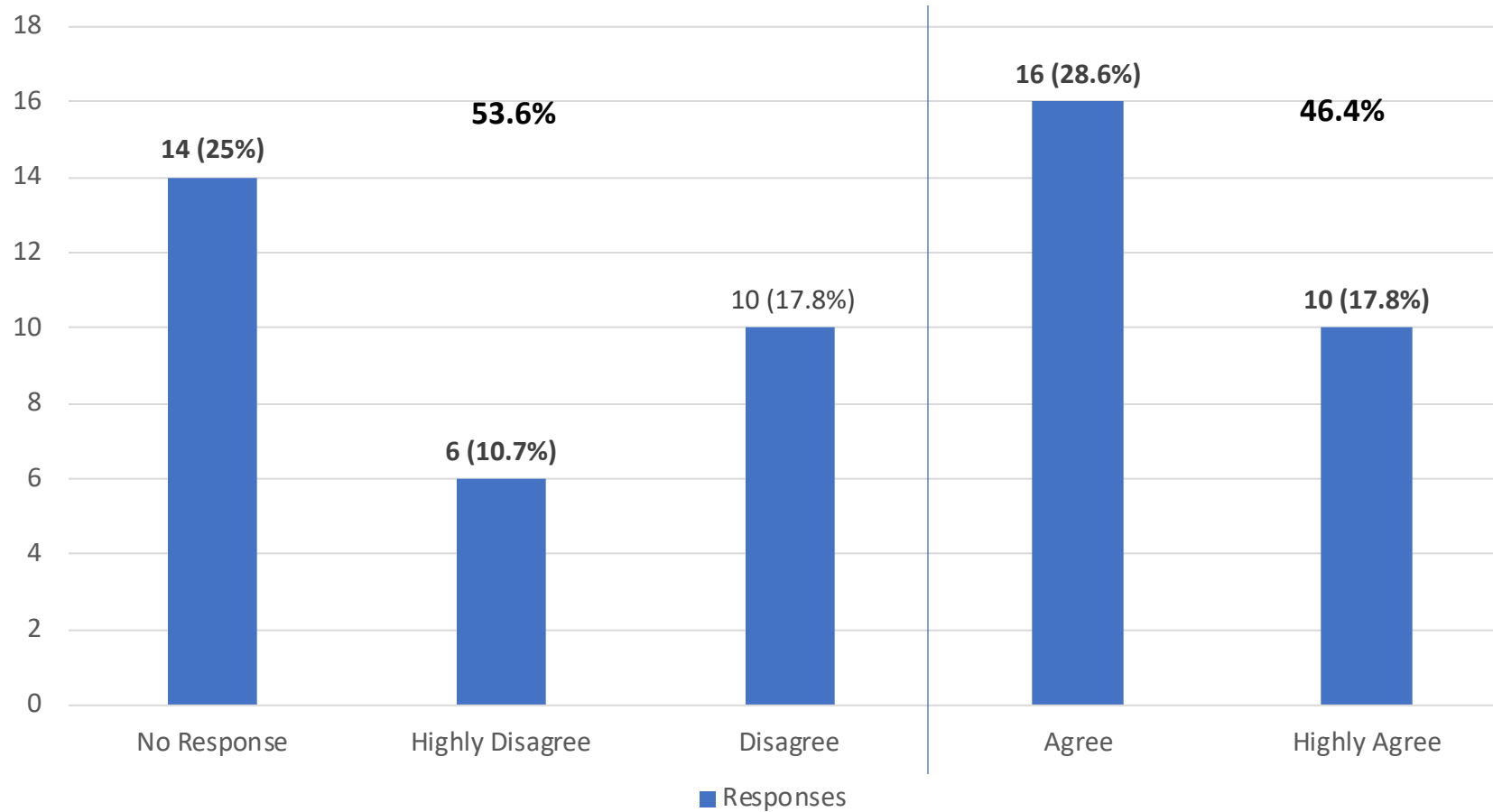
I attend monthly providers meetings held every 1st Friday of the month regularly.



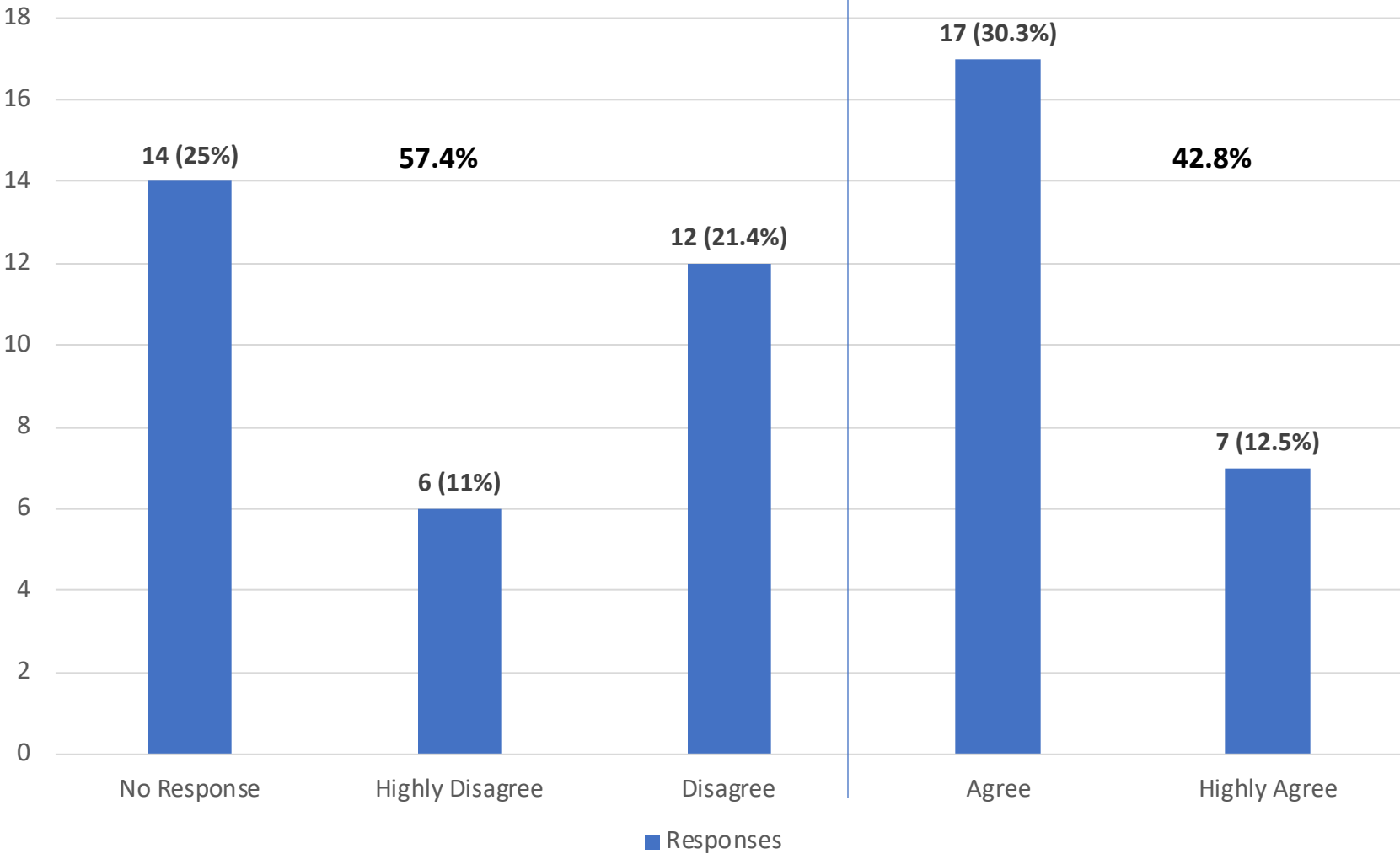
The topics of discussion at the provider meetings are useful and helpful and there are tangible agenda objectives for each meeting.



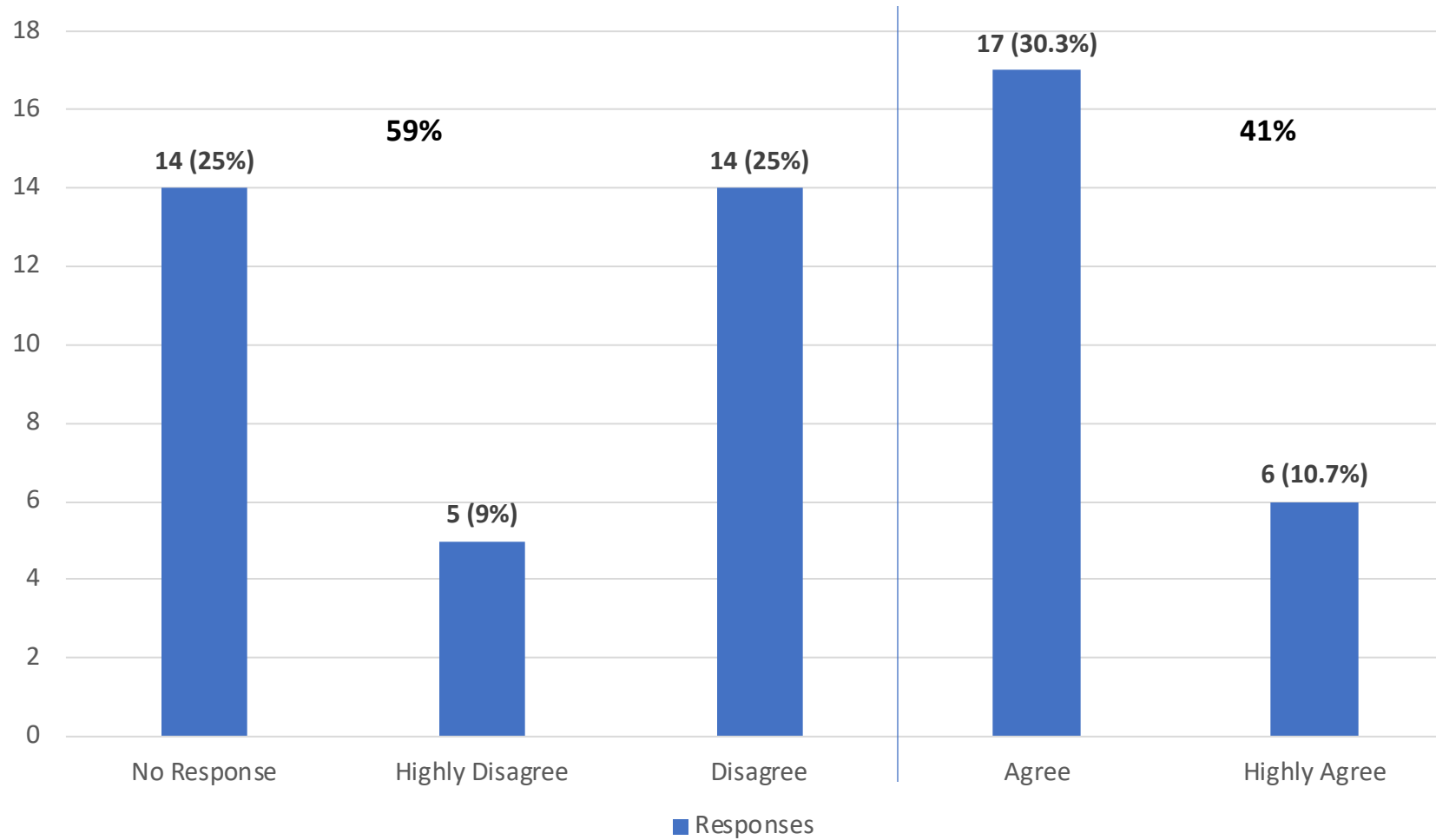
I attend monthly Continuum of Care (COC) meetings held every 3rd Friday of the month regularly and there are tangible agenda objectives for each meeting.



COC meetings are effective and answers my questions.



The quality of these meetings, encourages me to continue to attend the Provider and COC meetings regularly.

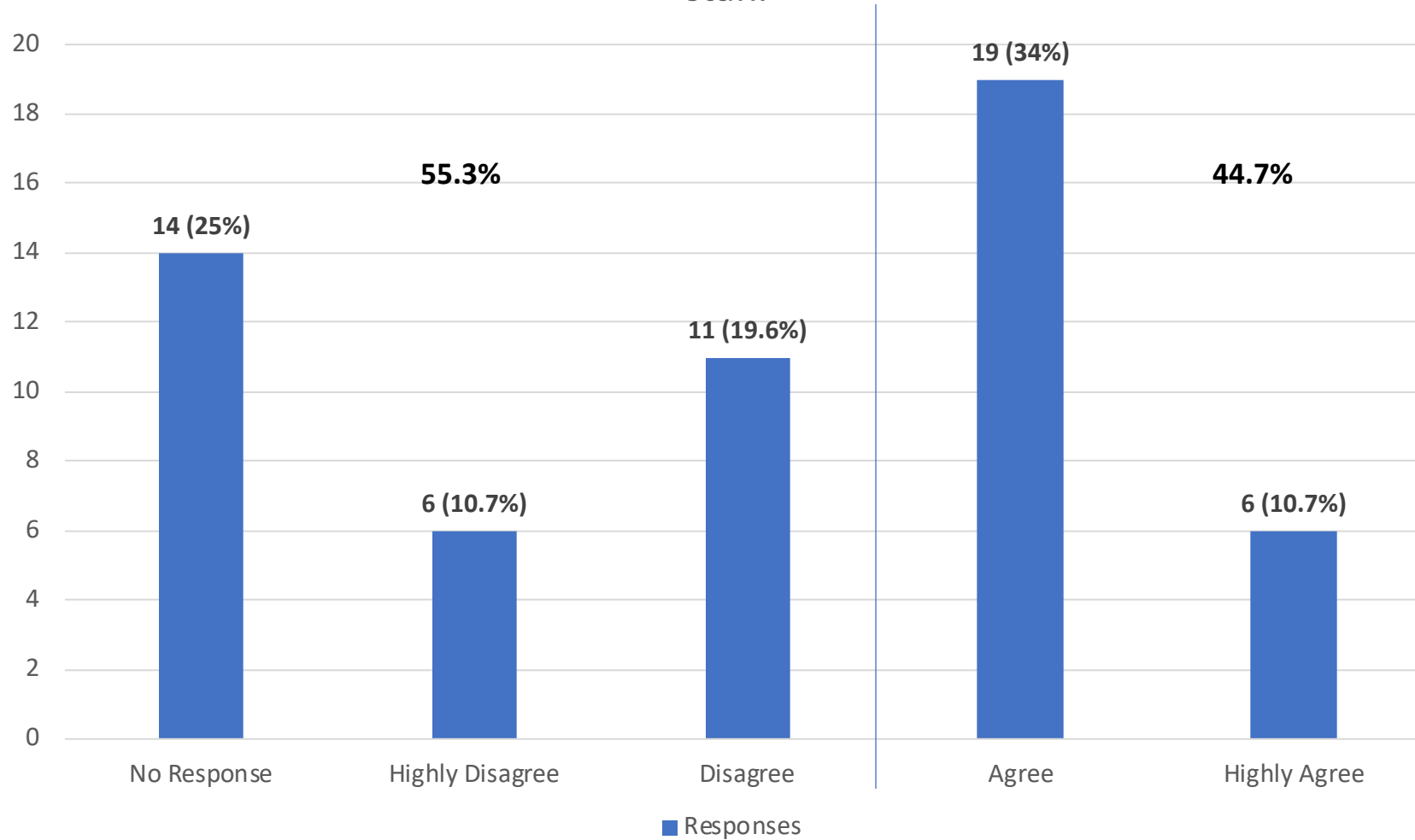




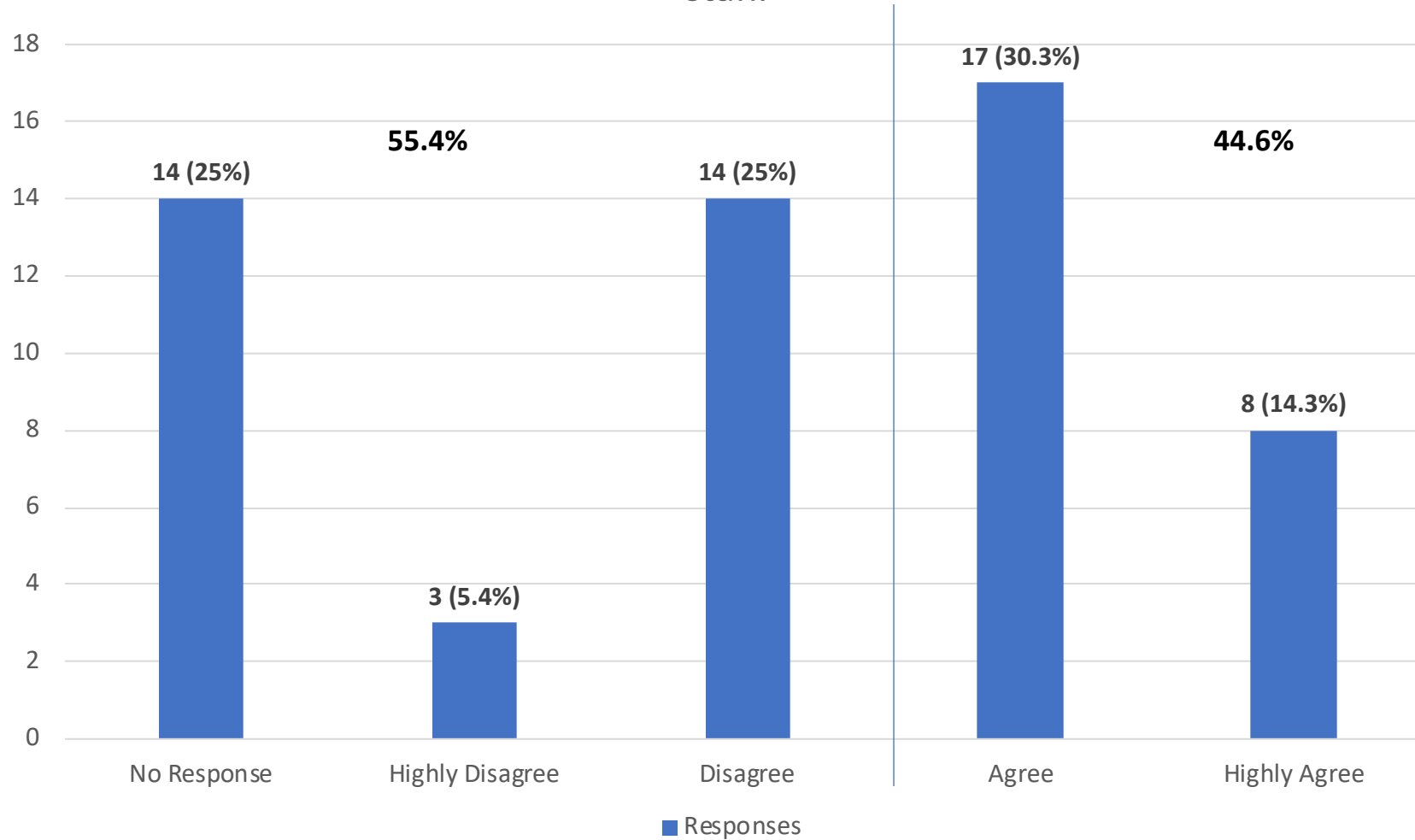
Hawai'i CARES



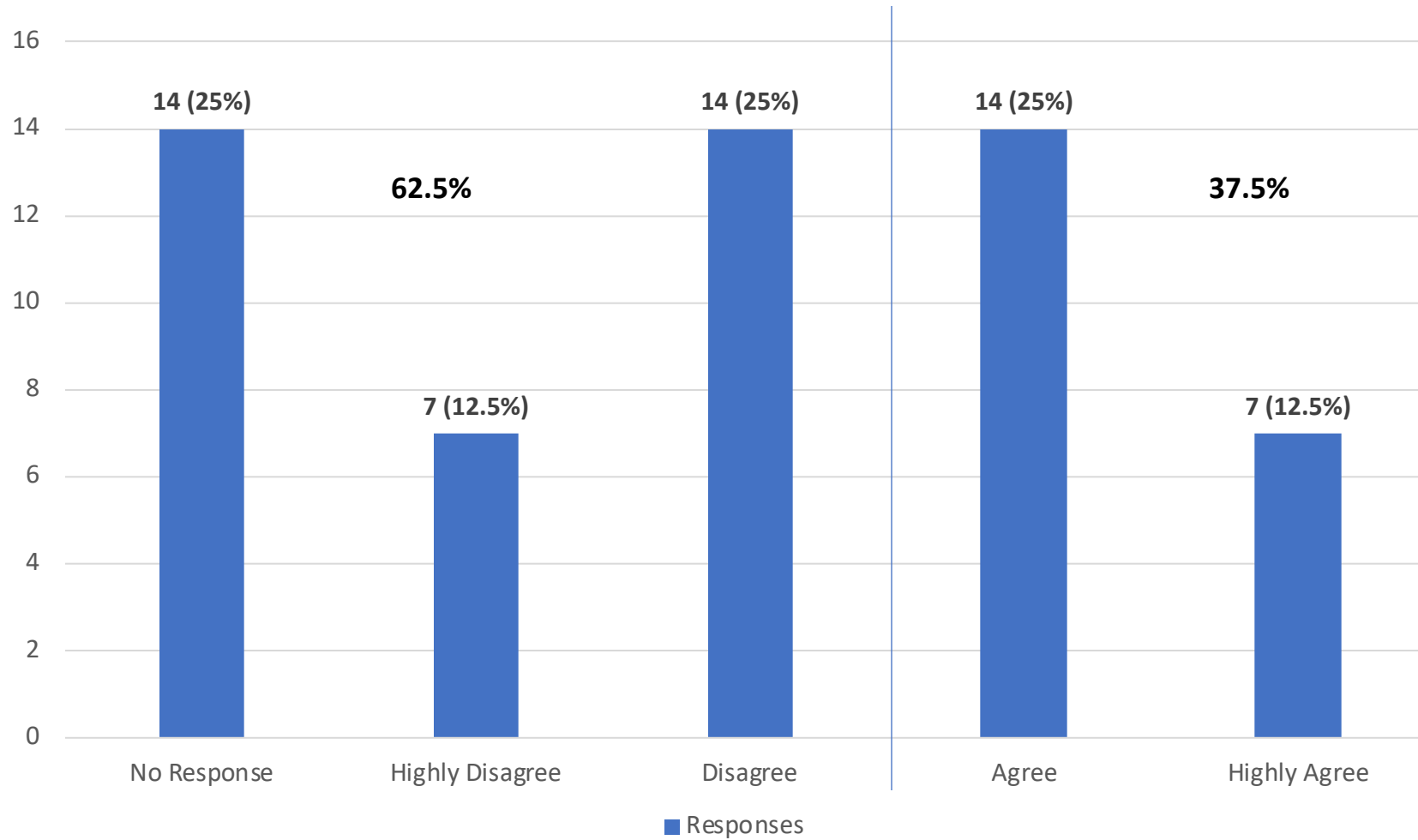
I get clear directions/instructions and support from Hawaii CARES staff.



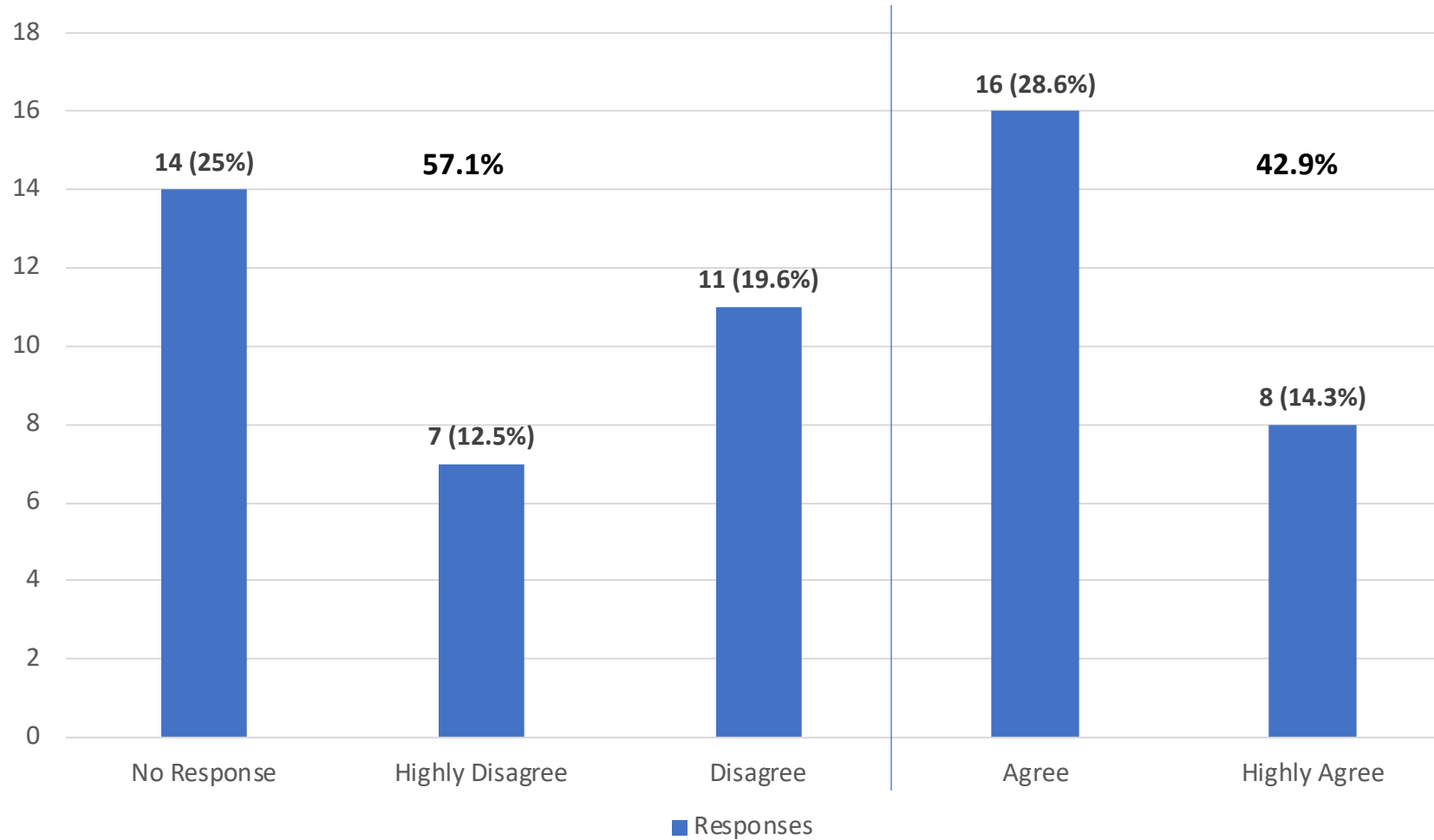
My questions are answered whenever I talked with a Hawaii CARES staff.



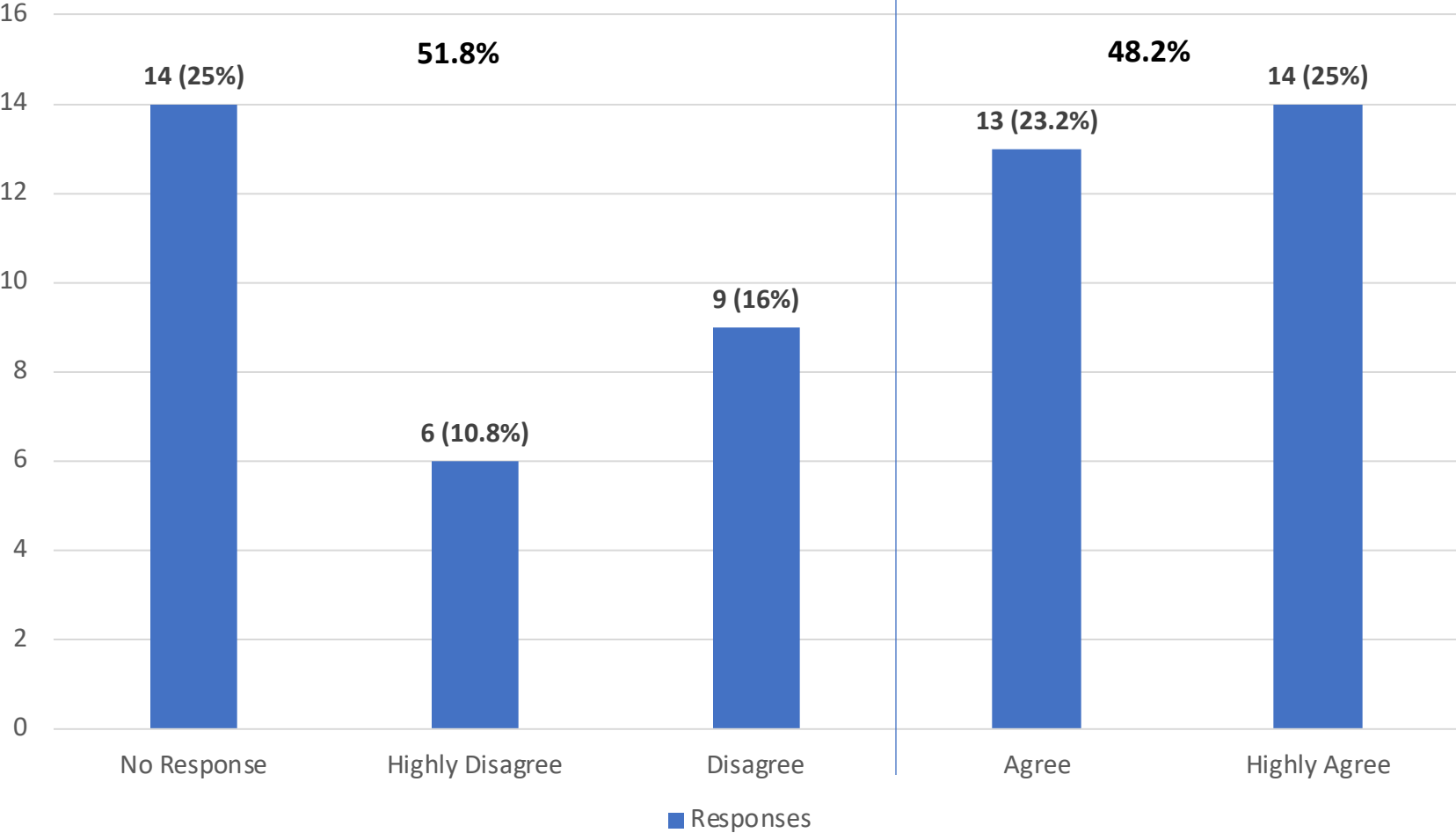
Hawaii CARES staff are knowledgeable about community resources.



Hawaii CARES has been effective in helping me link clients to services when/where they are needed.

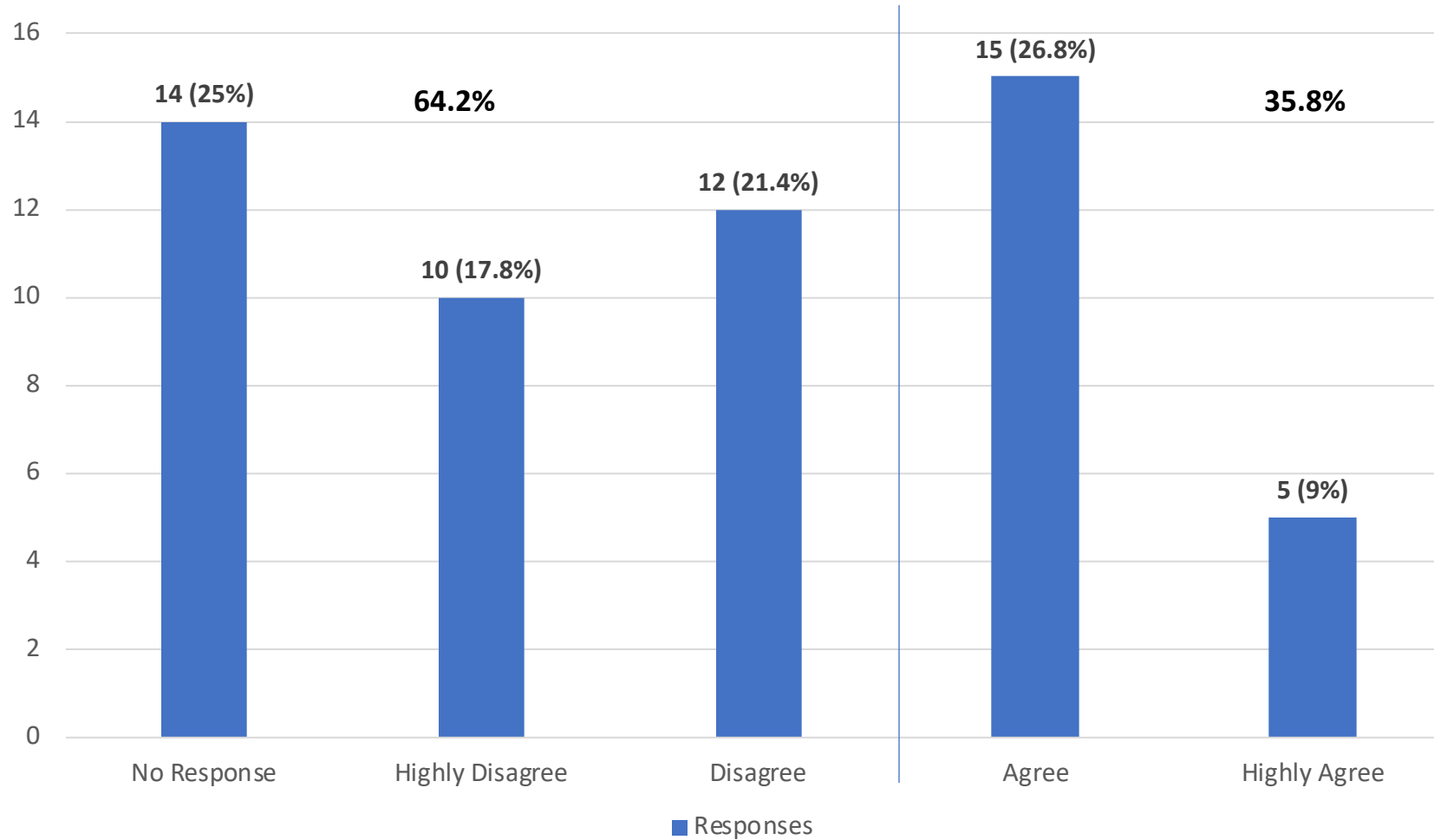


Hawaii CARES has the potential to increase overall system integration across the behavioral health care system.

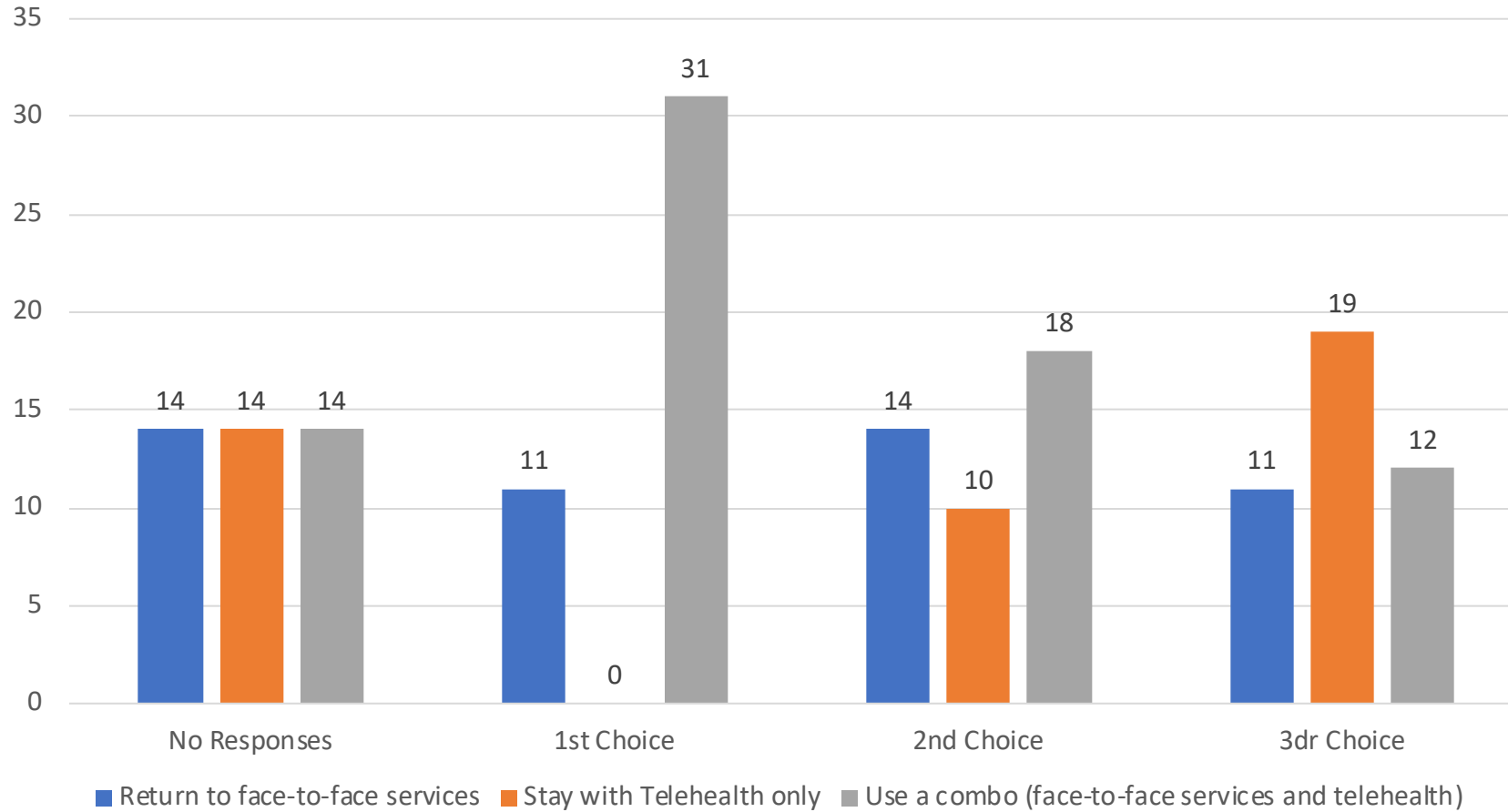


COVID-19 Impacts on Provider Services

Our agency foresees a delay in consumers returning to Residential,
Day Treatment, IOP and/or OP services.



As COVID-19 restrictions are relaxed, our agency will return to face-to-face services, stay with telehealth only, or use a combo.
Please rank in order



Please indicate what this will look like for your agency:

- For a period of time we will use tele health. After a month we may have both. After a month we plan on having face to face unless requested otherwise by our clients.
 - Youth are presently being assessed in person and are treated via telehealth. When more days pass without COVID-19 cases, we will begin in person treatment. Our clients say they miss the house
 - Looking forward to returning to work and conducting face to face sessions with clients.
 - We would conduct face to face services in the community, meeting the youth where they are at.
 - We want to ensure the safety of both our clients and our staff moving forward, so we are still continuing with the use of telehealth primarily for now and will watch how things go in the community with the re-opening of business, services, schools, etc. Our return to the "new normal" of program operations will happen in phases. We are continuing to do our emergency services face-to-face as we have been during the stay-at-home orders. We are seeing that telehealth does work better for some of our clients, so we are planning to use a combination of both face-to-face and telehealth in the new normal.
 - Groups of 9 or more clients are done via telehealth; Groups with less than 9 are done in person; clients who do not have access to needed equipment attend in person; clients who Counselor's feel need close monitoring report in person.
 - We are current providing both telehealth and face to face services. We will continue to provide both services which works best for us to provide the needed services to our consumers.
 - we will likely use a combination of services as there is a pocket of clients who do not have access to telehealth; the quality of care has definitely gone down with telehealth - especially with providing groups in this setting; we hope to start bring back clients who have not been able to engage with telehealth first and slowly move toward face to face services - as is safe and within CDC guidelines
 - a combination of services
 - Not sure how to answer this.
 - Utilize telehealth for those clients that are unable to report in, but resume face to face with all others. And comply with CDC regulations on protocols for clients and staff.
-

Please indicate what this will look like for your agency:

- Offering telehealth services first identify barriers for telehealth for clients and address individually.
 - Our agency is prepared to provide assistance to clients in need of electronic media, or train clients who may not have the knowledge. Our preferred method of providing services is face to face. In some cases we are still using telehealth via phone or facetime. We have purchased notebook pads to lend to clients who may need them. Our staff have adapted and are doing a great job, being flexible when needed.
 - we will not go to face-to-face until it is safe to do so.
 - Blended telecare and f2f as described in the next question.
 - We serve all across the board on the continuum of care. Various levels will be providing different platforms.
 - Telehealth will offered for sessions mainly for rural underserved areas.
 - Efficient services increased for our consumers
 - We're not sure when or if all outpatient services will be returning to the facility. And if they do, how it will look. Following CDC guidelines--6 feet distancing, 9 people max in classes, PPE, etc.
 - Our program works best with face to face training and interaction. If the COVID 19 restrictions allow, we will use this approach exclusively.
 - All levels of care to incorporate a hybrid of in-person and telehealth services especially for day treatment, iop/ops, ac clients. Touch points can become most effective as support and services become more accessible to clients, especially those with transportation challenges but who may have access to devices that can keep them connected with their services. For residential clients this may look like Zoom classes for more educational emphasis where there may be only limited need for contact with staff or guest speakers. However, it may be most effective for face to face interactions (group or individual) for skills rehearsal or other hands on group dynamic processes, depending on the nature of the group (i.e. cultural practices, skills demonstration through role play, etc.) and to be responsive to clients' learning styles (sensitive to responsivity of using evidence based practices).
 - Clients will be interviews in person
-

Please indicate what this will look like for your agency:

- Face to face and telehealth
 - It will depend on the client's preference.
 - we never stopped doing face to face services.
 - We will provide in-person services only if there are guidelines put in place and enforced; guidelines that protect staff and clients.
 - We're already open for most services again.
 - A reduction in capacity
 - Face to face services will be smaller groups and census, combination of face to face and telehealth will allow for a larger census via telehealth while adhering to social distancing in face to face groups
 - For clients who have access to TeleHealth Video on computer or smartphone, we ask clients to continue TeleHealth sessions. Clients who are medically fragile, we will do our best to push for TeleHealth sessions. Face to face sessions will be primarily for those that are without internet/smartphone/laptop available to do sessions by video.
 - Staff will have the option to utilize telehealth to conduct classes and ICs or have do everything in person using safe practices.
 - Based on client need
 - Services will differ per location of project (statewide services)
 - Once the stay at home order is lifted, KSS will decrease group sizes to accommodate for social distancing, put most at risk clients on the roster to participate in person, and the other clients will be required to attend group services via telehealth. There will be a rotation so all clients can participate face to face and receive fair and equal treatment. KSS will follow and enforce all CDC guidelines. Face masks, temperature tests, and hand washing are enforced upon entry to our facility.
 - We provide prevention services, so this does not apply to us
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We are interested in your view of the pros and cons of conducting telehealth services for the following levels of care (residential, day treatment, intensive outpatient, outpatient and aftercare):

- Ease of you after trainings
- It is a cost savings since we don't drive vans or feed clients but we cannot introduce outdoor sober activities and we cannot do UAs and we really miss seeing our clients in person
- N/A
- Client's do not like telehealth therapy because they are in the home with others and want their sessions to be confidential.
- We currently conduct outpatient services, intensive outpatient services, and after care. It has been a lifesaver to conduct telehealth to the clients during the COVID-19 Pandemic. The struggle has been to get in contact with the youth who do not have a phone and or do not have access to the internet. In addition, some of the parents are not open to allowing us to speak to the youth on their phone. Face to Face services is something that we look forward to implementing as soon as it is safe to do so.
- In residential and day treatment, you would need staff working with the clients in person, while practicing safety protocols and utilizing PPE for staff and clients. In IOP, Outpatient, and Aftercare, telehealth may work better for some clients that have the ability to access telehealth platforms. For clients that may have child care or transportation needs, telehealth may allow them to access treatment services more consistently. For other clients, they may do better with face-to-face services, if it is safe to do so. It may be easier to engage some clients face-to-face and pick up on non-verbal cues.

- Pro's- everyone is safe and following State mandates; clients are still receiving Tx. Cons- Difficult to gauge client participation & understanding of material.

- Pros to providing telehealth services to our consumer. We are able to reach more consumers and meet them where they are at during these challenging times.

- pros - we have seen improvements in attendance - clients are less likely to miss treatment or groups if they just have to roll out of bed and connect with their devices; we are able to block client's from entering groups if needed (i.e. they did not contact their counselor or there are concerns about their status - they cannot "barge" into groups and disrupt the milieu); we are able to turn off certain/all client's volume when another person is sharing cons - cannot assess in person clients potential signs of substance use, i.e. smell alcohol on them, see dilated pupils, recognize agitation - it is easier for them to hide suspicious behavior online than in person; it has been a challenge sending them for drug screens - we have had to use labs and they often do not observe; it seems more difficult for clients to bond over telehealth (although they have in some cases) and also seems more challenging to develop therapeutic rapport with clients via telehealth

- pros- more participation cons- clients too relaxed

- Not all insurance companies pay for substance abuse telehealth services.

- There doesn't seem to be any benefit to doing telehealth with residential clients. Groups have been a small challenge, but workable and IC were the easiest to manage with telehealth.

- Pros to telehealth keeping clients/staff safe is a priority. There are a few benefits when it comes to telehealth we have seen great attendance and engagement in groups. Cons are for some clients who do not have access to phones due to socio-economic issues or connecting to the internet. I feel like the cons for telehealth can be address through proper training and resources (technical and financial support).
- We believe there are more cons to using telehealth services with the particular population that we serve. This is primarily due to a small community that is a majority not tech savvy. The pros are that there are no issues around transportation. However there continues to be the issue of lack of privacy and disruption from kids, etc, in the client's homes. The advantage is that, long term use of telehealth does ultimately translate to not needing as much physical space as one normally needs when clients are coming in to the office. The converse is that when internet services go out, or someone's phone hasn't been paid, there is a particular challenge that is not there when they're showing up in person. Another con to telehealth is that groups do not seem to be working very well for us, it really has been more individual sessions that are working, but not the groups so much. Groups require more technological savvy and equipment that our clients don't all have. Counselors can miss signs that would be evident in a face-to-face encounters. Accountability of Counselors working from home is also a challenge. Drug screens are also not possible when working just telehealth only.
- telehealth has been shown to be an effective tool, though there are expenses involved in ensuring client safety and quality.
- Residential in impossible, the rest we can move to a mixture of platforms.

- Level 3.3- no telecare beyond initial admission and referral prior to placement Level 2.5- blended minimal telecare w/ f2f Level 1.0 - equally blended telecare w/ f2f Level .5 - blended minimal f2f w/ telecare Pro: hours are flexible for working or parenting clients; staff has more autonomy; limited direct services can continue during quarantine. Con: More western - moves further away from cultural practices; disconnectedness is not conducive to sobriety; group catharsis is limited; socialization and modeling prosocial Bx is not a priority; and basically is not why we as providers became counselors in the first place.

- I believe that telehealth options for all levels of care (except residential) is beneficial.

- Doing telehealth classes for 4 hours is grueling for clients and staff. It's challenging to monitor classroom behaviors. Doing individual sessions via telehealth is also different. Staff need to adjust to need media. The level of care that gets impacted the most is outpatient services--day tx, IOP, OPS, aftercare.

- Telehealth has opened an array of opportunities to meet consumers and provide services

- Our program is educational in nature so the "telehealth" principles do not really apply.

- see response above

- Unless trained to conduct online interviews we find our people will only go through the motions without giving a thorough interview.

- Four outpatient, telehealth has been very helpful

- pros: work from home, more flexible to client availability
- OP: pros: no travel, indirect time for clients and staff, cons: teens can be difficult to engage via Telehealth
- telehealth in residential use should be very limited in scope or you dilute the benefits of residential services - being able to interact with our clients in a more timely and personal manner.
- Pro: Ensuring the safety of clients, staff is of the utmost importance in addition to limiting the likelihood of being exposed/contracting COVID-19. Telehealth, ensures that residential, day treatment, intensive outpatient, outpatient and aftercare are still receiving the same services while lowering the likelihood of spreading COVID-19 to staff, clients, and individuals coming to treatment centers to render services. The nature and quality of our work is not impacted by telehealth, which is a pro. Con: The cons are minimal pertaining to telehealth. Barriers to telehealth could be treatment centers not providing enough information/sending referrals via WITS. Also, treatment centers that may have limitations to accessing laptops/WIFI.
- I don't perform these services.
- Telehealth is good up to a point when face to face is needed
- Pros = allows for much larger groups, less missed sessions Cons = learning curve for new clients, no cell phone or stable wifi/data plan
- NA

- Telehealth benefits are: Easier to schedule and for some, removes barriers to treatment if working or if client lives far from treatment facility. Also allows continuity of care during the current pandemic. TeleHealth reduces Covid19 spread risks in crowded treatment facilities by minimizing face to face sessions. Provides safety for all clients and providers
- Telehealth is difficult in a residential setting because client behaviors cannot be addressed as quickly. Also, staff observation is minimal due to only a few number of staff on property at any given time so a lot of their criminal behaviors will go unnoticed.
- Overall very supportive and we use them but some skills are harder to work on virutally while counseling has been easier
- Pros - it allows for treatment to continue no matter the circumstance. Cons - Less structure, harder to enforce and get compliance, especially for dual diagnoses clients.
- Don't use telehealth for our cohors

We are interested in hearing how your agency manages your policies and procedures for if a consumer tests positive for COVID-19?

- We haven't had a client test positive for Covid 19 however each case will follow PCP regimen and practice isolation until clear of the virus.
- We haven't addressed it since we moved to telehealth early
- My company encourages us to go to the doctor and stay home if feeling under the weather.
- Any youth and staff are required to have a temp check upon coming to the building or in the community. They are also required to wear a mask and practice social distancing. If anyone has a fever of 100.4 or higher they are required to go home and cannot return until they have had no fever for three days. If someone tests positive for COVID-19 they are required to be placed in quarantine and cannot return until they are considered recovered from COVID-19 by their physician. Anyone that may have been exposed to COVID-19 by the individual is then placed on a 14-day quarantine.
- Screening is conducted on all clients with temperature checks and asking them the CoVID screening questions. If a consumer tests positive for COVID-19, they would be serviced through telehealth until they are medically cleared for COVID. If they are in a residential program, they would be quarantined in a isolated section of the program. If a consumer had contact with staff prior to being diagnosed as COVID-19 positive, contact tracing within the organization would be conducted and staff that came into contact with the consumer would be required to self-quarantine and be tested for COVID-19.
- Residential- we have a room we can utilize for quarantine; Outpatient- Telehealth

- CARE Hawaii follows CDC guidelines for all face to face services. All positive cases for Covid-19 are required to quarantine for 14 days before returning to face to face activities. Telehealth services will be an option for clients continued services. Client that attended face to face services are required to wear a face mask and wash hand frequently. All program/office space and supplies are sanitized And cleaned during and at the end of classes.
- N/A
- We are part of the hospital so manuals have been written and distributed via our intranet which outline safety precautions and procedures for managing patients who test positive for COVID
- we isolate them
- We have created policies and procedures in the event this happens and we continue to update the policy as recommendations and guidelines are changed.
- Recommend that they go to the nearest health care facility.
- We look at BHHSURG for guidance and procedures as well as our HR Proservice.
- We have not had the occasion to have to adjust our policies at this time. The roads to our area are closed to outsiders and there have been no COVID-19 cases.
- we follow CDC and DoH guielines

- If a client tests +, the agency will immediately close to f2f services while telecounseling will continue exclusively for 14 days. All staff and exposed clients will be covid-19 tested and antibody tested at the local hospital. Because all persons entering our agency will have ppe in place, sanitization stations, and a temperature check prior to entering, exposure will be limited. Clients have daily sign in sheets which indicate self-assessment of general wellness and recent activities. This will aid in contact tracing prior to quarantine.
- We did provide a COOP and everything we will do to address CV19 are addressed there.
- We haven't had any thus far however, we would follow our protocol: isolation/implement quarantine areas, contact our medical director, and contact DOH.
- We have special policies in place for this and our executive leadership along with DOH meets to ensure a plan is in place.
- We are still adjusting and working on these.
- We would follow the policies set forth by the State of Hawaii.
- n/a
- Isolated to room with roommates bringing meals
- connect to TQIC

- Planning and procedures in place for isolation and treatment to be provided in alignment with CDC and state/city official guidance if a resident ends up testing positive. Disinfection steps to be followed for the residential milieu as well as continued safe provisions of services to the remaining residents. Staff need to be trained and briefed as circumstances change (at some points there were daily/weekly adjustments).
- We have daily check in regards to anyone coming in contact with someone or if someone has tested positive, we would notify the supervisors who notifies island director, who then notifies up from there. We would utilize trace contacting as best as possible and ensure this individual is seen by medical staff
- We will and do use masks and PPEs. We do OP so we will continue to do Telehealth as they quarantine.
- our medical director would oversee the response. we have a designated space for quarantine.
- Being that we are connected to a clinic, our protocol is unique being that we are a clinic. We are required/mandated to render services or to provide care. Our process, briefly, is as follows for individuals that are positive for COVID-19: quarantine for 14 days, screening prior to coming to clinic, when at the clinic being placed in a designated room, all staff required to wear full PPE gear, notification on exam door that lets staff know patient is positive for COVID-19, when services have been rendered the room is then disinfected by sanitational engineers.
- We don't have in-patient, out patient, residential or day services.

- We have not reopened as of yet. We are working on those policies now.
- Internal weekly meetings and updates regarding COVID-19. Our agency has a screening protocol, plans for referrals, testing, and isolation
- Action with Aloha ED will have the policies and procedures on how to deal with a consumer who tests positive for Covid-19.
- We have identified a room for the client to remain in where they can be monitored until we get guidance from the DOH on what to do with the client.
- Work with client to isolate in place or get to TQIC if no safe place. Work with DOH to do contact tracing and work to get folks tested that may have been exposure.
- following CDC and DOE guidelines
- CDC guidelines are followed. KSS does not allow entry, clients are required to quarantine for two weeks, report to their appropriate PCP, and obtain clearance prior to returning to treatment. They will not get discharged for missing treatment during this time if COVID19 or any illness is verified by a physician.
- Work from home was in place since 03/15/2020 with staff gradually return to the office while following CDC guidelines

Please share any insight or information you have regarding the impact of COVID-19 to your overall revenue including but not limited to ADAD funding. Please include how it impacted other funding sources as well.

- n/a
- Covid 19 has prolonged some of our collection processes for services rendered.
- We have concerns we will not be able to utilize our funds due to disruptions in DOE schedules
- Funding has gone down due to clients not responding to me and wanting to set up sessions on telehealth.
- COVID-19 has resulted in a lower amount of services being provided to the youth we serve weekly. Counselors continue to contact them every week in order to reach out and continue services.
- Program revenue under the ADAD contract has decreased greatly because of not being able to continue with services via telehealth with many of our clients. Some of them do not have phones or computers/internet access. Overall funding has decreased but not as much as initially anticipated might happen. Unfortunately, one long-standing program will be closed down because of lost funding due to COVID-19 pandemic.
- Revenue is down 37% due to decreased census and decreased Billable services caused by "Stay at Home." Managed Care changed Billing codes to account for Telehealth which caused confusion for Fiscal resulting in rejected Billing that needed to be redone and resubmitted.
- Home Street bank funded us to open an additional house.

- The current pandemic has caused CARE Hawaii to incur a steep revenue loss through out our array of programs that we offer the community. We have worked diligently to overcome the revenue loss to continue to provide excellent service to the people that we serve. In the event that there is additional state cuts in service it would cause a hardship for CARE Hawaii and the community that we serve. If there is a potential service or budget cut we would like to work with the state and providers to help come up with a viable solution.
- There has been maybe a slight decrease in census; overall - use of ADAD addiction care coordination services have increased considerably - because we are doing a lot of outreach and connecting with clients because of increased emotional stress and vulnerability.
- Some insurance companies are not paying for telehealth services for some services or all services, therefore our ADAD funding utilization has increased.
- Referral continued at a steady pace and telehealth actually increased attendance!
- Reduced phone call referrals. All contracts from judiciary and ADAD have reduce funding and referrals. Staffing was an issue as far as unable to bring on new staff due funding cuts.
- Our revenue source from the County has been decreased significantly. Our ADAD funding is reliable and highly needed, in particular when other funding sources are diverting their funds. Our ADAD funds keep us going while we seek to adjust and find more financial support. Without ADAD funds we would not be able to provide the services that we can provide now; which is particularly important in hard to serve, rural areas

- we are working longer hours but not necessarily compensated.
- We have work reduced contractual providers which has limited direct service hours. Expenses have increased as they are related to Covid-19 safety improvements, new equipment, supplies, and lack of local availability which forces price escalation. Funding sources are currently discussing budget cuts.
- We need to have a discussion on this.
- Several insurance companies are not covering telehealth services for certain LOCs.
- City and State funding were effective
- COVID-19 has impacted our residential services the most. We can't make up for lost time/revenue. We needed to learn how to work in this new environment and how to keep our clients and staff as safe as possible. We have had to lay off staff, furlough a whole department, cut our budget.
- Our ability to implement our program has ceased since the 3rd week of March. We cannot bill ADAD for many things. The COVID 19 has had a very negative effect on our bottomline.
- N/q
- Revenue has remained the same, with an increase in clients

- Inability to bill for certain services during the stay at home work from home and safer at home orders over the past 2 months have taken a toll on the budget. Prior to COVID-19 reductions in ADAD contract funds available greatly impacted operations as well. Some anticipated impact on other state contracts but no reductions as of this date.
- We have some houses that have taken huge loss as few are working and have not yet received unemployment or qualify for unemployment insurance
- When COVID first hit, services ceased abruptly. We were running out of funds anyway, so this pause in services will allow us to be funded through the end of the contract year.
- we have definitely slowed down the number of clients we would usually admit for treatment.
- COVID-19 has impacted our revenue greatly. We anticipate that we will not meet our proposed encounters.
- We have used federal funds to lessen the impact of buying supplies and prevention items with regard to the COVID response.
- Our ability to fundraise has become very scarce and keeping staff will be a continued challenge. Without staff we will not be able to serve our youth.
- AWA ED handles contracts, revenue, funding sources.

- With the limited PPE resources in the state, we have managed to keep our clients and staff protected and safe. Keeping the facilities, personal workspace, and common areas sanitized have been quite expensive.
- Overall revenue dropped significantly as referrals have pretty much dried up. Our agency relies heavily on CJ referrals and as the POs are working remotely too there are a lot of barriers in the way of getting clients scheduled for admission or even chasing them down once a referral is made.
- While we have had some loss of revenue, thus far the extra COVID \$ available has helped fill the gaps
- Were told we would receive add'tl funding from July till new contract in Sept. and encouraged to spend down budget in mtgs. in Feb. March. To be told in May that we would receive a no cost extension instead was not projected so staff will be laid off.
- There has been a delay in receiving payment for all revenue streams impacting the overall flow of operations.
- COVID-19 has affected our services as well as our funders across the board.

Other Comments/Feedback

- Appreciate the opportunity to give feedback
- Thank you for conducting this survey.
- Overall, Stay at Home has caused difficulty gauging progress with our particular population because Support Meetings are online so attendance and participation is difficult to monitor; also lack of engagement in community makes it difficult to monitor practical application of learned skills.
- I would like to say thank you to our contract manager Amihan Aiona who has been extremely knowledgeable, supportive, and readily available to answer questions; she offers suggestions and help us problem solve issues around our ADAD contract and monies. We did not ever get our orientation sessions/meeting because it was cancelled due to COVID. monthly providers meetings held every 1st Friday are not as valuable as monthly Continuum of Care (COC) meetings held every 3rd Friday; it is frustrating when certain providers drone on about issues that only seem relevant to their agency.
- Responsiveness to questions (via email/telephone) of ADAD staff could be worked on. I understand that they have a lot of providers to keep up with however, a simple response is better than no response.
- I enjoy monthly provider meetings when they are structured and stay on topic. When there is meaningful information shared, I find it very beneficial. The provider group has grown too large for us to waste time doing round table discussions or having each person share.

- If possible I would like to be informed about the feed back of this evaluation and survey as far as what the general consensus. The reason is if my answers is something that only I have an issue with or if it's something that I as a provider need to work on. I hope the answers to this survey can be looked on as a way to bring everyone together during this time. There are instances in this whole process as a provider that I should have spoken up more or talk with management one of one to address these issues of utilization and cut backs. Mahalo
- We appreciate ADAD in so many ways. We feel they understand the field and that our service provision is important to them. They are supportive and understanding when flexibility is needed, as in these COVID times. So grateful for the funding that keeps our offices open, but also grateful for the spirit in which ADAD staff serve. We think they are wonderful and extremely helpful. We love it when they come to do trainings or site visits... so very positive and solution oriented. Big MAHALO!!!
- the 3s in my responses should be interpreted as "not applicable". My office has contracts with ADAD but not for direct services. If this survey is for direct service organizations only, please disregard. Your office is doing a great job!
- Some of the questions above regarding interaction with other provider groups or associate partners working with ADAD do not apply to our program context. There was no option to hit "Does not apply" so I was forced by the survey to respond. I responded "Highly Disagree." The responses to our specific interaction with ADAD had the same answer for the most part, but that was a legitimate assessment.

- Communication from ADAD in relation to contract award amounts can/should be more upfront. Developing a close collaborative relationship with each provider is time well spent. Understanding and appreciating each provider and what they bring to round out service options for the state (for their special population(s)) has not been evident in the past 2 ADAD contract terms. Instead, across the board standardization was the goal but at the expense of understanding the special populations served by each provider and at the expense of being able to provide evidence based treatment. Hopefully there is a different end goal for this approach which may be realized at a later time for all providers. The EHR and the tiered system of reimbursement has been a huge burden for larger agencies that serve intensive special populations in larger volume. The structure of the current services payment/reimbursement seems to be advantageous to smaller for profit outpatient types of facilities/services as demonstrated by shortened lengths of residential stays and the need to justify extension of care at a certain tier. Data may be retrieved (outputs and outcomes) and external evaluation of the data would seem to provide a basis now for justification and advocacy for additional funds for SUD prevention/treatment. The contracts should be in alignment with what the EHR can manage. Often it is not and the providers help workout bugs in the system. This is taxing on direct care staff or staff who assist with billing for services and their work load in some cases have quadrupled with the added tiered system which is extremely cumbersome by nature. Suggest to remove layers of authorizations and specifics related to tiers and allow providers to justify services based on clinical need. Thank you for the opportunity to provide input and give feedback.

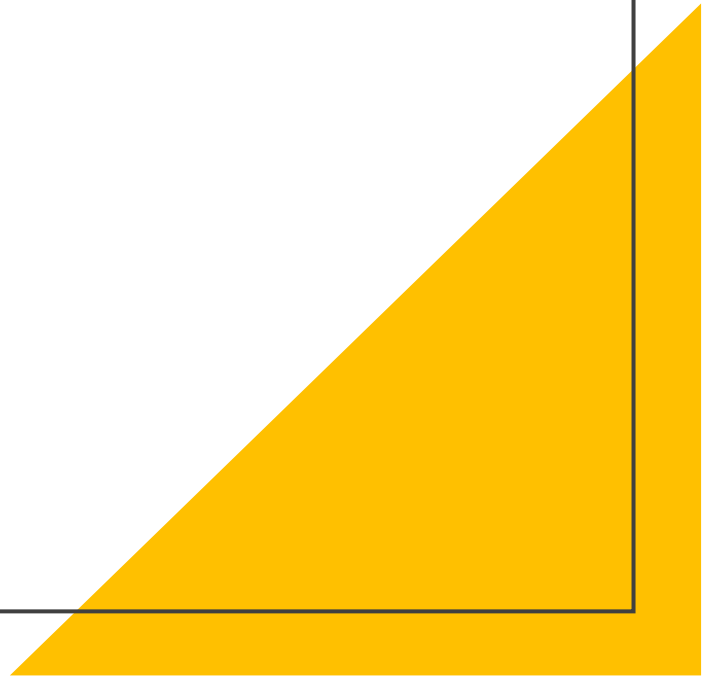
- I believe that the overall vision of Hawaii CARES is stalled. CARES should to be the UM..the reff hub of all providers to ensure an unbiased treatment placement and referral process.

- I do not attend Cares Meeting so I don't know how I can be required to answer questions about the meeting

- ADAD has been relatively supportive of our agency and our needs. They have listened to us and worked with us. However, the tiers system is not working and is not a good idea. ADAD is not an insurance company and should give the treatment providers the means of setting up how to spend down their funding. Providers know the clients and their needs. The tiers system is cumbersome and takes away clinical time from the counselors/client relationship and replaces it with "paperwork". Another cumbersome system is the CARES system. The way it is being used sets up more barriers to treatment than streamlining clients into treatment. As a provider, when we get a CARES referral, many times we have to "hunt" the client down and it's a hit or miss on whether or not we "find" them.
- CARES requires too many assessments on WITS. DENS ASI, ASAM, CAGE AID, and GPRA is too time consuming and unnecessary barriers for someone at their "rock bottom". Can ADAD please provide more funds for treatment? Programs are requesting hundreds of dollars upon admission (Hope Inc for food, Poailani for rent) from people who are experiencing hardships and lack of resources such as homelessness or being released from jail. Women's Way is significantly cutting services for lack of funding. This is negatively impacting our communities.
- My agency is in community prevention instead of direct service/treatment, so questions about Continuum of Care and CARES did not apply to the services we provide.
- Our reopening date is July 1, 2020 or we will receive additional information by that time.
- Thank you for your ongoing support to treatment providers. I appreciate CARES reaching out to us when questions arise.

- My main concern is about CARES and how the tables have turned. In the past the client was responsible for contacting the treatment agency and scheduling their own appointments. With CARES, the treatment providers are now chasing the clients as they feel they did their part by talking with a CARES representative. This agency only had successful CARES admits from those clients that were currently in custody at OCCC. In addition, the agencies that have been contracted to go into OCCC and do assessments don't follow a standard criteria when making recommendations. Statements put in the narrative sometime show things of great concern (homeless, jobless, self-medication for a SMI) and recommendations are for low level of care, community based care, etc. I've also had assessments come to me from agencies like IHS with instructions for the Intake Counselor to contact IHS and leave a message for the client to call them back- I don't understand why IHS couldn't just assist in the client in calling us if they did the assessment and referral. It was like right hand and left hand not communicating and it took a while for the Intake Counselor to chase down the client and schedule an admission. I've also gotten CARES referrals from neighbor islands where the client has never been in treatment and they want to place them on Oahu. The client comes only to get homesick and leave treatment. I think it would be in the client's best interest to explore programs on their respective island before being sent to an island that they might not be familiar with or accustomed to. It would also be a good idea for CARES staff to familiarize themselves with the strengths of the different programs that they make referrals to and also with the criminal justice flow and understand the difference between a Parolee and Probationer.
- Appreciate you doing this - although we never saw results of the CARES survey? Please share both outcomes or summary with us, thanks.

- Appreciate you doing this - although we never saw results of the CARES survey? Please share both outcomes or summary with us, thanks.
- could not answer to the COC mtgs. as I never knew those existed.
- Still struggling through the necessary changes while looking forward to what prevention services looks like when schools are back in session.



Hawai'i CARES Data Initiatives

ADAD Continuum of Care Meeting
June 19, 2020

Data and Quality Improvement Efforts

1. Call Screenings and Referrals to Providers
2. Bed Inventory and Service Availability
3. Utilization Management
4. System and Service Quality Improvement

Data collected by our graduate assistants and clinical teams.

Some things we already do, some are a work in progress.

1. Call Screenings and Referrals to Providers

Examples from

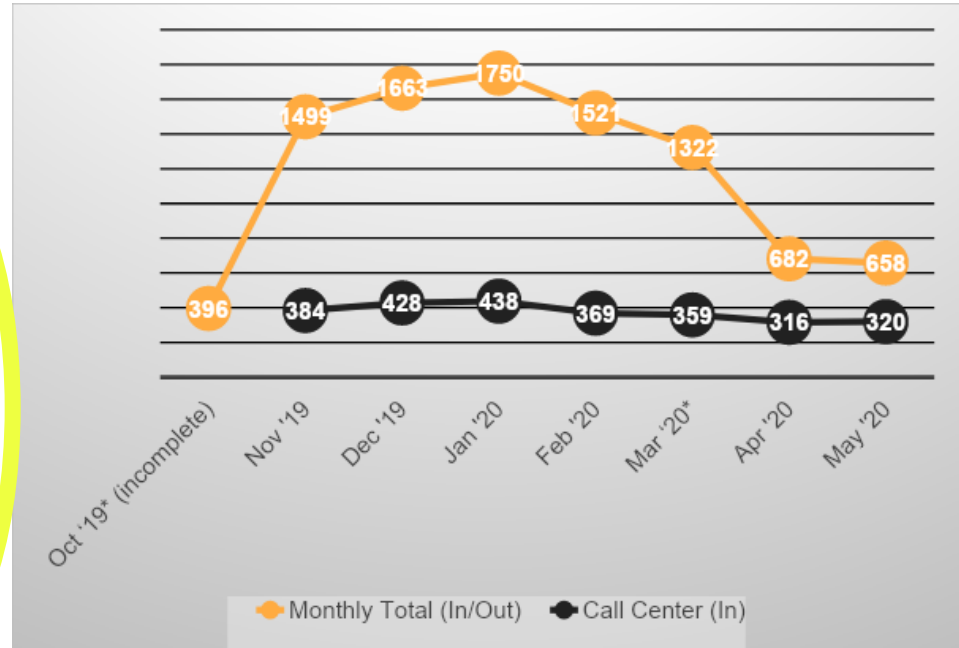
- Provider & COC Meetings
- Monthly Reports

Quantitative Data

- Call Center Monthly Call Volume
- Call Center Screenings (USIS), and % CJ Clients Referred
- N WITS referrals from CARES to ADAD Providers for Assessments and Services
- Out (WITS report) (assessment/services)

Number of Call-Center Calls (In/Out)

	Monthly Total (In/Out)	Call Center (In)
Oct '19* (incomplete)	396	
Nov '19	1499	384
Dec '19	1663	428
Jan '20	1750	438
Feb '20	1521	369
Mar '20*	1322	359
Apr '20*	682	316
May '20*	658	320



*Daily average calls decreased due to: 1) COVID-19 system transitions and 2) CARES operational on additional weekend business days, with fewer calls

*30-40 calls per day since pandemic

Agency Referred To	Total Referred Prior to TX	% Referred Prior to TX	Total Referred During TX	% Referred During TX	Total Referred	% of All Referred to this Agency
Action with Aloha, LLC						
Alcoholic Rehabilitation Services of Hawaii, Inc	0	0.00%	13	100%	13	13.50%
Aloha House, Inc.	0	0.00%	13	100%	13	13.50%
Big Island Substance Abuse Council	0	0.00%	6	100%	6	6.30%
Bobby Benson Center						
Bridge House, Inc						
CARE Hawaii, Inc.	1	5.60%	17	94.40%	18	18.80%
Child and Family Service						
Coalition for a Drug-Free Hawaii						
Hawai'i Health & Harm Reduction Center						
Ho'omau Ke Ola						
Hope Treatment Services	0	0.00%	2	100%	2	2.10%
IHS, The Institute for Human Services, Inc.	0	0.00%	3	100%	3	3.10%
Ka Hale Pomaika'i						
Kline-Welsh Behavioral Foundation	0	0.00%	3	100%	3	3.10%
Kokua Support Services	0	0.00%	4	100%	4	4.20%
Ku Aloha Ola Mau	0	0.00%	1	100%	1	1.00%
Malama Na Makua A Keiki						
Maui Youth and Family Services, Inc						
North Shore Mental Health, Inc	4	17.40%	19	82.60%	23	24.00%
Ohana Makamae						
Oxford House						
Po'ailani, Inc	0	0.00%	2	100%	2	2.10%
Salvation Army	0	0.00%	1	100%	1	1.00%
The Queen's Medical Center	0	0.00%	1	100%	1	1.00%
The Salvation Army	0	0.00%	2	100%	2	2.10%
Waikiki Health Center						
Waianae Coast Comprehensive Health Center						
Women In Need	0	0.00%	4	100%	4	4.20%
Young Men's Christian Association of Honolulu						
[Totals]	5	5.20%	91	94.80%	96	100%

Referrals between CARES & SU Providers

Referrals Out By Agency

1. North Shore Mental Health, Inc.
2. CARE Hawaii, Inc.
3. Aloha House, Inc.
4. Alcoholic Rehabilitation Services of Hawaii, Inc.
5. Big Island Substance Abuse Council

15 out of 30
agencies
were utilized

13 - April

11 - March

15 - February

(Based on agencies who contributed at least 5% of total referrals)

2. Bed Inventory and Service Availability

Qualitative Data

- Changes in provider COOP
- Changes in provider availability to accept clients

Quantitative Data

- Daily bed space availability (residential and detox)



Bed Space Inventory in Past Month (Completion of Data and Space Availability)

Provider	Service Type	Proportion of data inputted per month	Proportion of Bed Availability per month
Aloha House	Residential (Male)	18/31	6/18
	Residential (Female)	18/31	12/18
	Social Detox (Male)	18/31	17/18
	Social Detox (Female)	18/31	11/18
Bobby Benson	Residential (Adolescent Male)	17/31	17/17
	Residential (Adolescent Female)	17/31	17/17
Salvation Army (FTS)	Residential (Female)	19/31	12/19
	Social Detox (Female)	0/31	0/0
Salvation Army (ATS)	Residential (Male)	19/31	0/19
	Residential (Female)	19/31	0/19
	Social Detox (Male)	0/30	0/0
	Social Detox (Female)	0/30	0/0
Sand Island Treatment Center	Residential (Male)	0/30	0/0
	Residential (Female)	0/30	0/0
	Social Detox (Male)	0/30	0/0
	Socieal Detox (Female)	0/30	0/0
Poailani	Residential (Male)	20/31	15/20
	Residential (Female)	19/31	5/19
Ho'omau Ke Ola	Residential (Male)	13/31	9/13
Hina Mauka	Residential (Male)	20/31	0/20
	Residential (Female)	18/31	0/18
	Social Detox (Female)	18/31	0/18
	Social Detox (Male)	18/31	0/18

3. Utilization Management

Quantitative Data

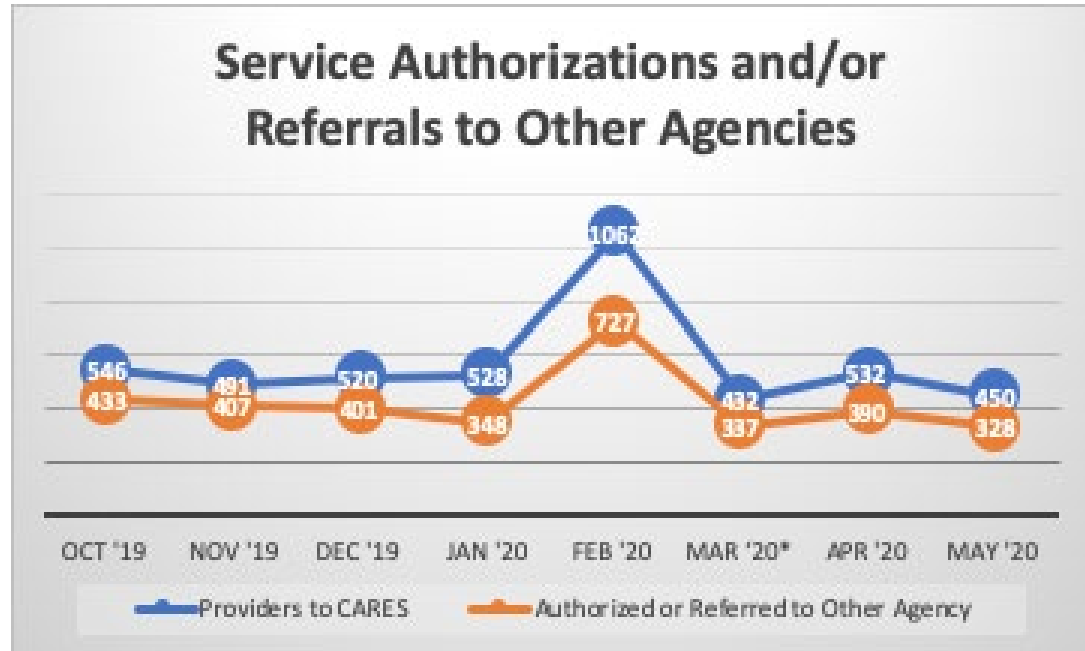
- N WITS Referrals from Providers to CARES for:
 - Referrals to other agencies
 - Service authorization
 - Benefit Exceptions
- Length of Stay by costliest services

Qualitative Data

- Context for patterns in frequent authorization rejections
- Context for patterns in frequent Benefit Exceptions

Bundles to CARES for Authorization or Referral to Other Agency

	Providers to CARES	Placed/ Accepted (Authorized or Referred Out)
Oct '19	546	433
Nov '19	491	407
Dec '19	520	401
Jan '20	528	348
Feb '20	1062	727
Mar '20*	432	337
Apr '20	532	390
May '20	450	328





Agency Referred by	# Placed/Accepted	# Referral Terminated	# Refused Treatment	# Rejected by Program	# Placed on the Waitinglist	Total Referred	% Referred by this Agency
Action with Aloha, LLC	2	0	0	3	0	5	1.10%
Alcoholic Rehabilitation Services of Hawaii, Inc	109	1	0	10	0	121	26.90%
Aloha House, Inc.	11	0	0	5	0	16	3.60%
Big Island Substance Abuse Council	61	0	0	2	1	64	14.20%
Bobby Benson Center							
Bridge House, Inc							
CARE Hawaii, Inc.	34	1	1	17	4	57	12.70%
Child and Family Service	7	0	0	1	0	8	1.80%
Coalition for a Drug-Free Hawaii							
Hawai'i Health & Harm Reduction Center							
Ho'omau Ke Ola							
Hope Treatment Services							
IHS, The Institute for Human Services, Inc.	0	0	0	0	1	1	0.20%
Ka Hale Pomaika'i	2	0	0	0	1	3	0.70%
Kline-Welsh Behavioral Foundation	37	0	0	3	0	41	9.10%
Kokua Support Services	0	0	0	0	2	2	0.40%
Ku Aloha Ola Mau							
Malama Na Makua A Keiki	13	0	0	2	0	15	3.30%
Maui Youth and Family Services, Inc	3	0	0	2	0	5	1.10%
North Shore Mental Health, Inc	13	4	3	0	14	34	7.60%
Ohana Makamae							
Oxford House							
Po'ailani, Inc	8	0	0	17	0	25	5.60%
Salvation Army	0	0	0	3	0	3	0.70%
The Queen's Medical Center	5	0	0	9	0	14	3.10%
The Salvation Army	13	0	0	6	0	19	4.20%
Waikiki Health Center							
Waianae Coast Comprehensive Health Center	0	0	0	0	1	1	0.20%
Women In Need	0	0	0	1	0	1	0.20%
Young Men's Christian Association of Honolulu	10	0	0	2	0	12	2.70%
[Totals]	328	6	5	83	26	450	100%



Qualitative Data Being Collected to Contextualize...

- patterns in frequent authorization rejections
- patterns in frequent Benefit Exceptions

Example: Length of Stay by Service (FY 19)

Modality	Age Group	Amount Paid	Dollars per Admission
Residential PPWC Treatment	Adult	\$299,191.00	13,600
	Modality Total	\$299,191.00	\$13,600
Residential Social Detoxification	Adult	\$517,789.00	\$1,564
	Modality Total	\$517,789.00	\$1,564
Residential Treatment	Adult	\$1,829,695.00	\$4,529
	Children	\$117,095.00	\$7,318
	Modality Total	\$1,946,790.00	\$4,635
Therapeutic Living	Adult	\$186,148.00	\$6,005
	Modality Total	\$186,148.00	\$6,005
Therapeutic Living PPWC	Adolescent	\$9,840.00	\$9,840
	Adult	\$330,386.00	\$6,883
	Children	\$162,326.00	\$5,411
	Modality Total	\$502,552.00	\$6,361
Law Enforcement Assisted Diversion	Adult	\$15,988.00	\$7,994
	Modality Total	\$15,988.00	\$7,994

- This illustrates the total amount paid per age group.
- Next step, drill down by agency to understand commonalities/differences.

4. System and Service Quality Improvement

Client, Provider, Stakeholder Feedback

- CARES Satisfaction Surveys
- Qualitative feedback from providers, callers, etc.
 - Website
- Logging Provider/Stakeholder in-service trainings, orientations, meetings
- HOI Workgroup 1 (Treatment Access)
- CARES Advisory Group



Feedback Surveys

- First Feedback Survey (N=27, from Jan-Mar 2020, compiled 3/24/2020)
 - Results available: (<http://manoa.hawaii.edu/cares/wp-content/uploads/sites/23/2020/06/Hawaii-CARES-Feedback-Survey-2020.06.16.pdf>)
- In Progress
 - Web-based Feedback Survey
 - Clients/Consumers and Family Members
 - Providers
 - Phone-based follow-up

Next Steps: Website feedback, meetings, etc.

- Qualitative feedback from providers, callers, etc.
 - Website
- Logging Provider/Stakeholder in-service trainings, orientations, meetings
- HOI Workgroup 1 (Treatment Access)
- CARES Advisory Group

What do we do with all this data?

- Increased transparency
- Consider how to change CARES policies and processes
- Share with DOH partners, providers, community

Data Sharing

- Monthly ADAD Meetings
 - Provider Meeting
 - Continuum of Care (COC) Meeting
- UH CARES Website
 - <http://manoa.hawaii.edu/cares/data-and-reports/>

OFFICIAL USE ONLY
Case Name:
Case No.:
Received Date:

CHANGE OF CIRCUMSTANCE REPORT FORM

You must report any changes to your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income or employment status **within 15 days of the event**. If this report does not provide enough room to document a change, attach a sheet of paper with the additional information. You may also report changes online at www.mybenefits.hawaii.gov, by telephone or in person. Failure to report changes may result in benefits being denied, terminated or stopped. Auth.: H.A.R. §17-1712.1-4

Primary Individual Name: (Last, First, MI)		Date of Birth: (mm/dd/yyyy)	Client ID or SSN:
Current Address (Street, City, State, Zip code):			Phone:
Check one if you are completing on behalf of the Medicaid beneficiary		Must Check one:	
<input type="checkbox"/> Authorized Representative (DHS1121)	<input type="checkbox"/> Legal Guardian, POA or Conservator (Legal document)	<input type="checkbox"/> ON FILE or <input type="checkbox"/> ATTACHED	
Name: (Last, First, MI)			
Requests for change of circumstance by an Authorized Representative, Legal Guardian, Power of Attorney or Conservator on behalf of the Medicaid beneficiary requires proof of authorization. If the Department does not have a signed authorization on file from the beneficiary, the request for a change of circumstance on the Medicaid beneficiary's behalf will not be processed until proof is received by the Department.			

INTERPRETER REQUESTED: YES NO **LANGUAGE REQUESTED:**

<input type="checkbox"/>	SECTION 1 – TERMINATE MEDICAL ASSISTANCE CASE: Effective Date: (mm/dd/yyyy)
Reason:	
<input type="checkbox"/>	SECTION 2 - NAME CHANGE: (Attach copy of legal document)
Reason for change: (complete section 5 if applicable) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption/Court Order <input type="checkbox"/> Other-Specify:	
From:	(Last, First, MI):
To:	(Last, First, MI):
<input type="checkbox"/>	SECTION 3: ADDRESS &/OR TELEPHONE CHANGE (This change will apply to <u>ALL</u> household members in your case, if this is incorrect, please specify in Section 8 who this change applies to.)
New Residence:	(Street No. & Name) (City) (State) (Zip Code)
New Mailing:	(Street No. & Name) (City) (State) (Zip Code)
New Phone No.:	Email Address:
<input type="checkbox"/>	SECTION 4 - REPORT OR CHANGE OF PREGNANCY:
Pregnant Woman Name (Last, First, MI)	Date of Birth: (mm/dd/yyyy) Client ID (or SSN optional):
Number of Babies Expected:	Due Date: (mm/dd/yyyy) End Date of Pregnancy: (mm/dd/yyyy)
<input type="checkbox"/>	SECTION 5 - REPORT OR CHANGE OF THIRD PARTY LIABILITY (TPL) COVERAGE: (Attach copy of insurance card if available)
Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy) Client ID (or SSN optional):
Health Plan Name:	Subscriber/Member No.:
Type of Plan Coverage: (Check all that apply)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug <input type="checkbox"/> Psych <input type="checkbox"/> Other-Specify:
Effective Date of TPL: (mm/dd/yyyy)	Termination Date: (mm/dd/yyyy)
Do you receive Medicare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicare Number:

If you need to ADD additional insurance, please make a copy of this sheet, complete and submit together.

SECTION 6 - CHANGE IN HOUSEHOLD MEMBERS:

<input type="checkbox"/> ADD TO HOUSEHOLD		<input type="checkbox"/> CHANGE INFORMATION		<input type="checkbox"/> DELETE FROM HOUSEHOLD	
		<input type="checkbox"/> Date of Death:		<input type="checkbox"/> Other:	
Do you need medical assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO		• The date this form is received by the Department will be the date considered for medical assistance redetermination.			
If you received any medical services in the past ten (10) calendar days, you must complete & attach a DHS 1100-Application for Health Coverage. Medical assistance shall be considered for the ten (10) calendar days prior to the date the DHS 1100 application is received by the Department. A Social Security Number (SSN) is required if you are applying for medical assistance.					
Name: (Last, First, MI)		Date of Birth: (mm/dd/yyyy)		Client ID (or SSN optional):	
NEWBORN(S): Mother's Name (Last, First, MI)		Date of Birth: (mm/dd/yyyy)		Mother's Client ID (or SSN optional):	
NEWBORN(S): Father's Name (Last, First, MI)		Date of Birth: (mm/dd/yyyy)		Father's Client ID (or SSN optional):	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Citizenship Status: <input type="checkbox"/> U.S. <input type="checkbox"/> Alien		Number: <input type="checkbox"/> Other:	
Relationship to the Primary Insured: (check one)		<input type="checkbox"/> Spouse of <input type="checkbox"/> Civil Union of <input type="checkbox"/> Parent of <input type="checkbox"/> Child of		<input type="checkbox"/> Sibling of <input type="checkbox"/> Grandparent of <input type="checkbox"/> Sibling of <input type="checkbox"/> Other	
Claimed as a Tax Dependent: <input type="checkbox"/> YES <input type="checkbox"/> NO		Tax Filer Name: (Last, First, MI)			
Do you receive or need Long-Term Care services in a Nursing Home, Adult Foster home, In your own home, Assisted Living home or Retirement/Life Care Community?		<input type="checkbox"/> YES		<input type="checkbox"/> NO	
Do you have a disability lasting more than 12 months?		<input type="checkbox"/> YES		<input type="checkbox"/> NO	
Do you receive Social Security Supplemental Income (SSI)?		<input type="checkbox"/> YES		<input type="checkbox"/> NO	

SECTION 7 - REPORT OR CHANGE IN INCOME:

Name: (Last, First, MI)		Date of Birth: (mm/dd/yyyy)		Client ID (or SSN optional):	
<input type="checkbox"/> CURRENT INCOME			<input type="checkbox"/> ADD INCOME		
<input type="checkbox"/> No Change Continue <input type="checkbox"/> Change Effective Date: _____ <input type="checkbox"/> End Effective Date: _____			Start Effective Date:		
Employer Name/Source of Income:			Employer Name/Source of Income:		
Income (before taxes) \$		Average hours per week:		Income (before taxes) \$	
<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a week		<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a week		<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a week	

If you need to ADD additional person(s) or income, please make a copy of this sheet, complete and submit together.

SECTION 8 - OTHER CHANGES-Indicate below:

The Department may send you additional forms for additional information based on eligibility on a basis other than modified adjusted gross income (MAGI) and/or for long-term care. A change in information submitted by you could affect the eligibility for member(s) of your household. The Department of Human Services will obtain information to verify eligibility with electronic databases including but not limited to the Internal Revenue Service, Social Security Administration, Department of Homeland Security or a consumer reporting agency. If the information does not match, we may ask you to send us proof. **I certify the information that is provided on this Change of Circumstance Report form is true and to the best of my knowledge. If I intentionally make false statements on this form, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements.**

Signature:		Date:	
DHS/MQD USE ONLY		COMPLETED DATE:	
COC COMPLETED IN KOLEA BY:			

INSTRUCTIONS
DHS 1179A (03/15)

CHANGE OF CIRCUMSTANCE REPORT FORM

PURPOSE:

The DHS 1179A, Change of Circumstance Report form shall be used by the Primary individual or Authorized Representative, Legal Guardian, Power of Attorney or Conservator of the Primary individual for the case to report changes and to provide information which may affect the eligibility of the household. Such information may include, but is not limited to interpreter request; name change, address, telephone number, report of pregnancy or termination of pregnancy, third party liability (TPL) coverage, add or delete a household member including birth or death; and income.

GENERAL INSTRUCTIONS:

1. Use a separate form if more than one (1) household member needs to be added or if any additional information needs to be reported than spaces available.
2. Information provided on this form by the beneficiary or authorized/legal representative on behalf of the client shall be entered on the appropriate KOLEA screen(s) and file/scan form to the case record.
3. Information asked for on this form must be completed and signed by the beneficiary or authorized/legal representative. Authorized/legal representatives must have the proper authorizations to sign, receive copies, act on behalf, complete & submit information on behalf of beneficiaries.
4. Reporting of changes that affect Medicaid eligibility must be reported with ten (10) calendar days of the event. A beneficiary may report changes in person by completing this form or by telephone, via KOLEA client portal account, United States Postal Service, or by any other available electronic means.
5. The Department will obtain information to verify eligibility with electronic databases including but not limited to the Internal Revenue Service, Social Security Administration, Department of Homeland Security or a consumer reporting agency including existing federal and state databases. If information cannot be obtained electronically or is not reasonable compatible, the Eligibility Worker may request proof of information.
6. The effective date of redetermination due to a change of circumstance will be the date this form is received or the date it is reported to the Department by any other means unless specifically stated.
7. Retroactive medical assistance requests of an individual residing in the household that is now requesting medical assistance that received any medical services in the past ten (10) calendar days or in the past three (3) months if requesting long-term care services, a completed DHS 1100 Application for Health Coverage must be received in order for those services to be considered for that period.

SPECIFIC INSTRUCTIONS:

Beneficiary, authorized representative, legal guardian, power of attorney, or conservator to complete:

1. The Primary Individual name and identifying information shall be entered.
 - a. If an Authorized Representative, Legal Guardian, Power of Attorney or Conservator of the primary individual is reporting a Change of Circumstance on behalf of the primary individual. Check the appropriate box indicating type of authorization, if an authorized form is on file or is being attached and enter the name of the authorized individual.
 - If the Department does not have an authorized representative on file or if it has changed please have the primary individual complete form DHS 1121 "Designate Authorization Representation" form authorizing an individual to act on their behalf to assist with an application, a redetermination of eligibility and other on-going communications with the Department and attach to this form.
 - If legal authorization exists or if it has changed and the Department does not have it on file, attach a copy of the legal authorization.
 - Reporting of changes made by an individual that has not been authorized by the beneficiary will not be accepted without authorization.
2. The Primary Individual or authorized/legal representative shall complete the section(s) pertinent to the change(s) being reported.
 - a. Section 1: Terminate Medical Assistance Case: Enter the date of termination and reason.
 - All household members on the case will be terminated. If you only need to terminate specific household members, complete Section 6 to request delete from household instead.
 - b. Section 2: Name Change: Enter "From" as the current name and "To" as the new name.
 - Attach a copy of the legal name change document. Complete Section 5 (if applicable) for change in household member(s).
 - c. Section 3: Address &/or Telephone change.
 - All household members on the case will be affected. If only specific household members have this change, complete Section 8 to indicate specific household members.
 - d. Section 4: Report or termination of pregnancy: Self-explanatory.
 - e. Section 5: Report or change of Third Party Coverage: Self-explanatory
 - Attach a copy of the insurance card(s) if available.
 - f. Section 6: Change in household member(s). Enter appropriate information. If any individual(s) moved in or out of the household, is now requesting medical coverage, changed tax dependent(s) status &/or tax filer status, or is now requiring long-term care services or have a disability lasting more than 12 months.
 - g. Section 7: Report or Change in Income: Enter the name and identifying information of the individual with the change. Check whether change is to current income or to add income and enter all appropriate information.
 - h. Section 8: Other changes: Self-explanatory.

3. Signature & Date is required to certify the information reported.
4. The DHS 1179A shall be submitted to any Med-QUEST office.

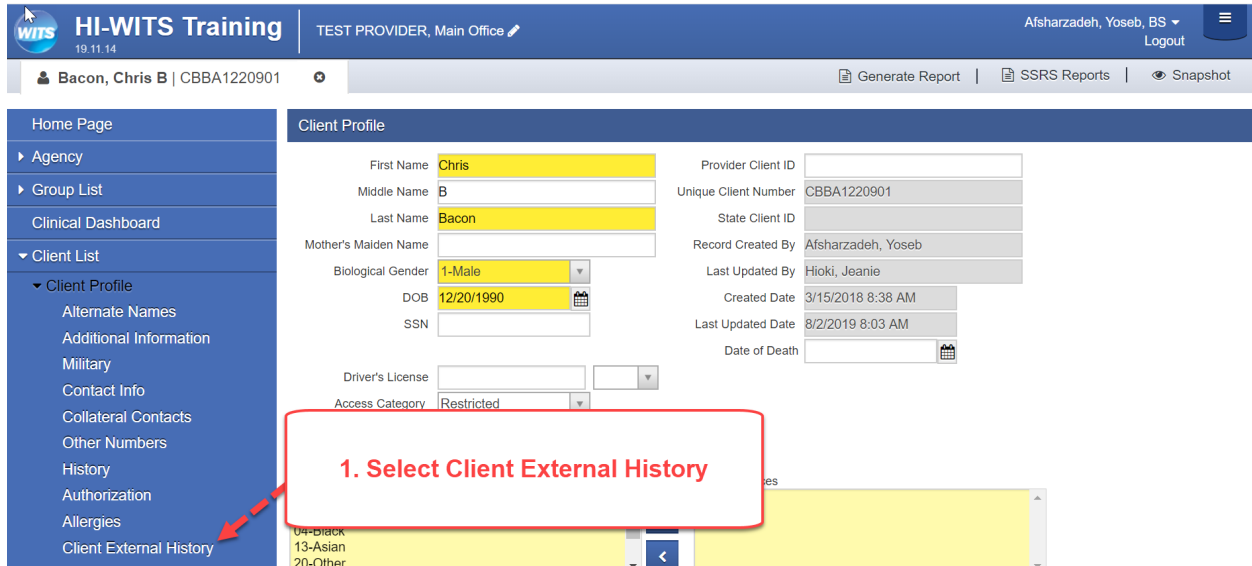
Eligibility Worker to complete:

1. The Eligibility Worker (EW) shall review the DHS 1179A and make a redetermination of eligibility based on the reported information or as received via electronic data matching including existing federal and state agency databases. If any missing/incomplete information is needed and cannot be obtained electronically or if information reported is not reasonable compatible with information obtained electronically, the EW shall issue a fifteen (15) day pending notice requesting only the information needed to make a redetermination or is directly connected to the State plan.
2. A DHS1100-Application for Health Coverage that requests medical assistance for a period prior to the date of a reported change in circumstance shall be considered for the ten (10) calendar days prior to the date the DHS 1100 form is received by the Department or if applying & eligible for long-term care services in the past three (3) months prior to the application received date.
3. EW shall use "DHS/MQD Use Only" box to record date action taken. File/scan the completed DHS 1179A form to the case record. The "Official Use Only" box shall be used to identify the proper case and effective date of change.

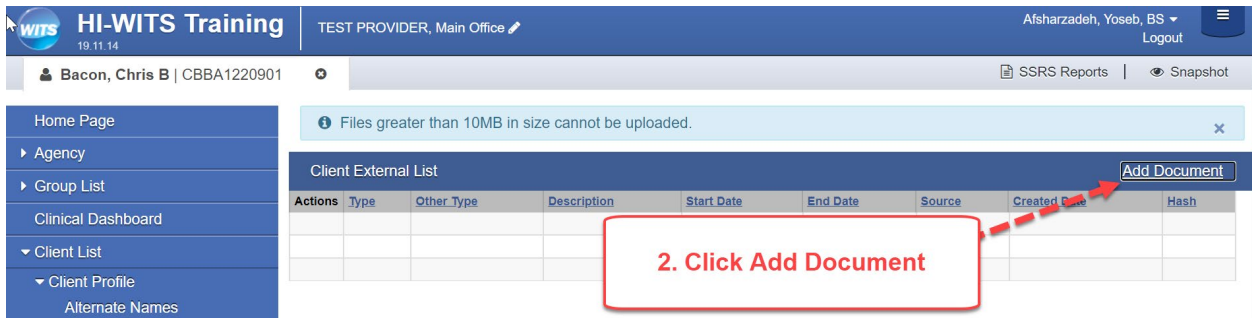
Uploading Documents to WITS

Upload documents on WITS to the Client External History. Two (2) documents up to 10 MB are allowed per Client. In order to access this feature User Account must have **Client External History (Full Access)** role.

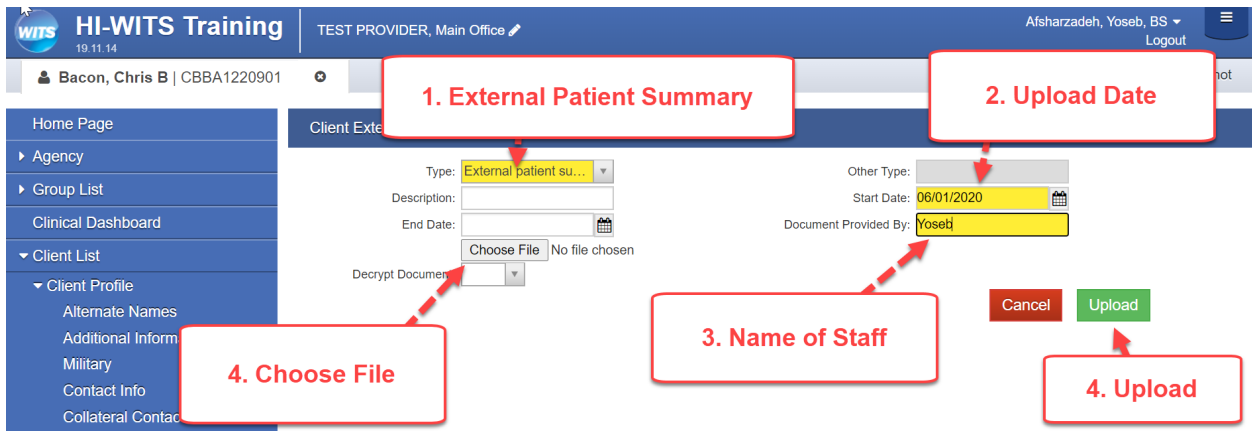
1. Under Client Profile, select Client External History link.



2. Click the Add Document link



- 3. Select type, set Start Date, Type your Name in Document Provided by field, choose file and click Upload



- 4. Once saved you can Download a copy, Encrypt & Download and Delete functions are available.

