
OFFICE OF LONG TERM CARE

Traumatic Brain Injury Initiatives

Home and Community-Based Services

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Waiver for Individuals with

Traumatic Brain Injury

PROGRAM MANUAL

April 2009

NOTE: Full implementation of the Program Manual and all TBI waiver forms is required by OCTOBER 1, 2009.

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Section I

Introduction and Philosophy of the HCBS/TBI Waiver

The Program Manual

The Home and Community Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (HCBS/TBI) began providing services in April 1995. The original Program Manual was created to provide guidelines about the processes and services associated with this innovative program.

Since its inception, the waiver has remained flexible and responsive to the needs of participants and providers. This revised Program Manual reflects these changes and provides further clarification of definitions and scope of the HCBS/TBI waiver services.

The revised Program Manual is dedicated to all participants of the past, present and future, and to those individuals who have assisted people with brain injuries to be in control of their lives and to live as independently as possible in the community.

Introduction to the HCBS/TBI Waiver

The HCBS/TBI waiver is administered centrally by the New York State Department of Health (DOH) and implemented through Regional Resource Development Centers (RRDC) and Specialists (RRDS) who serve to assure access to services in communities throughout the State.

The waiver uses Medicaid funding to provide supports and services to assist individuals with a traumatic brain injury (TBI) toward successful inclusion in the community. Waiver participants may choose to move into the community from a nursing facility. Others may choose to participate in the waiver to prevent unnecessary institutionalization.

HCBS/TBI waiver services are available to supplement informal supports; the broad array of local, State and federally funded services, as well as Medicaid State Plan services to assure the health and welfare of the individual in the community.

Philosophy of the HCBS/TBI Waiver

The dignity of risk and right to fail are integral parts of the waiver's philosophy. The philosophy of the waiver supports the participant's right to choose where to live, who to live and socialize with, and what goals and activities to pursue.

Waiver services are provided based on the participant's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in cooperation with providers to develop a plan for services. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful and productive activities.

Section II

Becoming a Waiver Participant

Eligibility Criteria

An individual applying to participate in the waiver must meet all of the following criteria:

1. Be a recipient of Medicaid coverage that supports community based long term care services.
2. Have a diagnosis of traumatic brain injury (TBI).
NOTE: Individuals who experience deficits similar to a traumatic brain injury as a result of anoxia, toxic poisoning, stroke or other neurological conditions may also be eligible. Individuals with gestational or birth related difficulties such as cerebral palsy or autism or who have a progressive degenerative disease, are not eligible for the waiver.
3. Be between the ages of 18 and 64 upon application to the waiver.
4. Be assessed to need a nursing home level of care as a direct result of the traumatic brain injury. Nursing home eligibility is determined by the Hospital and Community Patient Review Instrument and SCREEN (PRI/SCREEN). The form must be dated within 90 calendar days of the individual's application packet to the waiver and be completed by an individual certified to use the tool (Appendix C-1).
5. Choose to participate in the waiver rather than reside in a nursing facility by signing the Freedom of Choice form, Application for Participation form and Service Coordination Selection form (Appendix B-1).
6. Identify the residence in which the waiver participant will be living when receiving waiver services.
7. Complete an Initial Service Plan and Application Packet (Appendix C-1) in cooperation with a Service Coordinator and be approved by the RRDS. This Plan must describe why the individual is at risk for nursing home placement without the services of the waiver and indicate how the available supports and requested waiver services identified in the Plan will support the health and welfare of the potential participant.
8. Have a completed Plan for Protective Oversight (PPO) (Appendix C-1).

Steps to Becoming a Waiver Participant

The following steps describe the application process for becoming a waiver participant:

- STEP 1** Potential participant contacts the RRDS in the region where he/she chooses to reside.
- STEP 2** The RRDS describes the waiver philosophy and available services to the potential participant and makes a preliminary determination of probable

eligibility for the waiver.

- STEP 3** The RRDS provides the potential participant with a list of approved Service Coordination providers and encourages him/her to interview potential Service Coordinators.
- STEP 4** The potential participant selects a Service Coordination Agency from the list of approved providers, completes the Service Coordinator Selection Form (Appendix B-1) and returns it to the RRDS.
- STEP 5** The RRDS forwards the Service Coordinator Selection form (Appendix B-1) to the selected provider for their signature, indicating that they are willing and able to accept the applicant.
- STEP 6** The applicant, and anyone he/she may choose, work with the Service Coordinator to develop an Initial Service Plan and complete the Application Packet.
- STEP 7** The Service Coordinator sends the completed Application Packet to the RRDS (see Section V – The Service Plan).
- STEP 8** The RRDS reviews the Application Packet and either approves the Packet or requests, in writing, revisions and/or additional information needed for approval.
- STEP 9** A Notice of Decision (NOD) is issued by the RRDS for an approved Application Packet. The Notice of Decision indicates the start date for the initial six months of waiver participation. Ongoing program participation is based on the participant's choice to remain in the waiver, continued Medicaid and level of care eligibility, and the completion of periodic Revised Service Plan updates and approval by the RRDS.

Every NOD must include information regarding an individual's fair hearing rights.

NOTE: On occasion, a participant may choose to relocate. If the participant relocates to a region covered by another RRDS, the current RRDS is responsible for making the initial contact with the RRDS in the relocation region. The RRDS from the new region must then contact the individual to provide the list of approved Service Coordination providers in that region.

Notice of Decision for Denial or Discontinuation of Waiver Services

A Notice of Denial is sent when an individual is not eligible to receive waiver services for the following reasons:

- (1) The participant chooses not to receive waiver services.

- (2) The participant is:
 - Not Medicaid eligible;
 - Not assessed to a nursing home level of care based on the PRI/SCREEN; or
 - Not capable of living in the community with a combination of informal supports, non-Medicaid public and/or private supports, State Plan Medicaid services, and/or supports available through the waiver program.
- (3) The services and supports available through the waiver and all other sources are not sufficient to maintain the individual's health and welfare in the community.
- (4) The participant chooses to receive services from another Home and Community Based Services Medicaid Waiver.
- (5) The cost of the Service Plan is above the level necessary to meet the federally mandated requirement that waiver services must be cost neutral in the aggregate when compared to statewide nursing home costs.

A Notice of Discontinuation will be sent to the participant when any of the following occur:

- (1) The participant is hospitalized for more than 30 days and there is no scheduled discharge date;
- (2) The participant is admitted to a nursing home, psychiatric facility or other institution for other than a short term; or
- (3) The participant is incarcerated for more than 30 days.

Fair Hearings/Administrative Meeting

Introduction

Individuals receiving a Notice of Decision (NOD) for issues related to the waiver are eligible for a fair hearing and, in some instances, may request aid to continue. All NODs must include information regarding an individual's fair hearing rights.

Fair Hearings

An individual has the right to seek a Medicaid Fair Hearing for many reasons including issues related to the HCBS/TBI waiver. Decisions regarding Medicaid eligibility are addressed through the fair hearing process with the local Department of Social Services.

Administrative Meeting

If a participant receives any Notice of Decision from the RRDS, an Administrative Meeting may be conducted prior to pursuing a formal Medicaid Fair Hearing. A review by the RRDS may be requested by the participant, an advocate, Service Coordinator or anyone involved in the development of the Service Plan.

This review is an opportunity for the participant and advocates to review with the RRDS the reasons for the NOD and address information they feel is not properly represented. Through discussion and negotiation, it may be possible to resolve issues without a Medicaid Fair Hearing.

Issues about the waiver that are addressed through the Medicaid Fair Hearing process include:

- (1) Was the applicant offered the choice of waiver service(s) as an alternative to a nursing home;
- (2) Was the applicant or participant denied the service(s) of his or her choice;
- (3) Was the applicant or participant denied the services of a qualified provider that was willing to serve the applicant or participant;
- (4) Was the decision of denial or discontinuance of waiver services correct; and
- (5) Was the decision to reduce or eliminate waiver services correct.

Issues about the waiver that are NOT addressed through the Medicaid Fair Hearing process include:

- (1) Was the applicant or participant in need of a nursing home level of care (as determined by the PRI/SCREEN);
- (2) Does the waiver have any openings based on the number of participants approved for the waiver as specified by the federal government; and
- (3) Does the applicant have a traumatic brain injury (TBI) as defined by the waiver.

Waiver Participant's Rights and Responsibilities

A waiver participant is assured certain rights, and must agree to certain responsibilities related to participation in the waiver program.

The Service Coordinator is responsible for explaining to the waiver applicant/participant, the rights and responsibilities of being a waiver participant. These rights and responsibilities should be reviewed with the participant at least annually, and any time the Service Coordinator is aware that the participant does not understand his/her rights or responsibilities.

The Waiver Participant's Rights and Responsibilities (Appendix C-1) must be signed and dated by the applicant. The original document is included in the Application Packet. A copy is given to the participant to be maintained in an accessible location in the participant's home.

As a Waiver Participant, You Have The Right To:

- (1) Be informed of your rights prior to receiving waiver services;
- (2) Receive services without regard to race, color, creed, gender, national origin, sexual orientation or disability;
- (3) Be treated as an individual with consideration and respect;
- (4) Have access to services that support your health and welfare;
- (5) Assume reasonable risks and have the opportunity to learn from these experiences;
- (6) Be provided with an explanation of services available through the HCBS waiver and other health and community resources that may benefit you;
- (7) Have the opportunity develop, review and approve all Service Plans, including changes to the Service Plan;
- (8) Select individual service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;
- (9) Request a change in services (increase, decrease or discontinuation) at any time;
- (10) Be informed of the name and duties of any person providing services to you under your Service Plan;
- (11) Have input into when and how waiver services will be provided;
- (12) Receive services from approved, qualified individuals;
- (13) Receive from the Service Coordinator a list of telephone numbers and supervisors for all your service providers, the RRDS and DOH;
- (14) Refuse care, treatment and services after being fully informed of and understanding the consequences of such actions;
- (15) Have your privacy respected, including the confidentiality of your personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medicaid requirements;
- (16) Submit complaints about any violation of rights or and any concerns regarding your services provided without jeopardizing your participation in the waiver;
- (17) Receive support and direction from the Service Coordinator to resolve your

- concerns and complaints about services and service providers;
- (18) Receive additional support and direction from the RRDS and/or DOH in the event that if your Service Coordinator is not successful in resolving your concerns and complaints about services and service providers;
 19. Have your complaints responded to and be informed of the resolution;
 20. Have your service providers help protect and promote your ability to exercise all your rights; identified in this document; and
 21. Have all rights and responsibilities outlined in this document forwarded to the committee or legal guardian authorized to act on your behalf.

Waiver Participant's Responsibilities

As a participant, you are responsible for:

- (1) Working with your Service Coordinator to develop/revise your Service Plan to assure timely reauthorization of the Service Plan;
- (2) Working with waiver providers as described in your Service Plan;
- (3) Talking to your Service Coordinator and your other waiver service providers if you want help to change your goals or services;
- (4) Not participating in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the waiver program may be jeopardized.
- (5) Maintaining your home in a manner which enables you to live in the community.
- (6) Complying with the rules of the waiver program, and the terms and conditions of any contract you sign regarding the provision of waiver services.

Section III

Becoming a Waiver Provider

Introduction

The HCBS/TBI Waiver program is committed to providing high quality and cost effective services offered through qualified waiver providers. This section describes the provider's qualifications, the provider's responsibilities, steps in the application process, subcontracts, vendor hold, termination of contracts and provider owned housing.

Qualifications for Provider Agencies

All providers, including those already approved to provide services under the Medicaid State Plan or another Medicaid waiver are required to be separately approved as a HCBS/TBI waiver provider.

Providers must be located in and able to provide services in New York State.

Providers must meet all licensure and other qualifications of the service(s) included on the application they are applying for as specified in this Program Manual (refer to Section VI-Waiver Services).

Providers may request approval for any number of waiver services. Providers may apply to provide additional services or become a provider in additional Regional Resource Development Center regions at any time. The approval process to add services or Regions is the same as the initial application process.

If at any time a provider is unable to maintain qualified staff for a service, it will not be able to provide that service. The waiver provider must report any changes in status to the appropriate RRDC.

Providers who have not provided waiver services in two or more years and wish to begin providing services must contact the appropriate RRDC to reapply as a waiver provider with current and appropriate documentation.

Providers who are approved as self-employed providers may not also be employed as a HCBS/TBI service provider by a HCBS/TBI Waiver Provider Agency.

Providers may terminate provision of one or all approved waiver services by submitting a written notice to DOH at least sixty days prior to termination. The provider must assist in transitioning services to an approved HCBS/TBI waiver provider selected by the waiver participant.

The DOH may terminate the approval of any or all waiver services of a provider with at least sixty days written notice to the provider.

Providers are responsible to know, understand and implement the waiver in accordance with the policies and procedures issued by DOH, including those outlined in the Program Manual or in any updates or changes to the Manual.

Providers must adhere to all Health Information Portability and Accountability Act (HIPAA) requirements and ensure the confidentiality of the waiver participant. Providers must adhere to all responsibilities and conditions delineated in the Provider Agreement.

Provider Responsibilities

I. Providers applying for Assistive Technology (AT), Community Transitional Services (CTS), and Environmental Modifications Services (E-mods) must satisfy the following conditions:

1. Assure participant's right of choice;
2. Establish and maintain current safety and emergency policies and procedures;
3. Have personnel files on every employee including resumes and job descriptions; if a provider has more than one office and the personnel files are housed in the main office when the other office(s) is surveyed by DOH, the personnel files need to be provided to the surveyor(s) at that location per their request;
4. Have knowledge of the TBI Waiver's Incident Reporting Policy regarding Serious Reportable Incidents (SRI) (refer to Section X – Incident Reporting Policy and Complaint Procedure) including the obligation to report to the Service Coordinator (SC) in relation to the investigation of SRI, (i.e. staff interviews);
5. Establish and maintain a tracking system to ensure staff will provide the expected amount/type of service in accordance with the participant's Service Plan (SP);
6. Establish and maintain an accurate system for documenting when services are provided and billed;
7. Establish and maintain a process for surveying participant satisfaction of its service; this process includes obtaining information from the participant on his/her satisfaction of the service provided, staff availability to make appointments, timeliness and provide services as agreed upon;
8. Establish and maintain a policy for handling complaints raised by participants, family members or advocates and concerns addressed by the SC, Regional Resource Development Specialist (RRDS) and documenting outcomes;
9. Establish and maintain a file for each participant regarding the waiver participant's individual information provided by the SC including: a copy of the Notice of Decision (NOD), the first page of the SP and the page(s) describing the need for the requested waiver service(s); and
10. Cooperate with DOH, Office of Medicaid Inspector General (OMIG) and other government agencies with jurisdiction to conduct surveys and audits.

II. All other providers applying to become a waiver provider must satisfy the following conditions:

1. Assure participant's right of choice;
2. Establish and maintain current safety and emergency policies and procedures;
3. Establish and maintain personnel files on every employee including resumes and job descriptions; if a provider has more than one office and the personnel files are housed in the main office, when the other office(s) is surveyed by DOH, the personnel files need to be provided to the surveyor(s) at that location per their request;
4. Follow the TBI Serious Reportable Incident Policy and Procedure (refer to Section X – Incident Reporting Policy and Complaint Procedure);
5. Establish and maintain policy and procedure for documenting Recordable Incidents; (refer to Section X – Incident Reporting Policy and Complaint Procedure);
6. Establish and maintain a tracking system to ensure that staff is providing expected amount of service in accordance with the participant's SP;
7. Establish and maintain a method for self-appraisal of service provision including suggestions and methods for improvements;
8. Establish and maintain a process for surveying participant satisfaction of its service. This process includes obtaining information from the participant on his/her satisfaction of the service provided, staff availability to make appointments, timeliness and provide services as agreed upon;
9. Establish and maintain a method for recording and addressing complaints made by the waiver participants, families, legal guardians and others; this information is included in an annual report stating the number and types of complaints made/received, including an analysis of these complaints and the provider's response to them;
10. Establish and maintain a method for recording and addressing concerns expressed by the SC, RRDS, and/or DOH waiver management staff;
11. Establish and maintain participant records which include functional assessments, detailed plans, notation of every encounter and contact with the participant, a copy of all Individual Service Reports (ISR), documentation of all communication with the SC, documentation of the times of visits, billing records, current copy of the NOD, a copy of the current approved SP, a copy of the most current PRI/SCREEN and a copy of the current Waiver Participant Rights and Responsibilities (refer to Appendix C – form 1.6);
12. Provide appropriate and relevant training including DOH established curriculum; and

13. Cooperate with DOH, OMIG and other government agencies with jurisdiction to conduct surveys and audits.

Note: Providers approved under section II above (subsection II in Provider Responsibilities) are expected to attend the RRDS provider meetings. At times, these meetings cover policies and procedures relevant to the health and welfare of the participants. These meetings are a critical opportunity for the providers to remain current regarding TBI policies and procedures. Not attending these meetings could result in noncompliance with policies and procedures, which will ultimately lead to restrictions to the provision of waiver services.

All providers are responsible to inform DOH and the RRDCs in writing of any and all service address changes.

The Application Process

The following eight (8) steps describe the application process for becoming a waiver provider:

STEP 1 Provider Inquiries

The potential waiver service provider for the HCBS/TBI Waiver will obtain a copy of the Program Manual from the DOH website or the RRDS, which includes the application forms for becoming a waiver provider (refer to Appendix A – forms 1.1 and 1.2).

STEP 2 Application

The potential waiver service provider submits the Provider Application Packet to the RRDC in the region/regions it wants to serve. The packet includes:

- Letter of Intent including:
 1. A brief description of the agency's history of providing services to individuals with TBI or other disabilities. If TBI experience is limited, include a description of how the agency proposes to develop the expertise to effectively provide services.
 2. A list of service(s) for which the provider is seeking approval.
 3. Identification of the RRDC region(s) and/or counties within the RRCC region where service(s) would be provided.
- An Employee Verification of Qualifications form (Appendix A – form 1.4) and resume for each individual providing: Service Coordination, Independent Living Skills Training and Development, Community Integration Counseling, Intensive Behavioral Program Positive Behavioral Interventions and Support Services, Substance Abuse Program Director

and Structured Day Program Director only).

- A provider applying to become a self-employed provider must submit three (3) letters of reference, including one reference from the previous employer.
- Signed original Provider Agreement.
- Signed original Medicaid Provider Enrollment Form and Disclosure of Ownership and Control, including:
 1. A list of the Board of Directors, including any relationships that exist between Board members (e.g., spouses, children, etc.), or individuals with the same last name.
 2. The location of the agency including street address, even if the mailing address does not include a street or road.
- Copy of the Federal Employee Identification Number (FEIN #). Self-employed providers must submit a copy of their Social Security Number if they do not have a FEIN.
- A provider applying for Home and Community Support Services and/or Respite must submit a copy of the agency's license as a Licensed Home Care Services Agency, as well as an Employee Verification of Qualifications form and a resume for the supervising Registered Nurse and at least one Personal Care Aide.
- A copy of provider policies and procedures which include:
 - HIPAA compliance;
 - Safety and emergency procedures;
 - Human Resource (personnel) records;
 - Serious Reportable and Recordable Incident Reporting;
 - Service provision tracking system;
 - Plan for self-appraisal of service provision including suggestions and methods for improvements;
 - Participant satisfaction survey;
 - Recording and addressing waiver participant complaints and grievances;
 - Recording and addressing concerns of RRDS, SC, and DOH Waiver management staff and record keeping/ documentation.

The completed Provider Application packet must be submitted to the RRDS(s) for review and recommendations in the region/regions the provider will be serving. If a prospective provider is interested in providing services in more than one region, the Application Packet must be sent to each RRDC for review by the RRDS(s).

STEP 3 RRDS Preliminary Review

Prior to arranging an interview with the potential provider, each RRDS will review the Provider Enrollment Application Packet for potential providers in his/her region and determine preliminary eligibility. This includes reviewing and verifying the provider meets the licensure, certification and staff qualifications which support the services requested. When two or more RRDCs are involved, the RRDSs will contact each other to discuss preliminary reviews and then set up a joint interview with the potential provider.

STEP 4 RRDS Interview and Review

The RRDS administering the waiver in the region(s) for which the provider is requesting approval is responsible for the review and recommendation about the application. The RRDS will:

- Explain the HCBS/TBI waiver, its philosophy and services
- Interview the potential provider;
- Review resumes of proposed staff and Employee Verification of Qualifications;
- Review training materials developed by the provider;
- Review provider policies and procedures;

The RRDS must visit the proposed site for a Substance Abuse Program and a Structured Day Program and obtain a copy of the Certificate of Occupancy.

STEP 5 RRDS Recommendations

The RRDS is responsible for making recommendations regarding approval of the proposed service(s) based on: personnel qualifications; the capacity of the agency to develop and maintain high quality services; and the provider's understanding of and willingness to adhere to the philosophy and policies of the waiver.

The RRDS must submit to DOH waiver management staff the completed Provider Enrollment Application Packet and the Provider Interview form, which explains the RRDS recommendation to DOH and which, if any, services should be approved.

If there is a difference of opinion between the potential provider and the RRDS about whether the provider should be recommended for approval or what services the provider will be able to provide, DOH waiver management staff will be responsible for the final decision.

STEP 6 DOH Waiver Management Staff Decisions

If any additional information or clarification is needed, DOH waiver management staff will contact the RRDS or the potential provider agency, as appropriate. DOH waiver management staff will send written notification to the potential provider indicating which, if any, services are approved by the Department and the starting date of the approval. If the provider disagrees with the decision, the potential provider may discuss concerns with DOH waiver management staff.

DOH waiver management staff is responsible for making a judgment about the character and competence of each potential provider as it impacts the provider's ability to deliver waiver services. DOH waiver management staff must obtain reasonable assurances that the applying agency is capable of delivering services in accordance with the operational standards and intent of this waiver. DOH waiver management staff may contact other New York State agencies or their counterparts in other states to gather information about the current status and background of the potential provider including any past experience in providing Home and Community-Based Services waiver services.

STEP 7 Billing

DOH waiver management staff will forward the necessary provider information to the appropriate DOH office for processing to become approved to bill Medicaid. This office informs the approved provider about eMedNY and ePACES for billing instructions. The Billing Manual is available at www.eMedNY.org.

STEP 8 List of Approved Providers

DOH waiver management staff notifies the appropriate RRDS(s) of the Medicaid approval and services approved. The RRDS adds the provider to the list of approved providers for the RRDS region

Subcontracting for Waiver Services

Subcontracting is defined as the approved provider's use of another agency to fulfill the responsibilities and services delegated to the approved provider in the Service Plan.

Subcontracting in the HCBS/TBI waiver is allowed for the following services **only**:

- Environmental Modifications;
- Assistive Technology; and
- Community Transition Services.

For these services, subcontracting may occur when the approved provider cannot complete the specified tasks with their resources. However, the provider is responsible for supervising the completion of the project in accordance with the Service Plan, assuring that all workers are skilled or appropriately licensed, and determining that the completed project meets State and federal codes, if appropriate.

Provider Termination of Waiver Services

An approved provider of waiver services may choose to terminate the provision of any or all waiver service(s), with a written notice of termination to DOH, and a copy to the RRDS, at least sixty calendar days prior to the date of termination in accordance with the Provider Agreement (Appendix A).

The provider must also send a written notice of termination to all participants receiving the service to be terminated at least sixty days prior to the date of termination. The notice must direct the participants to contact their Service Coordinators to select another provider.

The provider must assist each participant in the selection of other service providers and assist with the smooth transition of services, including participation in a transition meeting with the new provider and the waiver participant.

In situations where the service being terminated is Service Coordination, the notice must direct the participant to contact the RRDS to select another provider. The Service Coordination agency must assure all Notices of Decision for participants who the agency served are current prior to termination and provide the new agency with the initial service plan, current plan and any other pertinent documents. Since billing is done on a monthly basis, the agency may only terminate services at the end of the month to permit the new agency to begin service at the beginning of the next month.

Provider Termination of Waiver Services to an Individual Waiver Participant

An approved provider may also choose to no longer serve an individual waiver participant. In such instances, for services other than Service Coordination the provider must send a letter to the waiver participant, the participant's Service Coordinator and the Regional Resource Development Specialist (RRDS) at least 10 calendar days prior to stopping the provision of service(s). For Service Coordination, a 30 calendar day notice to the waiver participant is required. The letter must be sent via certified mail or delivered directly to the participant.

The participant must be advised in the letter to contact his/her Service Coordinator to assist with the selection of another approved provider for that service. When the service being stopped is Service Coordination, the participant must be directed to contact the RRDS for assistance in selecting another approved Service Coordination provider.

The current provider must assist in the transition to another provider including supplying copies of all evaluations, Individual Service Reports, and an update of what has been

accomplished since the last Service Plan, as specified in the Program Manual.

Licensed professionals and/or provider agencies may have other standards or regulations that dictate procedures they must follow in stopping services to an individual. This waiver policy is not intended to over-ride or replace those standards or regulations.

Vendor Holds and Disenrollment Initiated by DOH Waiver Management Staff

As noted in the Provider Agreement, DOH may terminate a provider for any reason with 60 calendar days written notice.

When DOH waiver management staff is informed by the RRDS of an issue(s) regarding the provision of services by a waiver provider, DOH waiver management staff may choose to restrict a provider's opportunity level (Vendor Hold). This is done by sending the provider a letter via certified mail advising the provider that it will be placed on Vendor Hold, specifying the reason(s) for the restriction, the effective date and time period of the Vendor Hold and request for a correction plan.

The provider will be informed that it is ineligible to receive new referrals of waiver participants. This restriction may be for one specific service or for all services that the waiver provider offers. Reasons for this may include:

- late SP (refer to Section V - The Service Plan);
- late ISR (refer to Section V - The Service Plan);
- unacceptable provider practices;
- questionable quality of services;
- provider inability to deliver the specific services; and
- provider inability to follow the HCBS/TBI waiver policies and procedures.

The waiver provider must submit to DOH waiver management staff a plan describing actions to address the specific issue within seven (7) calendar days of receiving the certified letter. If DOH determines the actions are appropriate and sufficient, a letter will be issued to the waiver provider by DOH waiver management staff indicating the Vendor Hold has been lifted.

If the matter is not corrected by the waiver provider within the allotted seven (7) calendar days, DOH waiver management staff will initiate the provider disenrollment process.

DOH waiver management staff initiates the disenrollment process by sending a Provider Disenrollment Notification letter via certified mail to the waiver provider agency Executive Director indicating that the sixty (60) day disenrollment process has begun and the date the provider agreement will be terminated. The letter also informs that waiver provider that Vendor Hold restrictions remain in effect. It further provides information regarding the process for waiver participants to select a new waiver provider agency(s).

To stop disenrollment, the waiver provider must submit a plan of action to DOH waiver management staff. Upon review and approval of this plan, DOH waiver management staff

will decide whether to stop the disenrollment process. If the plan of action is approved, DOH waiver management staff will issue a notice to the waiver provider Executive Director indicating this.

If DOH Waiver management staff does not approve the plan of action, the SC must assist the participant(s) in choosing a new provider and with completing the Request for Change of Provider form (refer to Appendix C – form 4.4). The SC will assist the participant(s) and the terminating waiver provider through the period of transition from current to new provider(s). The terminating waiver provider is responsible for sending the applicable new waiver provider(s) the following copies of all evaluations, ISR, a copy of the detail plan and an update on the participant's accomplished goals.

In situations where the service being terminated is Service Coordination, the notice must direct the participant to contact the RRDS to select another Service Coordination provider agency. The RRDS must assist the participant in completing the Request for Change in Service Coordinator Form (refer to Appendix C – form 4.5). The RRDS must assure that all applicable documents (e.g., ISP, current SP, evaluations, current PRI/SCREEN, ISRs, Detailed Plans, etc.) are transferred from the current SC to the new SC.

Housing

Provider agencies which choose to function as landlords for waiver participants must allow participants to select waiver services from all approved providers and support access to unbundled services. Provision of housing must not be contingent upon the selection of services from the provider. Waiver participants choosing to reside in a provider owned living arrangement must have a choice of where they live, whom they live with, and must be issued a one year lease. Refer to the HCBS/TBI Housing Manual for specific information about the rent subsidy program.

Section IV

Regional Resource Development
Centers/Specialists &
Clinical Consultants

Regional Resource Development Center (RRDC)

The RRDC administers HCBS waiver program initiatives at the regional level under the direction of the DOH waiver management staff. The RRDC is responsible for managing the operation of all aspects of the waiver with emphasis on ensuring quality, availability, and cost effectiveness of services in their contracted region. Each RRDC in the State is required to retain, at a minimum, one Regional Resource Development Specialist (RRDS) and one assistant.

Roles and Responsibilities of the RRDC

- Employ the RRDS and assistant(s).
- Function as an initial point of contact for potential applicants, their families, legal guardian and/or authorized representatives.
- Administer the day-to-day activities of the waiver.
- Develop and maintain waiver resources and supports in the contracted region.
- Maintain reciprocal relations with local Departments of Social Services.
- Reduce the incidence of unnecessary institutionalization through:

Transition: Assisting eligible individuals currently living in nursing homes to move to appropriate community-based settings.

Repatriation: Assisting individuals who have been in out-of-state facilities return home to New York State.

Diversion: Preventing out-of-state and in-state facility placements through individual and systems advocacy and the development of needed supports for eligible individuals.

- Other roles and responsibilities as defined by DOH and supported by the RRDC contract with DOH.

Qualifications of the RRDC

The RRDC must:

- Be an organization or agency capable of supporting the work of the RRDS and the philosophy of the waiver.
- Not be a provider of HCBS waiver services OR any sub-corporation, foundation or other legal entity under the control of a waiver provider agency.

- Possess an internet service provider capable of providing e-mail and file transfers with DOH, and comply with all specific e-mail encryption programs mandated by DOH.
- Be HIPAA and Medicaid confidentiality compliant to assure the confidentiality of all waiver participants.

Regional Resource Development Specialists (RRDS)

The RRDS is responsible for the development, management, administration, and monitoring of the HCBS waiver for the RRDC on a regional level. The RRDS promotes participant choice, ensures the delivery of high quality services, assists in the development of needed services and oversees waiver cost-effectiveness. The RRDS collaborates with local government entities, service providers and advocacy groups to develop a network of services and supports in the community. The RRDS is the central component in managing and delivering the program objectives of transition, repatriation, diversion, waiver administration and resource development. He/she is responsible for implementing the HCBS waiver, facilitating access to waiver program supports for eligible individuals, and interfacing with the HCBS/TBI Housing Program.

Qualifications of the RRDS

The RRDS must:

- Demonstrate a commitment to integrated community-based services for individuals with traumatic brain injury, their family members and other natural supports.
- Be skilled in assessing, identifying and addressing gaps in services.
- Be able to develop collaborative relationships with regionally based stakeholders, including local Departments of Social Services, other local government entities, providers, advocacy organizations and others necessary to assure a comprehensive coordinated approach to services for individuals with brain injuries.
- Demonstrate expertise in brain injury and extensive familiarity with HCBS waivers.

Roles and Responsibilities of the RRDS

The RRDS has the right to meet with the participant at any time or place and has the right to access all records regarding a participant's or a provider's activities related to the waiver. The RRDS works closely with DOH to provide data and input as needed regarding the administration of the HCBS waiver in their region. It is the responsibility of the RRDS to assist DOH in ensuring that waiver participants in New York State with traumatic brain injury are able to live as independently as possible in the community.

RRDS responsibilities include:

1. Information, Resource and Referral

- Work closely with DOH to disseminate public information regarding brain injury and the waiver to meet the needs of persons with brain injury, their family members and the community in their regional area.
- Respond to calls from individuals with brain injury, family members, advocates, professionals and others requesting information regarding waiver services.
- Meet with potential participants to explain the waiver philosophy and services, make a preliminary determination of appropriateness for the waiver, and offer the choice of approved Service Coordinators to individuals.
- Make referrals to available resources in the community if an individual is determined not appropriate for the waiver.
- Track intake and information calls and referrals.
- Provide resource information and education regarding TBI.

2. Development of Community Resources

- Interview potential waiver service providers using the Potential Providers Interview form (Appendix B-2).
- Make provider enrollment recommendations to DOH based on factors such as regional need, the provider's understanding of the waiver philosophy and participant choice and control, and the provider's ability to deliver high quality, cost-effective services.
- Network to attract quality new providers to offer needed services.
- Provide training to potential providers regarding the philosophy, policies and procedures of the waiver.
- Report to DOH regarding provider capacity and capabilities in their region.
- Promote the quality and availability of services.
- Develop strong linkages with inpatient rehabilitation units and long term care facilities to strengthen the integrated system of TBI rehabilitation and to facilitate community re-entry from these institutions.
- Work in coordination with local Departments of Social Services to appropriately

use Medicaid State Plan and waiver services for eligible applicants.

3. Interview and Preliminary Assessment of Potential Waiver Participants

- Meet with all potential waiver participants to complete an intake interview and explain the waiver's philosophy, goals and available services using the Potential Participant Interview form (Appendix B-1).
- Conduct a preliminary assessment of and gather initial information to determine potential eligibility for the waiver.
- Offer individuals the choice of participation in the HCBS/TBI waiver and, when the individual chooses the waiver, a choice of Service Coordination providers.
- Make referrals to local Departments of Social Services to determine Medicaid eligibility.
- Provide applicants with a choice of available Service Coordination providers who can assist the individual with the application process.
- Maintain contact with an applicant until a Service Coordinator is selected.
- Forward all preliminary information and a release of information to the Service Coordinator selected by the applicant.
- Obtain signed Freedom of Choice and Application for Participation forms (Appendix B-1) from the applicant.
- Maintain a current list of all approved providers in their region.

4. Review and Approve All Service Plans

- Review completed Application Packets (Appendix C-1) and Revised Service Plans submitted by the Service Coordinator to determine appropriateness for participation or continued participation in the waiver. Service Plans received by the RRDS must be approved or denied no later than 15 calendar days from the date of receipt. Review of all Initial Service Plans (included in the Application Packet) and Revised Service Plans is to focus on all necessary factors, including:
 - completeness;
 - the needs and goals of the waiver participant, including the continuing eligibility of the participant for waiver services;
 - the ability of waiver services to support the health and welfare of the participant;
 - the timely provision of services;

- participant rights and choices;
 - the efficiency and cost effectiveness of the Plan; and
 - other factors noted in Section V (Service Plans).
- Approve or disapprove the Application Packet, Initial and/or Revised Service Plans and/or Addendums, using the Initial or Revised Service Plan Review form (Appendix B-3) and providing a written evaluation of the review to the Service Coordinator indicating any necessary revisions.

In those instances in which the service plan is not approvable "as is" (e.g. when there are questions related to accompanying documentation, the adequacy of the plan or any of its components), the 15 day review/approval "clock" will be paused until those issues are satisfactorily addressed. The 15 day review/approval "clock" will be resumed upon receipt of a corrected service plan.

- If a complete, signed and acceptable RSP has not been received within thirty (30) calendar days prior to the end of the six month approval period; notify the Service Coordinator and/or DOH as explained in the "Submission of Revised Service Plans" subsection of Section V (Service Plans).
- Forward all appropriate Notices of Decision (NOD) to the Service Coordinator, participant, legal guardian (when applicable) and local Department of Social Services (for initial Authorization only).
- Track time elapsed from Service Coordinator selections to Notices of Decision (NOD) for Authorization/Reauthorization (Appendix B-5).

5. Maintain Regional Budgets

- Review all Service Plans in their region to ensure that the aggregate average cost for all waiver participants does not exceed that of serving such individuals in an institutional setting.
- Maintain information and data regarding the annual cost for each waiver participant.
- Maintain information and data regarding the average aggregate cost for all participants in the region.

6. Administer the HCBS/TBI Housing Program in accordance with the Housing Guidelines

- Work closely with DOH to facilitate participant choice and access to housing in the most integrated setting appropriate to the participant's needs.

- Review and make a determination on all rental subsidy and housing support applications submitted by Service Coordinators on behalf of waiver participants.
- Manage costs within a budget allocated by the HCBS/TBI Housing Program.
- Maintain tracking of all rental subsidy expenditures and submit quarterly reports to DOH.
- Provide training and technical assistance to Service Coordinators regarding the HCBS/TBI Housing Program and Quality Assurance/Quality Improvement initiatives.
- Support the development of local, affordable and accessible housing within the RRDC region.
- Distribute HCBS/TBI Housing Guidelines, policy clarifications and updates and address provider questions pertinent to the Guidelines.

7. Incident Reporting

- Review all information and investigations regarding Serious Reportable Incidents in accordance with the Serious Reportable Incident policy.
- Assign a number to each Serious Reportable Incident using the RRDS Initial Incident Report Response form (Appendix B-3), which is to be used for all communications regarding the incident.
- Determine whether the Serious Reportable Incident should be closed or whether further action is needed and notify the investigating provider agency of the determination using the RRDS Incident Status form (Appendix B-3).
- Inform DOH waiver management staff of Serious Reportable Incidents requiring DOH involvement.

8. Technical Assistance to Participants, Family Members and Others

- Be available to participants, family members and legal guardians to answer questions and address concerns.
- Support participants' rights to be the decision maker regarding life goals, activities, services and providers.
- Provide information, resources and referrals regarding TBI to meet the needs of persons with TBI, their family members and the community in their regional area.

- Develop strong working relationships between RRDS, regionally based inpatient rehabilitation units and long-term care facilities to identify prospective participants and facilitate community re-entry from these institutions

9. Technical Assistance to Providers

- Provide training and technical assistance to waiver service providers on all aspects of the waiver program, including the needs of waiver participants, development and implementation of comprehensive waiver Service Plans, and standard documentation and reporting requirements.
- Conduct regularly scheduled provider meetings to review waiver policy and provide waiver related training.
- Provide on-going technical assistance and receive feedback from providers regarding the policy and procedures of the waiver.
- The RRDC is responsible for holding a minimum of 8 provider meetings per calendar year. These meetings are meant to provide a forum for sharing information, reviewing new DOH HCBS/TBI waiver policies and discussing state/regional trends.

It is the expectation that the RRDC will cover specific subject matter during the course of the year, to include Medicaid and billing specifics, Service Plan /ISR development and other issues identified by the regional RRDC/DOH as relevant to the overall quality assurance in the region. The RRDC may solicit subject matter experts to provide training to the providers, dependent on regional needs and requests.

All scheduled regional provider meetings are considered mandatory for waiver providers. Failure of a provider agency to have a minimum of one appropriate employee attend scheduled provider meetings may lead to vendor hold status of the provider agency and/or disenrollment, should the issues be consistent. This mandatory attendance at provider meetings, and subsequent consequences, extends to Independent contractors as well.

10. Technical Assistance to Other RRDS, Community Agencies and the State

- Provide cross training and technical assistance and share areas of expertise with RRDSs in other regions.
- Provide information and assistance to State and community agencies.

11. Develop and Submit Reports to DOH

- Provide data to DOH regarding regional needs, outcomes, quality assurance, quality improvement and cost savings.

- Prepare and submit quarterly reports summarizing services provided and progress made toward attaining waiver program objectives,
- The RRDS is responsible for maintaining a data base for tracking activities related to individual waiver participant service plans. The database must contain the following information for each participant:
 - dates of service plan submission;
 - dates of all RRDS requests for information including response dates;
 - date RRDS decision is issued;
 - service coordinator; and
 - service coordination agency.

Information must be collected to allow for the production of ad hoc reports as requested by DOH including the percentage of overdue plans by service coordination agency and identification of issues which may be delaying RRDS plan approvals – including those requiring additional clarification and provider training. The RRDS is also responsible for the following activities:

- tracking the outcome of all intake and referral requests;
- sign-in sheets and minutes from provider meetings and training; and
- reports of all Serious Reportable Incidents and their outcomes.
- Work closely with DOH to provide information, records and statistical and narrative reports regarding regional needs, outcomes, quality assurance and improvement and cost savings.
- Communicate regularly with DOH, including attending meetings, to review policies affecting the waiver and to receive ongoing technical assistance through phone calls and e-mails.
- Attend quarterly RRDS meetings in Albany and other meetings upon the request of DOH.
- Maintain waiver participant applications, Service Plans and other required documentation.

12. Oversee Provider Services in the Region

- Track timeliness of submission of Service Plans and follow up as needed to assure compliance.
- Assess quality of services in the region.

13. Other Roles and Responsibilities as Defined by DOH and Supported by the RRDC Contract with DOH

Clinical Consultant

As a liaison between DOH, RRDC, RRDS, Service Coordinators, providers, and waiver participants regarding the waiver, DOH contracts Clinical Consultant services. This individual(s) reports directly to DOH waiver management staff on quality management issues.

Qualifications of the Clinical Consultant

- Knowledgeable about HCBS waivers.
- Experience in developing and implementing quality management programs.
- Knowledgeable regarding issues concerning individuals with TBI.

Roles and Responsibilities of the Clinical Consultant

- Assist the DOH HCBS/TBI waiver management staff, as needed, regarding any function of the waiver.
- Assist in the retrospective review of a sample of waiver Service Plans as part of a quality assurance process to confirm adherence to proper authorization procedures and satisfaction of federal review requirements.
- Assist in the review of all Service Plans over an established monetary amount determined by DOH.
- Review compiled data of all statewide DOH incident reports to identify service trends and emerging issues and submit compiled tracking reports to DOH annually or at other times upon request.
- Assist the RRDS to review and/or investigate reported serious incidents in situations of allegations of abuse, neglect, or when a participant dies or at other times upon request.
- Provide technical assistance, written guidance and training to RRDC staff and waiver providers, as needed.
- Conduct surveys of waiver participants to assess program satisfaction and monitor quality assurance activities.
- Submit quarterly and annual reports summarizing services provided and progress made towards attaining program objectives.
- Make recommendations to DOH for improvements in waiver policies and procedures.

Section V

The Service Plan

Development of Service Plans

An individualized Service Plan is developed jointly by the participant, the Service Coordinator and, when necessary, a court appointed guardian. The participant may choose to include family, friends and advocates.

The Service Plan must reflect the participant's strengths and abilities. It details the services necessary to maintain the participant in the community and prevent institutionalization while allowing for dignity to risk and the right to fail. It specifies all supports to be provided to the participant, including: informal caregivers (i.e. family, friends); local, state and federally funded services; Medicaid State Plan services; and waiver services.

The Service Plan must reflect coordination between all providers involved with the participant. It is necessary to obtain input from agencies other than waiver providers that authorize and/or directly provide needed services. Some Medicaid funded services such as personal care services (known as home attendant services in New York City) require prior approval from the Local Social Services District.

Service Plans are expected to evolve as the participant experiences life in the community, requests revisions, experiences significant life changes, or as new service options become available.

Scheduling of Waiver Services

The Service Plan will include a biweekly schedule showing the services to be provided and the most likely configuration. The schedule should be flexible to accommodate the preferences and limitations of the participant, such as a limited attention span or reduced stamina. It should be designed to meet the goals and needs of the participant, support the waiver's philosophy of participant choice, and provide for the health and welfare of the participant.

The biweekly schedule to be included in the Service Plan is "proposed". It is intended in part as a tool to help the participant focus on his/her daily activities, allowing both the participant and the service providers to anticipate the most likely appointment routines and day-to-day activities for the week. It is not intended as a rigid schedule since flexibility is needed to accommodate potential variations in the HCBS/TBI participant's abilities and needs during any given week, (e.g. when services must be rescheduled or rearranged). For example, the participant may be ill and unable to attend his/her scheduled day program or a provider may become unavailable and need to reschedule an appointment. In such instances, service providers are expected to be flexible in scheduling and, if necessary, fill in with appropriate, alternate services to assure continued participant health and safety.

However, while flexibility within a Service Plan is essential, providers may not "bank" unused service units for billing purposes, for example, if a participant misses several hours of approved services one week, those hours cannot be routinely added to the next week

unless the participant's need for those services has changed. These changes must be documented in the case notes, including the anticipated duration.

When the individual requires 24 hour supervision; it is advisable to include a request for emergency PRN hours in the 6 month service plan. If emergency PRN hours become necessary, but none have been approved for the current service plan, the RRDS must be notified immediately, via fax or email, followed with submission of an Addendum for approval of the emergency services by the next business day.

Any variation in the weekly schedule must be noted by the provider in his/her case notes, including specific reason(s) why the service was not delivered as noted and the plan of action to successfully provide the service.

There are also occasions when two services must be provided or authorized for the same time period to ensure consistent and effective service provision. Services must be clinically justified and time limited. For example:

- When an Independent Living Skills Training (ILST) provider is training Home and Community Support Services (HCSS) provider to assist a participant in a specific task, or when the Director of Positive Behavioral Interventions and Support Services Program (PBIS) must observe a participant's behavior at the Structured Day Program (SDP). The overlap of services must be documented in the Service Plan in order for both services to be reimbursed.
- Additional HCSS services may be authorized to be used when the participant will be absent from a service and requires supervision, such as if the participant chooses not to attend SDP but needs supervision to assure health and welfare.

When the participant requests that a service be suspended for a day or more, the Service Coordinator must be notified. The Service Coordinator is responsible for contacting the participant to discuss the situation and for notifying the other service providers.

A provider must notify the Service Coordinator when a participant repeatedly refuses a service or repeatedly asks that the service be rescheduled. The Service Coordinator should review the Service Plan with the participant to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant and/or scheduling issues. Revisions to the schedule should allow enough time for the provider to make the necessary arrangements. When a participant refuses all waiver services, it is necessary to evaluate his/her continued participation in the waiver.

The participant and their legal guardian, if applicable, must review and sign the written Plan before the Service Coordinator submits it to the RRDS for review. The Service Plan must also be signed by the Service Coordinator and the Service Coordinator's supervisor prior to submission.

Types of Service Plans

The following is an explanation of the different types of Service Plans.

Initial Service Plan (ISP)

The ISP is used when an individual is applying to become a waiver participant. It is the primary component of the Application Packet and is due to the RRDC within 60 calendar days from Service Coordinator selection

The ISP contains an assessment of the individual's strengths, limitations, and goals. It identifies what services are necessary to maintain the individual in the community. For a potential participant presently in an institution, the ISP must include current summaries of all services provided and a discharge summary from the facility, including relevant medical reports and assessments.

The Service Coordinator must provide a detailed explanation of the potential participant's choices and needs, including information regarding relationships, desired living situation, recreation or community inclusion time activities, physical and mental strengths or limitations, spiritual needs and goals for vocational training, employment or community service. A description of why the waiver services are needed to prevent placement in a nursing home must also be included. The ISP identifies services for the first six months of waiver participation.

Application Packet

The initial Application Packet to become a waiver participant consists of several documents including but not limited to:

1. Initial Service Plan (ISP) (form C1.2) completed and signed by applicant, Service Coordinator, court appointed guardian (if applicable) and anyone designated by the applicant to participate in the development of the service plan;
2. PRI/SCREEN- completed within 90 calendar days prior to the effective date of the initial Notice of Decision/Authorization or notice date of the Notice of Denial of the Waiver. The PRI and SCREEN must be completed, signed and dated by a certified PRI screener using PRI form dated 12/05 and SCREEN form dated 04/04;
3. Medical documentation of Traumatic Brain Injury (TBI). Supporting documentation must be provided from a hospital, rehabilitation facility, neuropsychologist, neurologist or other qualified professional;
4. Current eMedNY report documenting proof of Medicaid eligibility for community based long term care services;
5. Completed Application for Participation (form B1.2);
6. Completed Freedom of Choice (form B1.3);
7. Completed Service Coordinator Selection (form B1.4);
8. Completed Provider Selection form (form B1.5)
9. Signed and dated Waiver Participants Rights and Responsibilities (form C1.6 Revised July 2008);
10. Completed Plan of Protective Oversight (PPO) (form C 1.3);
11. Waiver Service Contact List (C1.5);

12. Application and assessments for Environmental Modifications (form C 2.1), Assistive Technology (form C 2.4) and Community Transition Services (form C 2.6) if appropriate;
13. Completed Home Assessment Abstract (form C 4.6) if Home and Community Support Services are requested; and
14. Any additional documentation requested by the RRDS.

For individuals applying for assistance from the HBCS/TBI Housing Program see the HCBS/TBI Housing Guidelines for requirements and forms.

Revised Service Plan (RSP)

The RSP is due to the RRDC at least sixty (60) days prior to the last day of the six months covered by the most current Service Plan. At minimum, an update to the Service plan, referred to as the RSP, must be developed in the following situations:

- At least every six months if the participant chooses to continue waiver services;
- When a participant has been institutionalized or hospitalized for an extended period; or
- Any time there is a need for a significant change in the level or amount of services (e.g. a decrease/increase in the participant's abilities or a change in the participant's living situation).

The RSP must contain a review and evaluation of the participant's previous six months in the waiver. It must address how waiver services continue to prevent institutionalization and indicate whether these services should continue unchanged, be modified or discontinued.

The Service Coordinator is responsible for completing the RSP. To support this, information must be submitted to the Service Coordinator by each waiver service provider (Individual Service Reports - ISR) at the 6 month team meeting.

At the 6 month Team Meeting, the Service Coordinator must discuss with the participant and other participating individual(s) any proposed changes to the participant's existing Service Plan. Once the participant and participating individual(s) agree to the revisions, they, along with the Service Coordinator must sign the Revised Service Plan (RSP). The RSP must then be reviewed and signed by the Service Coordinator Supervisor before being forwarded to the RRDS for final review and sign-off.

The Service Coordinator is responsible to assure the waiver participant's PRI/Screen remains current each year in order to confirm and document that the participant continues to meet the Waiver's level of care eligibility requirement. Failure to do so will result in a Serious Reportable Allegation of Neglect and a Vendor Hold on the Service Coordination Provider Agency.

The RSP packet sent by the Service Coordinator to the RRDS must include:

- Completed 6 Month Review Form (including original signature page);

- Current Plan of Protective Oversight (including original signature page);
- All relevant Individual Service Reports (including original signature pages);
- Waiver Service Provider Contact List;
- Medicaid Verification Form;
- Team Meeting minutes outlining the review of previous service plan and development of current plan;
- Bi-Weekly schedule; and
- Copy of the Participant's Rights and Responsibilities

Addendum to the Service Plan

The Addendum is required when only a minor change is needed in the amount, type, or mix of waiver services (e.g. a participant wishes to increase/decrease the amount of time at a Structured Day Program).

Waiver services are eligible for reimbursement under the following circumstances:

- the services are part of the participant's individualized Service Plan developed in accordance with the guidelines in this section;
- the services have been agreed upon by the participant, the Service Coordinator and, when necessary, a court appointed guardian;
- the services are necessary to maintain the participant in the community and prevent institutionalization; and
- the services have been approved by the RRDS.

The Plan for Protective Oversight (PPO)

The PPO supplements the Service Plan and indicates all activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the assistance. The PPO must be included with an ISP, RSP or Addendum. PPOs must be signed and dated by the participant, the legal guardian if applicable, the Service Coordinator and the Service Coordinator's supervisor as well as any informal supports listed as providing critical supports, i.e. to be called in an emergency.

Approval Process for Service Plans

Each Service Plan must be submitted to the RRDS for review and approval within the timeframes outlined in this Manual. The RRDS reviews the plan(s) to determine:

1. Does the individual continue to be eligible for waiver services;
2. Is there a completed and reasonable PPO;
3. Is the PRI/SCREEN submitted, if necessary, and does it justify the need for nursing home level of care;
4. Is the current Service Plan reasonable given the context the participant's stated goals;
5. Are waiver services being used in a reasonable and effective manner;

6. Do the services described in the Plan assure the individual's health and welfare;
7. Have the goals and preferences described in previous Service Plans been the focus of the activities in the last six months;
8. If overall Plan and goals for each waiver describe the activities that each service will provide towards the accomplishment of the participant's goals; and
9. That all informal and non-waiver services are utilized wherever appropriate.

The Service Coordinator is responsible for ensuring that all service providers receive a copy of the approved Service Plan and are aware of the overall plan and goals. The approved plan must be forwarded to each waiver service provider or service provider agency within 3 calendar days of receipt by the Service Coordinator. Failure to do so will result in an allegation of participant neglect and the SC provider agency being placed on vender hold.

Ongoing Review of the Service Plan

The Service Coordinator should regularly review the Plan with the participant. This review is a natural component of the monthly meetings between the participant and Service Coordinator.

A formal review must be conducted when a RSP is due. Other events which may trigger a review include:

- The participant requests a change in services or service providers;
- There are significant changes in the participant's physical, cognitive, or behavioral status;
- A new provider is approved and the participant is interested in either changing providers or adding a newly available service; and
- The expected outcomes of the services are either realized or need to be altered.

The review should focus on all aspects of the participant's life, including:

- Satisfaction with the performance of providers and informal supports;
- Satisfaction with the living situation;
- Adequacy of supports and services;
- Sufficient opportunities to participate in community activities;
- Achievement of goals related to waiver services;
- Changes in functioning and/or behavior; and
- Changes in priorities or goals.

Timing and Timeliness of Service Plan Submission

Late submission of a Service Plan can result in the interruption of services to a participant and penalties to the provider agency. Required timeframes and potential penalties are described below.

Submission of the Application Packet and Initial Service Plan

Once the potential participant selects a Service Coordinator, the Service Coordinator has **sixty (60) calendar days** to submit a completed Application Packet, including the ISP, to the RRDS. The selected Service Coordinator must also submit a status report to the RRDS 45 days after selection to allow the RRDS to track progress of the ISP.

If a delay is expected in submitting an Application Packet, the Service Coordinator must notify the RRDS to receive technical assistance. The RRDS may choose to grant a brief extension of the sixty day deadline.

After sixty days, the Service Coordinator will receive written notification from the RRDS indicating that the Application Packet is due.

If the Packet is not received within the next **thirty (30) calendar days**, the RRDS will send a second notice to the Service Coordinator stating that the RRDS will meet with the potential participant to select another Service Coordinator.

When late submission of Application Packets becomes a repeated problem, the RRDS will notify the provider of removal from the list of potential Service Coordinators until a written Plan of Correction is submitted and approved. If this problem is not corrected, DOH will terminate the Provider Agreement.

Submission of Revised Service Plans

It is essential that a complete, signed RSP be submitted prior to the end of the six month approval period to prevent delays in service which would negatively impact the health and welfare of the participant.

The RRDS will send a reminder notice to the Service Coordinator and his/her supervisor sixty (60) calendar days prior to the end of the current approval period for each participant.

If a complete, signed and acceptable RSP is not received within thirty (30) calendar days prior to the end of the six month approval period, DOH will send a letter to the Service Coordinator indicating that failure to submit the RSP packet to the RRDS within seven (7) calendar days will result in initiation of the sixty (60) day disenrollment process in accordance with the Provider Agreement. To stop the disenrollment process, an acceptable RSP and a Plan of Correction must be submitted to the RRDS. DOH, in consultation with the RRDS, will determine if the disenrollment process should continue.

When late submission of RSP becomes a repeated problem, DOH and the RRDS may limit referrals or initiate disenrollment of the provider.

Delinquent Individual Service Reports from Waiver Providers

Individual Service Reports (ISR) are required by the Service Coordinator for the development of the RSP. The Service Coordinator is responsible for informing the waiver

service providers that the ISR are due.

When a provider is repeatedly or significantly delinquent in submitting ISR, the Service Coordinator should contact the RRDS for technical assistance. The RRDS will contact the provider and assist in obtaining the ISR.

Repeated late submissions of the ISR will result in the RRDS removing the provider from the list of available providers until the problem is resolved. Chronic late submissions of ISR may result in disenrollment of the provider.

Submission of the RSP by the Service Coordinator

A complete, acceptable RSP Packet must be submitted to the RRDS for approval at least sixty (60) calendar days prior to the last day of the six months covered by the most current Service Plan. Late submission of a RSP by the Service Coordinator can result in the disruption of services to a participant and potentially lead to Vendor Hold or Disenrollment of the Service Coordination provider agency.

When the Service Coordinator is facing unforeseen circumstances that may prevent the submission of the Service Plan within the required timeframe, the Service Coordinator must make immediate contact with the RRDS for technical assistance. A plan must be established that will prevent disruption of services to the participant, potential penalties to the Service Coordination agency, and billing concerns for all waiver service providers.

When a RSP packet is not submitted to the RRDS by the Service coordinator at least sixty (60) calendar days prior to the end date of the current Service Plan, the following protocol must be followed:

1. Late Letter

A Late Letter will be sent to the Service Coordination agency supervisor by DOH via certified mail at any time a RSP packet is not submitted to the RRDS within the required timeframe (thirty (30) calendar days prior to the end of the current Service Plan period). It informs the Service Coordination agency supervisor that communication with the RRDS is necessary and a plan to submit the RSP packet within seven (7) calendar days is expected. It further informs the supervisor that failure to comply will lead to the initiation of Vendor Hold process.

2. Vendor Hold

Vendor Hold restricts the Service Coordination agency from accepting any new HCBS/TBI referrals. If the Service Coordinator does not submit the RSP packet to the RRDS within seven (7) calendar days, the RRDS notifies DOH waiver management staff. DOH will send a certified Letter of Vendor Hold to the Service Coordination agency supervisor and the Executive Director informing him/her of continued non-submission of the RSP Packet. The letter informs the agency that an acceptable, completed and signed RSP Packet must be submitted within seven (7) calendar days to prevent further submission of late Service

Plans. Failure to submit an acceptable RSP Packet within this timeframe constitutes breach of the Provider Agreement, leading to provider disenrollment.

Services in an ISP cannot be initiated until prior approval is given by the RRDS; service changes or additions proposed in an RSP cannot be initiated without prior approval from the RRDS.

If the Service Coordination agency submits an acceptable RSP packet to the RRDS within seven (7) calendar days, the Vendor Hold status will be discontinued. If the agency continues to have other RSPs that are late, the Vendor Hold status will remain in place.

3. Pending Provider Disenrollment

If the Service Coordination agency fails to comply with the terms of the Vendor Hold notification, the RRDS must notify DOH waiver management staff. DOH will send the Service Coordination agency Executive Director, Service Coordination Supervisor and Service Coordinator a Notice of Pending Disenrollment via certified letter.

This notice informs the agency that due to continued non-compliance with the request(s) for submission of an acceptable complete RSP packet, the agency will be disenrolled from the HCBS/TBI waiver sixty (60) calendar days from the notice date. During this time, the Vendor Hold status remains in effect.

If at any time during this process the Service Coordination agency complies with the submission of the RSP packet(s), the disenrollment process will be stopped.

Repeated submission of late, incomplete and/or unacceptable RSP packets will result in the initiation of the provider disenrollment process whereby the Service Coordination agency will no longer be able to serve HCBS/TBI participants.

4. Provider Disenrollment

A Notice of Disenrollment is sent via certified mail by DOH to the Service Coordination agency's Executive Director when the agency has failed to provide the requested information (e.g. RSP or ISR). The letter specifies the final date of disenrollment. It informs the agency of the requirements for transitioning all waiver participants to new waiver service provider agency(s).

Changing HCBS/TBI Waiver Providers

The HCBS/TBI waiver participant has the right to select a new provider at any time during the period covered by an approved Service Plan.

There are many reasons why a participant may choose to change providers, including but not limited to:

- A desire to maintain consistent services with an individual provider who changes

- employment from one provider agency to another.
- A change in the residence of the participant.
- A change in the needs or desired outcomes of the participant.
- Dissatisfaction with the timeliness, consistency, responsiveness or quality of current services.

DOH has the responsibility to assure informed choice of providers for all participants. In the event of coercion by providers, the provider will be subject to appropriate remedial actions. Such actions may include suspension of the ability to provide services to new participants or disenrollment of the agency as an approved HCBS/TBI waiver provider.

Changing a Provider Based on a Request from the Participant

If the participant chooses to change their provider, the Service Coordinator must comply with the following procedure:

- The participant, his/her guardian, his/her advocate or current Service Coordinator informs the current provider of the participant's intention to change providers.
- The provider may request an opportunity to discuss this decision with the participant. If the meeting occurs, the waiver participant may invite anyone to attend and participate in the discussion.
- If the participant refuses to meet with the current provider, or if after the meeting the participant still chooses to change providers, a Change of Provider form will be sent by the Service Coordinator to the RRDS. His/her current Service Coordinator, guardian or advocate may assist the participant in completing the form.
- The Change of Provider form shall include: the participant's name, the service being changed, the names of the current and new service providers, and the requested effective date for the transition to the new provider.
- A transition of services meeting is conducted on a timely basis between the previous and new waiver service provider so that pertinent information regarding goals and assessments can be shared.
- The Service Coordinator sends a copy of the Change of Provider form to the RRDS and the current and new providers.
- The RRDS reviews the request and sets a date for the change. The RRDS will send the Verification of Provider Change form to the participant, Service Coordinator and the current and new providers.
- The participant, Service Coordinator or any provider may contact the RRDS if this procedure is not followed.

Changing Providers As a Result of Staff Leaving

When a staff member of a provider agency will no longer be providing services to a participant, the following procedures must be followed:

1. The staff member notifies the Service Coordinator of the termination of services.
2. The staff member notifies the participant and directs them to discuss the impact of the termination with his/her Service Coordinator. If it is the Service Coordinator who is terminating services, the participant will be directed to the RRDS to select a new Service Coordinator.
3. The Service Coordinator meets with the participant to determine if a new provider is desired and amend the Waiver Service Contact List to reflect the change.

Establishing the Date of Termination

- Service Coordination must change on the first of the month.
- Other waiver services may be changed within ten business days from the RRDS receipt of the signed Change of Provider form. The RRDS may make the change of providers effective upon receipt of the Change of Provider form if it is determined that the health and welfare of the participant is at risk. This may be accomplished verbally or in writing.
- The RRDS may, in limited situations, agree to a change in waiver providers, including Service Coordination, on a time line other than outlined above. Situations in which this may occur are incidents in which a waiver staff is involved in a Serious Reportable Incident, in which the participant adamantly feels the change needs to occur immediately or the participant's health and well being are at risk.

During the transition period, the Service Coordinator will arrange for a meeting between the current and new providers and the participant to exchange information. The current provider is responsible for providing the new provider with copies of all evaluations, Individual Service Reports, and an update of what has been accomplished since the last Service Plan. This process must comply with all laws, such as the Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality and the release of medical and HCBS/TBI waiver services material.

Waiver Provider Contact List

1. The Service Coordinator compiles the list of all service providers for the participant. This list includes the services provided, names of the provider agencies, names of the persons providing the services and their phone numbers, names of their supervisor, and the supervisor's phone number. Also included is contact information for the RRDS.
2. Providers are responsible for contacting the Service Coordinator when this list must be updated.

3. The Service Coordinator provides a copy of the list of services and phone numbers to the participant and to all service providers.
4. The Service Coordinator retains a copy of the most updated contact list in the participant's file.

This process must be repeated each time a new waiver service is started, when there is a change in the person providing the service or provider agency, and at least every six months with the submission of a Revised Service Plan.

Section VI

Waiver Services

Introduction

The HCBS/TBI waiver services are designed to address the unique needs of eligible individuals. All other services including informal supports, non-Medicaid services and those services provided through the Medicaid State Plan and other federally funded services must be explored and used, as appropriate, prior to utilizing waiver services. The provision of waiver services must be cost-effective and necessary to avoid institutionalization. When waiver services are appropriately combined with other services, individuals with traumatic brain injury can live in the community.

The purpose of each waiver service and the roles and responsibilities of the service provider are described in this section. The description of each waiver service includes:

(A) Definition of the Waiver Service

The definition indicates the purpose for the service and outlines the roles and responsibilities of the service provider.

(B) Provider Qualifications

This section identifies the variety of educational and employment experiences acceptable to become a qualified service provider. One year of qualifying employment is equivalent to 12 months of full time employment. Part time employment must be prorated, (e.g., two years of half time employment is equal to one year of employment). Internships and experience obtained in order to receive any degree required as a provider does **not** count toward qualifying experience.

(C) Reimbursement for Service

Only those services which are provided by a DOH approved provider and included in the Service Plan will be reimbursed. Billable units vary depending on the service and Medicaid may only be billed after the service has been delivered and/or completed.

Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided.

Example: A participant receives a service twice a week at 30 minutes each visit but the unit of service billable to Medicaid is one hour. The provider will bill for one hour of service after the second 30 minute session.

Service Coordination

Definition

The Service Coordinator assists the prospective participant to become a waiver participant and coordinates and monitors the provision of all services in the Service Plan. Services may include Medicaid State Plan services, non-Medicaid federal, state and locally funded services, as well as educational, vocational, social, and medical services. The goal is to increase the participant's independence, productivity and integration into the community while maintaining the health and welfare of the individual.

Roles and Responsibilities

The participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The Service Coordinator is responsible for assuring that the Service Plan is implemented appropriately and supporting the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the Service Plan, which reflects the participant's goals.

The Service Coordinator assists the participant in the development, implementation and monitoring of all services in the Service Plan. Additionally, the Service Coordinator must initiate and oversee the assessment and reassessment of the participant's level of care and on-going review of the Service Plan.

Questions that a Service Coordinator should explore with the participant include:

- What are the participant's goals?
- What can be done to help the participant fulfill his goals?
- How can the participant be assisted to become a member of the community?
- What can be done to assist the participant to be more independent?

The Service Coordinator must also be an effective advocate for the participant, ensure that the participant is receiving appropriate and adequate services from providers and maintain quality assurance.

Service Coordination has two basic components: Initial and Ongoing Service Coordination.

Initial Service Coordination encompasses those activities involved in developing the individual's Application Packet. After the individual selects a Service Coordinator, it is the Service Coordinator's responsibility to gain a full understanding of who this person is now, his/her life experiences, and his/her goals for the future. It is essential to interview those individuals who are of primary importance to the potential participant. Information from community services and medical facilities including information from a discharging facility should be obtained.

In assisting the individual to develop the Initial Service Plan, the Service Coordinator

should look to sources of support – informal caregivers (family, friends, neighbors, etc.), non-Medicaid services, such as VESID, and Medicaid funded services (physician, personal care, nursing, etc.). The waiver services are designed to complement other available supports and services available to Medicaid recipients.

Another important task of the Service Coordinator is to assist the participant in locating a place to live in the community. The HCBS/TBI waiver supports the individual's right to choose where to live and to have access to generic affordable and accessible housing. The Service Coordinator must complete a Housing Standards Checklist for waiver participants receiving a HCBS/TBI Housing subsidy with the Initial Service Plan and annually in accordance with HCBS/TBI Housing Guidelines.

There are no certified residences specifically/directly associated with the waiver; participants may live with up to three (3) other non-related individuals, unless they are in a living situation which is certified or licensed by the State (e.g. an Individual Residential Alternative or Adult Home). The Service Coordinator may assist the waiver participant and other supports to secure housing. In the RRDC regions of New York City, Hudson Valley and Long Island, assistance in locating housing is done by an agency under contract with DOH. Technical assistance to the Service Coordinator about housing issues is available through the RRDS.

Ongoing Service Coordination begins as soon as the individual is approved to become a waiver participant. The Service Coordinator is responsible for the timely and effective implementation of the approved Service Plan. The Service Coordinator is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant.

The ultimate responsibility for assuring that the Service Plan is appropriately implemented rests with the Service Coordinator.

A Service Coordinator must be knowledgeable about all waiver services, Medicaid State Plan Services, and non-Medicaid services. Informal supports are often a crucial factor if the participant is to live a satisfying life and remain in the community. The Service Coordinator's ability to make use of these informal supports is essential, and offers the Service Coordinator and other providers the greatest opportunity for creativity.

The Service Coordinator will also be responsible for:

1. Formally reviewing, updating and submitting timely Service Plans (ISP, RSP, and addendum) to the RRDS for review (refer to the Service Plan section of this Manual for specific information on Service Plan responsibilities);
2. Organizing and facilitating Team Meetings;
3. Maintaining records for at least seven years after termination of waiver services;
4. Assuring that the PRI/SCREEN is completed:

- a. at least every twelve months; or
 - b. whenever the participant experiences a significant improvement in his/her ability to function independently in the community.
5. Maintaining records of waiver transportation as described in the Manual section on Transportation Services;
 6. Assuring that all waiver service providers and the participant receive a current copy of the most recently approved Service Plan;
 7. Maintaining knowledge of all approved waiver service providers in their region; and
 8. Conducting in-home visits with the participant no less than once a quarter.

Although the Service Coordinator may be an employee of a provider agency, the Service Coordinator must always act as a neutral advocate in assisting the participant with the selection of providers.

Ratio of Waiver Participants to Service Coordinator

3. Full time Service Coordinators for HCBS/TBI waiver participants may not exceed a caseload of seventeen (17) waiver participants.
4. Service Coordinators providing services to HCBS/TBI waiver participants on less than a full time basis must limit their caseload proportionately. For example, a Service Coordinator working 50 percent may not exceed a caseload of eight (8) HCBS/TBI waiver participants.

Provider Qualifications

Not-for-profit or proprietary health and human services agencies may provide Service Coordination. The agency must be approved by DOH as a waiver provider.

Service Coordinators must be a:

- (A) (1) Master of Social Work;
- (2) Master or Doctorate in Psychology;
- (3) Registered Physical Therapist;
- (4) Professional Registered Nurse;
- (5) Certified Special Education Teacher;
- (6) Certified Rehabilitation Counselor;
- (7) Licensed Speech-Language Pathologist; or
- (8) Registered Occupational Therapist.

The provider shall have, at a minimum, **one (1) year** of experience providing

Service Coordination and information, linkages and referrals regarding community-based services for individuals with disabilities; OR

- (B) Be an individual with a Bachelor's degree and two (2) years experience providing Service Coordination and information, linkages and referrals regarding community-based services for individuals with disabilities; OR
- (C) Be an individual with an Associates degree and three (3) years experience providing Service Coordination and information, linkages and referrals regarding community-based services for individuals with disabilities; OR
- (D) Be an individual with a High School Diploma or equivalent (GED) with four (4) years experience providing Service Coordination and information, linkages and referrals regarding community-based services for individuals with disabilities; OR
- (E) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year in the HCBS/TBI Waiver Program.

Individuals identified in section (A) may supervise the following individuals to perform Service Coordination Services:

- Individuals with educational experience listed in (A) but who do not meet the experience qualification;
- Individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and knowledge about community resources; and
- Individuals with an Associates degree or a High School Diploma or equivalent (GED) and two (2) years of experience providing Service Coordination to individuals with disabilities and knowledge about community resources.

The supervisor is expected to:

1. Meet any potential participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision;
2. Have supervisory meetings with staff on at least a bi-weekly basis; and
3. Review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants in accordance with ratio guidelines.

Self-Employment

Professionals listed in (A) and (E) of this section who are self-employed may be Service Coordinators. In addition to the educational requirement, individuals eligible under part (A) must have three (3) years experience providing Service Coordination involving multiple

community resources to individuals with traumatic brain injury and have an understanding of the philosophy and content of this waiver. For individuals eligible under part (E), there are no additional education or experience requirements.

Team Meetings

The Service Coordinator must be a strong and effective team leader. After the participant has selected all service providers, the Service Coordinator organizes the team to provide individualized services for the participant. The Service Coordinator needs to coordinate communication among all team members, including the participant. This becomes especially important when cognitive deficits affect the participant's memory. Maintaining good communication contributes towards effective coordination of services to support the participant in the community.

Team Meetings must be coordinated and facilitated by the Service Coordinator and must occur, at a minimum, every six months when a Revised Service Plan is developed. Team Meetings are scheduled based on the service needs of the participant. A new waiver participant may benefit from monthly meetings while for an individual whose situation is stable. The participant, his/her legal guardian if applicable, and all waiver service providers for the individual must attend each Team Meeting. Failure to attend may jeopardize the ability of the waiver provider to continue to provide waiver services. Providers of essential non-waiver services and anyone identified in the Plan for Protective Oversight should also be invited to Team Meetings. Other potential members include advocates, family members, local department of social services staff, co-workers, etc. If the waiver participant is receiving the same service from different waiver providers, both providers should attend the Team Meeting. If the participant is receiving a service from several providers in the same agency, only one representative needs to attend. The RRDS may consult with the Service Coordinator to determine if Team Meetings are being used appropriately.

The Service Coordinator is responsible for assuring effective communication between the participant and all service providers. To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant's goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare.

On limited occasions, service providers may indicate the need to meet without the participant (e.g. the participant's behavior or other factors jeopardize the participant's ability to remain in the community). The Service Coordinator is responsible for informing the RRDS of the team's interest in holding a meeting without the participant. Following the meeting, the Service Coordinator and other members of the team must meet with the participant to explain the results of the meeting. This exception does not apply when the team is meeting to develop a Revised Service Plan.

Team Meetings must be documented in the Service Plan and written in the projected activities of the Service Coordinator and waiver providers. Participation in Team Meetings must be documented in the notes of each service provider.

Team Meetings are organized and facilitated by the Service Coordinator as part of his/her responsibility to oversee services. Reimbursement for this activity is included in the monthly rate for Service Coordination. All other waiver service providers participating in a Team Meeting will be reimbursed at the usual rate for their service (e.g. CIC will be able to bill as a face-to-face session with the participant).

Reimbursement for Service Coordination

Service Coordination must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

There are two types of reimbursement for Service Coordination:

Initial Service Coordination is reimbursed on a one-time only basis for each participant after the individual is an approved participant in the waiver. Reimbursement is for the work, time and travel expended in developing the Application Packet, including the Initial Service Plan.

Ongoing Service Coordination is reimbursed on a monthly basis. As with all waiver services, Service Coordination must be included in the Service Plan. The Service Coordinator must have, at a minimum, one face-to-face contact with the participant per month. At least quarterly, one of these visits must occur in the participant's home.

Independent Living Skills Training and Development Services (ILST)

Definition

It is the responsibility of the ILST provider to conduct a comprehensive functional assessment of the waiver participant, identifying the participant's strengths and weaknesses in performing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) related to his/her established goals. The assessment is the basis for developing an ILST plan that describes the milestones and interim steps necessary to attain these goals. The assessment must also include a determination of the participant's manner of learning new skills and responses to various interventions. This comprehensive and functional assessment must be conducted at least annually from the date of the last assessment.

ILST services may include assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

ILST services are individually designed to improve the ability of the participant to live as independently as possible in the community. ILST may be provided in the participant's home or in the community. This service is provided on an individual basis.

ILST must be provided in the environment and situation that will result in the most positive outcome for the participant. It is expected that this service will be provided in the real world, such as in the participant's kitchen as opposed to an agency's kitchen. This requirement addresses the difficulty many participants experience with transferring or generalizing knowledge and skills from one situation to another. However, it is recognized that there is need for some practice of skills before using them in the environment.

ILST services may also assist a participant with "real world" paid or unpaid (volunteer) employment. The use of ILST for vocational purposes may occur only when the services of Vocational and Educational Services for Individuals with Disabilities (VESID) and the Commission for the Blind and Visually Handicapped (CBVH) have been fully explored and it is determined that either the participant is not eligible for VESID or CBVH services or VESID or CBVH does not provide the needed service.

ILST providers are responsible for training the participant's informal supports and waiver and non-waiver service providers to provide the type and level of supports that allow the participant to become as independent as possible in ADLs and IADLs. ILST is a time limited service used to assess a participant's needs, develop a plan and train others to assist the participant. ILST is not intended to be a long-term support. The reasons to provide or continue ILST must be documented in the Service Plan.

Provider Qualifications

ILST may be provided by any not-for-profit or proprietary health and human services agency. Self employed individuals meeting the qualifications may also provide this service. An ILST must be a:

- (A) (1) Registered Occupational Therapist;
- (2) Registered Physical Therapist;
- (3) Licensed Speech-Language Pathologist;
- (4) Registered Professional Nurse;
- (5) Certified Special Education Teacher;
- (6) Certified Rehabilitation Counselor;
- (7) Master of Social Work; or
- (8) Master or Doctorate of Psychology.

These individuals must have, at a minimum, one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

- (B) An individual with a Bachelor's degree and two (2) years of similar experience; OR
- (C) An individual with an Associates degree and three (3) years of similar experience; OR
- (D) An individual with a High School Diploma or equivalent (GED) and four (4) years of similar experience.

Individuals identified in section (A) may supervise the following individuals to perform ILST services:

- Individuals with the educational experience listed in section (A) but who do not meet the experience qualifications;
- Individual with a Bachelor's degree with one (1) year of experience;
- Individuals with an Associates degree or a High School Diploma or equivalent (GED) and two (2) years of experience; and
- Individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the Office of Mentally Retarded and Developmental Disabilities HCBS waiver.

The supervisor is responsible for:

- Completing an initial assessment of the participant's functional abilities and developing a detailed plan of intervention;
- Training a service provider to implement the plan so that maximum benefit to the participant may occur;

- Re-evaluating the participant as needed, but not less than at the completion of the Individual Service Report (included in all Revised Service Plans) and whenever Addendums to the Service Plan are written, which include changes in the amount and/or frequency of this service; and
- Providing ongoing supervision and training to staff. Such supervision must occur no less than bi-weekly when the caseload is reviewed. Supervision must be more frequent when there is a new participant, new provider or when there is evidence that the expected progress is not occurring.

The ILST provider agency must make every possible effort to match the skills and experience of the individual provider to the specific goals of the participant.

Self-Employment

Individuals listed in (A) of this section who are self-employed may provide ILST services. In addition to the educational requirement, such individuals must have three (3) years of experience providing functionally based assessments and independent living skills training to individuals with traumatic brain injury, and demonstrate an understanding of the philosophy and content of the HCBS/TBI waiver.

Reimbursement

ILST must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

ILST is provided on an individual, hourly basis. Only in rare situations where the participant benefits specifically from a group setting will this service be approved on other than an individual basis. In such situations, the provider may bill for the percentage of the time spent with a participant (e.g. when the ILST is provided to two participants for two hours, the provider will bill one hour for each participant). Training provided to informal supports or waiver or non-waiver service providers must be included in the Service Plan in order to be reimbursed.

ILST providers participating in Team Meetings will be reimbursed at the hourly rate for their time at the Team Meeting.

Structured Day Program Services

Definition

Structured Day Program services are individually designed services, provided in an outpatient congregate setting or the community, to improve or maintain the participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision of, or assistance to, an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

Structured Day Program services may be used to reinforce aspects of other HCBS/TBI waiver and Medicaid State Plan services. This is permitted due to the difficulty many individuals with traumatic brain injury have transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. This service is intended to provide an opportunity for the participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program service may be provided within a variety of settings and with very different goals. Participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate goal, may be more interested in community inclusion and improving their socialization skills.

The Structured Day Program is responsible for meeting the functional needs of those served. The Program must provide adequate protection for the personal safety of the program participants, including periodic fire drills. The Structured Day Program must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of the Americans with Disabilities Act. If the RRDS or DOH identifies questionable situations, appropriate referrals will be made for necessary corrective action.

Whatever type of Structured Day Program(s) the participant chooses, it is essential that there be coordination between providers, assuring consensus in the type of supports and structures that are used in all settings and avoiding duplication of services. This is particularly important when the participant is receiving waiver services such as Independent Living Skills Training, Intensive Behavioral Program, and Home and Community Support Services.

An identified best practice is to have day programs specifically designed to meet the needs of individuals with TBI. Often individuals with traumatic brain injuries recognize that there are significant differences between themselves and other consumers of day programs, (i.e.

individuals with mental retardation, developmental disabilities or mental health difficulties). The structure, organization, activities and staff training needs are also different.

If a Structured Day Program includes the opportunity for participants to earn money, the provider must comply with all existing federal labor laws.

Provider Qualifications for the Director of Structured Day Programs

Structured Day Programs may be provided by any not-for-profit or proprietary health and human services agency. All Structured Day Programs must be identified in the Service Plan and provided by agencies approved as a provider of this waiver service by DOH.

These programs must be directed by an individual who is a:

- (A) (1) Registered Occupational Therapist;
- (2) Registered Physical Therapist;
- (3) Licensed Speech-Language Pathologist;
- (4) Registered Professional Nurse;
- (5) Certified Special Education Teacher;
- (6) Certified Rehabilitation Counselor;
- (7) Master of Social Work; or
- (8) Master or Doctorate of Psychology.

Structured Day Program Directors must have, at a minimum, one year of experience providing functional assessments, Positive Behavioral Interventions and Support Services, or Structured Day Program services to individuals with disabilities; OR

- (B) Individual with a Bachelor's degree and two years of similar experience.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old with a minimum of a High School Diploma or equivalent (i.e. GED); be able to follow written and verbal instructions; and have the ability, skills, training and supervision necessary to meet the waiver participant's needs that will be addressed through this service to assure the health and welfare of the waiver participant.

Reimbursement

Structured Day Program services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

Structured Day Program services are reimbursed on an hourly basis, not to exceed eight hours per day. Participation in Team Meetings organized by the Service Coordinator is reimbursed at the hourly rate.

The provision of Structured Day Program services must not occur in a sheltered workshop

environment. If a participant decides to make use of the services of a sheltered workshop, the reimbursement for that service must be provided through VESID.

Substance Abuse Program Services

Definition

Substance Abuse Program services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.

Substance Abuse Program services are provided in an outpatient group setting and may include an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the participant, family members, informal supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan may include both group and individual interventions and must reflect the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with traumatic brain injury.

The Program must develop a detailed plan describing how it will work with existing community support programs, such as Alcoholics Anonymous and secular organizations for sobriety, that provide ongoing support to individuals with substance abuse problems. Substance Abuse Program Services are also required to provide technical assistance to community-based self-help/support groups to improve the ability of the community support programs to provide ongoing supports to individuals with traumatic brain injury.

All Substance Abuse Program services must be documented in the Service Plan and must be provided by individuals or agencies approved as providers of the waiver services by DOH.

Individuals who may have been substance abusers in the past are not precluded from being a Substance Abuse Program provider. Substance Abuse Programs must have a written policy regarding consequences of any individual providing services who develops a substance abuse problem. No one abusing substances is allowed to work with HCBS/TBI waiver participants.

Individuals with a TBI have experienced very little success with using traditional substance abuse programs (often based on the 12-Step program) as the requirements associated with that program depend on cognitive abilities that may be difficult for individuals with a brain injury. It is essential that staff members in leadership positions are knowledgeable about both substance abuse treatment and working with individuals with cognitive deficits.

The Substance Abuse Program is responsible for meeting the functional needs of the participants served. The Program must provide adequate protection for the Program participants' safety and fire safety, including periodic fire drills, and must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the

requirements of Americans with Disabilities Act. If the RRDS or DOH identifies questionable situations, appropriate referrals will be made for necessary corrective action.

Provider Qualifications for Director of the Substance Abuse Program

Substance Abuse Program services may be provided by any not-for-profit or proprietary health and human services agency AND must be certified/licensed by the Office of Alcoholism and Substance Abuse Services (OASAS).

All Substance Abuse Program services must be documented in the Service Plan and be provided by agencies approved as providers by DOH AND certified/licensed by OASAS.

The Program Director must be a health care professional with an advanced human services degree such as a:

1. Master of Social Work;
2. Certified Rehabilitation Counselor;
3. Registered Occupational Therapist;
4. Registered Physical Therapist;
5. Licensed Speech-Language Pathologist;
6. Professional Registered Nurse;
7. Master or Doctorate of Psychology; or
8. Certified Special Education Teacher.

These individuals must have at least one year experience providing services to individuals with traumatic brain injury or providing services to individuals who abuse substances (e.g. Certified Alcoholism and Substance Abuse Counselor). If the Director has experience in only one of these areas, then there must be staff members in positions of significant policy making, procedure development and/or provision of service who have experience in the other.

At least one staff member must be a Certified Alcoholism and Substance Abuse Counselor.

Reimbursement

Substance Abuse Program services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

This service is reimbursed on an hourly basis, not to exceed five hours per day. Participation in Team Meetings is reimbursed at the hourly rate.

Positive Behavioral Interventions and Support Services (PBIS)

Definition

PBIS services are provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The primary goal of PBIS services is to decrease the intensity or frequency of targeted behaviors, and to teach more socially appropriate behaviors.

PBIS services include but are not limited to:

- A comprehensive assessment of the individual's behavior in the context of his/her medical diagnosis, abilities/disabilities and the environment which precipitates the behaviors.
- A detailed holistic behavioral treatment plan including a clear description of successive levels of intervention starting with the simplest and least intrusive.
- Arrangements for training informal supports and waiver and non-waiver service providers to effectively use the basic principles of the behavioral plan.
- Regular reassessments of the effectiveness of the plan and modifying the plan as needed.
- An emergency intervention plan when there is the possibility of the participant becoming a threat to himself, herself or others.

Provider Qualifications for Director of the Positive Behavioral Interventions and Support Services Program

PBIS services may be provided by any not-for-profit or proprietary health and human services agency. The two key positions in PBIS service are the Program Director and the Behavioral Specialist.

The Program Director is responsible for developing the PBIS plan for each participant. The Director may work as a Behavioral Specialist or provide ongoing supervision to a Behavioral Specialist who will implement the plan.

If a provider has more than one individual who meets the qualifications for the Program Director, all qualified individuals may develop individual PBIS plans.

The Program Director must be a:

- (A) Licensed psychiatrist with one year experience providing behavioral services;
OR
- (B) Licensed psychologist with one year experience in providing behavioral services or traumatic brain injury services; OR
- (C) 1. Master of Social Work;

2. Master or Doctorate degree in Psychology;
3. Registered Occupational Therapist;
4. Registered Physical Therapist;
5. Licensed Speech-Language Pathologist;
6. Registered Professional Nurse;
7. Certified Rehabilitation Counselor;
8. Certified Special Education Teacher; or
9. Licensed Mental Health Practitioner

Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services; OR

- (D) Individual who has been a Behavioral Specialist for two years and has successfully completed the apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

Provider Qualifications for Behavioral Specialists

The Behavioral Specialist is responsible for implementation of the individual intensive behavioral plans under the direction of the Program Director and must be a:

- (A) Person with a Bachelor's Degree;
- (B) Registered Professional Nurse;
- (C) Certified Occupational Therapy Assistant; or
- (D) Physical Therapy Assistant.

The Behavioral Specialist must have at least one (1) year of experience working with people with traumatic brain injury, other disabilities or behavioral difficulties. The Behavioral Specialist must successfully complete forty hours training in traumatic brain injury, behavioral analysis, and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Support Services Program. The Program Director will provide ongoing training and supervision to the Behavioral Specialist.

Supervision must occur no less than biweekly when the caseload is reviewed and must be more frequent when there is a new participant, new provider or when significant behavioral issues arise.

Self-employment

Self-employed individuals must meet the qualifications of the Program Director of the Positive Behavioral Interventions and Support Services Program.

Reimbursement

Positive Behavioral Interventions and Support Services Program services must be provided by a DOH approved provider and must be included in the Service Plan to be

reimbursed.

This service is reimbursed on an hourly basis. Participation in Team Meetings is reimbursed according to the hourly rate for this service.

Community Integration Counseling Service (CIC)

Definition

CIC is an individualized service designed to assist the waiver participant to more effectively manage the emotional difficulties associated with adjusting to and living in the community. It is a counseling service provided to a participant coping with altered abilities and skills, the need to revise long term expectations, and changed roles in relation to significant others. This service is generally provided in the provider's office or the participant's home. It is available to participants and/or anyone involved in an ongoing significant relationship with the participant when the issues to be discussed relate directly to the participant.

While CIC is primarily provided in a one-to-one counseling session, there are times when it is appropriate to provide this service to the participant in a family counseling or group counseling setting.

Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with accepted professional standards regarding client confidentiality.

CIC must **not** be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as Service Coordinators, ILST and HCSS.

Provider Qualifications

CIC may be provided by any not-for-profit or proprietary health and human services agency. Qualified self employed individuals may also provide this service.

A CIC must be a:

- (A) 1. Licensed Psychiatrist;
- 2. Licensed Psychologist;
- 3. Master of Social Work;
- 4. Master or Doctorate of Psychology;
- 5. Certified Rehabilitation Counselor;
- 6. Master of Counseling Psychology;
- 7. Licensed Mental Health Practitioner; or
- 8. Certified Special Education Teacher.

Each of these individuals must have a minimum of two (2) years of experience providing adjustment related counseling to individuals with traumatic brain injuries and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with traumatic brain injuries and their families in order to be considered qualifying experience.

Individuals listed in (A) may supervise the following individuals to perform CIC services:

- (B)
1. Licensed Psychologist;
 2. Certified Rehabilitation Counselor;
 3. Licensed Psychiatrist;
 4. Master of Social Work;
 5. Master or Doctorate of Psychology;
 6. Master of Counseling Psychology;
 7. Licensed Mental Health Practitioner; or
 8. Certified Special Education Teacher.

Individuals in section (B) must have, at a minimum, one year of experience providing adjustment related counseling to individuals with physical, developmental or psychiatric disabilities.

Supervisors are responsible for providing ongoing supervision and training to staff. Supervision must occur no less than once a month when reviewing the caseload and must be more frequent when there is a new participant, a new provider or there has been a significant change in the participant's emotional, psychiatric or life situation.

Self-Employment

Individuals meeting the requirements described in section (A) above may be self-employed and provide this service.

Reimbursement

CIC services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

CIC is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If CIC is provided in a group setting, the hourly rate is divided evenly among the participants. For instance, if the participant is one of four people in the group, only one quarter of an hour is billable to that participant. Providers must accumulate billable units until a whole hour is reached before billing for the service.

Home and Community Support Services (HCSS)

Definition

Home and Community Support Services (HCSS) are only appropriate when oversight and/or supervision is necessary as a discrete service to maintain the health and welfare of a participant living in the community. HCSS may also include personal care assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). HCSS is not a companion service. The service must be provided under the direction and supervision of a Registered Professional Nurse (RN) based on an assessment of the individual's needs and supported by physicians orders.

Oversight and/or supervision is necessary to protect a cognitively impaired individual from adverse outcomes related to his/her activities (for example, wandering or leaving the stove on unattended). Oversight and/or supervision includes cueing, prompting, directing and instructing. If a participant's need for oversight/supervision warrant HCSS during the night, the HCSS staff must remain awake throughout the duration of time assigned to the participant.

Individuals on the TBI Waiver generally require oversight and supervision due to the varied, unique and often subtle cognitive challenges inherent in brain injury.

Applicant/participants needing oversight and/or supervision may also be assessed to need assistance with ADL and/or IADL. Since HCSS staff are trained to the Personal Care Aide (PCA) Level II, they are qualified to perform the scope of Personal Care Aide level I and II tasks and functions, including some or total assistance with ADL (i.e. dressing, bathing, hygiene/grooming, toileting, ambulation/mobility, transferring and eating), and/or IADL (i.e. housekeeping, shopping, meal preparation, and laundry) essential to the maintenance of the participant's health and welfare in the community.

Applicant/participants who require oversight and supervision in addition to personal care services are not eligible to receive state plan personal care services from the Local Department of Social Services (LDSS). If a participant is receiving personal care and/or skilled tasks through the Consumer Directed Personal Assistance Program (CDPAP), the HCSS worker must provide the personal care services but the skilled services may only be provided through the CDPAP or other appropriate providers. Therefore, the Service Coordinator (SC) must clearly identify in the service plan, the skilled tasks beyond the personal care scope of practice which are provided by the CDPAP. The CDPAP authorization will be adjusted appropriately by the LDSS. Applicant/participants receiving CDPAP and HCSS must identify a "self directing other" in the Plan of Protective Oversight form [HCBS/TBI form C1.3].

Applicant/participants who do not require oversight and/or supervision, and are therefore not appropriate for HCSS, may still require assistance with ADL/IADL. When such assistance is not available through informal supports, the applicant/participant may be assessed for state plan personal care services through the LDSS. The SC will work with

the applicant/participant and the LDSS to assure the necessary evaluation is completed and needed services are arranged. This may include assisting the participant to obtain a physician's order for Personal Care Services.

Applicant/participants who require skilled tasks beyond the scope of a personal care aide may require an assessment for services provided through Medicaid State Plan services such as Home Health Aide or Private Duty Nursing.

Assessment Process

When the SC determines that the applicant/participant may be in need of HCSS, the SC will discuss the need for an assessment and provide the applicant/participant with a list of approved LHCSA HCSS providers. The SC contacts the selected HCSS provider and forwards the Provider Selection form to that agency. The HCSS provider will complete and return the Provider Selection form to the SC.

The SC then completes the designated sections of the Home Assessment Abstract (DSS-3139) and forwards the tool to the selected HCSS provider's supervising Registered Professional Nurse (RN) for completion. [See form C 4.6 Home Assessment Abstract]. The HCSS RN must complete the appropriate nursing-related sections of the DSS-3139 and, within fourteen (14) calendar days, return the completed tool to the SC, including documentation supporting the need for oversight and/or supervision. In addition, there must be clearly documented recommendations for the amount, frequency and duration of HCSS for the participant and identification of any additional areas of support needed. The completed assessment tool must be provided to the SC for review with the applicant/participant and to be included in the Service Plan (SP). The RRDS has the final determination regarding the amount, frequency and duration of HCSS to be provided.

For an applicant/participant who is in a nursing home or hospital at the time the assessment is conducted, the HCBS/TBI SC and the RN must complete the Home Assessment Abstract (DSS-3139) tool. For the section of the tool regarding the home environment, it is necessary to access the participant's residence. However, if this can not be done prior to discharge from the hospital or nursing home, it must be completed on the first day HCSS is scheduled to begin. In this situation, HCSS may be approved to begin by the RRDS based on the information available in the preliminary HCSS assessment.

The RN is responsible for obtaining physician orders to support the need for HCSS as approved in the SP, developing a plan and for orienting the HCSS staff. Physician's orders must include documentation of the need for oversight and/or supervision as a discrete service based on medical diagnosis.

Other Considerations

The RN must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. The focus of the orientation visit is to introduce the staff to the participant, assure services established during the initial assessment continue to be sufficient and, if necessary, complete the environmental portion of the preliminary

assessment tool. Any changes indicated will be communicated to the Service Coordinator and/or physician as appropriate. If a particular activity requires on-the-job training, it will be provided during this visit.

Often times, when HCSS is being utilized, there may be other services involved, for example, Independent Living Skills Training (ILST), and/or Positive Behavioral Intervention and Support (PBIS), previously called Intensive Behavioral Program (IBP). For ILST an assessment will be completed and a Detailed Plan developed for cueing, prompting or supervising the participant in ADL and IADL. The ILST provider will work cooperatively with the RN and HCSS staff to assure implementation of the Detailed Plan and provide needed guidance and/or additional training. In the case of the PBIS, a PBIS Specialist may also train the HCSS staff in behavioral interventions based on a Detailed Plan. The provision of these types of complementary trainings will serve to enhance the level of consistency, cooperation, communication and team work between providers and the participant.

It is important to consider the interests and needs of the waiver participant when assigning HCSS support. The ability of the HCSS staff to support the strengths, interests and needs of the participant will promote a better working relationship and help to meet the established goals for the service. It is the right of the participant to request a change in HCSS staff. Attempting to find the best match between the HCSS staff and participant from the start decreases the occurrence of staff turnover and Serious Reportable Incidents while increasing participant satisfaction and success in the community.

Given the critical need for continuity in oversight and/or supervision to maintain the health and welfare of the HCBS/TBI waiver participant, HCSS providers are required to assure sufficient back-up for HCSS staff. If the HCSS provider believes there may be difficulties meeting the requirements specified in the participant's Service Plan, the provider must report these concerns to the SC. In accordance with NYCRR 766.9 (g) –Governing Authority, "the agency shall employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with prevailing standards of professional practice." Therefore, the HCSS agency must have an available a system in place to provide supervision during times when services are being provided. If the HCSS provider believes there may be coverage difficulties under the Service Plan, the provider must report these concerns immediately to the Service Coordinator. The SC and LHCSA HCSS provider must work together to obtain the necessary coverage which may include seeking services from other LHCSA HCSS providers.

Provider Qualifications

HCSS may only be provided by a Licensed Home Care Services Agency (LHCSA) licensed under Article 36 of the NYS Public Health Law. All regulations governing the LHCSA will be in effect for the provision of this service, (e.g. patient rights, patient service policies and procedures, plan of care, medical orders, clinical supervision, patient care records, governing authority, contracts, personnel, and records and reports).

HCSS staff must:

- Be at least 18 years old;
- Be able to follow written and verbal instructions;
- Have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service;
- Have a valid certificate to indicate successful completion of a forty (40) hour training program for Level II PCA, or PCA Alternate Competency Demonstration equivalency testing that is approved by DOH;
- Attend Basic Orientation Training and Service Specific Training as specified in the HCBS/TBI Program Manual Section VIII prior to providing any billable services;
- Attend six (6) hours of in-service education per year that includes HCBS/TBI waiver-specific training; and
- Meet all health requirements specified in 10 NYCRR 766.11

The selected provider's supervising Registered Professional Nurse (RN) must:

- Be licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law and be currently certified to practice as a RN in New York State;
- Meet all health requirements specified in 10 NYCRR 766.11; and
- Meet one of the following qualifications:
 1. Two years or more satisfactory recent home health care experience; or
 2. One year satisfactory home health care experience and act under the direction of an individual who meets the qualifications listed above.

Reimbursement

Reimbursement can only be made to DOH approved providers for services included in the participant's approved Service Plan.

HCSS services are reimbursed on an hourly basis. When HCSS is provided to more than one person at a time, the ratio of provider to participants must be stated in the SP and the billing must be prorated. For example, if HCSS is providing 6 hours of service to two individuals living together, the Service Plan for each individual reflects a 1:2 ratio and billing reflects 3 hours of HCSS per person.

HCSS staff and/or the provider's supervising Registered Professional Nurse must attend Team Meetings. However, the provider may claim reimbursement for only one agency representative attending a Team Meeting.

The RN assessment visit, orientation visit and visits to conduct on-the-job training are considered administrative costs and are not billable as a separate service.

Respite Care Services

Definition

Respite Care Services may be included in the Service Plan to provide relief to informal, non-paid supports who provide primary care and support to a participant. These services are usually provided in the participant's home. As Respite Care Services are used in a 24 hr. unit, no other waiver services can be provided during this time unless specifically outlined and justified in the Service Plan. Specific attention is to be placed on tasks that would typically be completed by informal supports, but which may be above the scope of practice of a Respite Care provider (i.e., medication administration, wound care, etc.)

Services may be provided in another home in the community if this is acceptable to the participant and the people living there. If a participant is interested in seeking a brief respite in a nursing facility, this may be accomplished through a Scheduled Short Term Admission and is not considered a Waiver service.

Provider Qualifications

Providers of Respite Care Services must meet the same standards and qualifications as the HCSS providers. If the participant needs services beyond HCSS, then the other services must be included in the Plan with Respite Care Services.

Reimbursement

Respite Care Services must be provided by a DOH approved provider and included in the Services Plan to be reimbursed.

Respite Care Service is provided in blocks of 24 consecutive hours. Since Respite Care Service is provided on an intermittent basis, the Service Coordinator must determine when participation in Team Meetings is appropriate.

Environmental Modifications Service (E-mods)

Definition

Environmental Modifications are internal and external physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the individual. E-mods also include modifications to a vehicle. These modifications enable the participant to function with greater independence and prevent institutionalization.

E-mods must be provided where the participant lives. E-mods may be obtained at the time the individual becomes enrolled as a participant, up to thirty days prior to a Notice of Decision, or during the development of any Service Plan. Modifications must not be completed more than thirty days prior to the issuance of the Notice of Decision. All modifications must meet State and local building codes.

If necessary, an E-mod may alter the basic configuration of the participant's home. All environmental and vehicle modifications must be included in the Service Plan and provided by agencies approved by DOH.

Contracts for E-mods must be less than \$15,000, unless approved by DOH waiver management staff, and participants are limited to no more than one modification within a 12 month period. Approval of modifications is contingent upon available funding.

E-mods do not include improvements to the home (carpeting, roof repair, central air conditioning), which are not medically necessary or do not promote the participant's independence in the home or community.

Allowable Environmental Modifications

E-mods in the home include installation of:

- Ramps
- Lifts: hydraulic, manual or electric, for porch, bathroom or stairs (Lifts may also be rented if it is determined that this is more cost-effective.)
- Widened doorways and hallways
- Hand rails and grab bars
- Automatic or manual door openers and doorbells

Bathroom and kitchen modifications, additions or adjustments to allow accessibility or improved functioning, include:

- Roll-in showers
- Sinks and tubs
- Water faucet controls
- Plumbing adaptations to allow for cutouts, toilet/sink adaptations
- Turnaround space changes/adaptations

- Worktables/work surface adaptations
- Cabinet and shelving adaptations

Other home adaptations include:

- Medically necessary heating/cooling adaptations required as part of a medical treatment plan. (Any such adaptations utilized solely to improve a person’s living environment are not reimbursable under the waiver.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that have been determined medically necessary.
- Other appropriate environmental modifications, adaptations or repairs necessary to make the living arrangements accessible or accommodating for the participant’s independence and daily functioning and provide for emergency fire evacuation.

Provider Qualifications

Any not-for-profit or proprietary health and human services agency may provide E-mods. Agencies must be approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD). An organization that has both the personnel and expertise to complete the E-mod and is an approved Medicaid provider may also be approved by DOH to provide the services for HCBS/TBI waiver.

The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements.

Safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes must be strictly adhered to.

Approval Process for E-mods for a home

- STEP 1** The participant, Service Coordinator, and anyone selected by the participant determine if any E-mods are required during the development of any Service Plan.
- STEP 2** A comprehensive assessment must be completed to determine the specifications of the E-mod.
- STEP 3** The participant, the Service Coordinator and anyone selected by the participant must explore all other available resources to pay for E-mods (i.e. informal supports, community resources and State/federal agencies).
- STEP 4** When all other resources have been utilized, the Service Coordinator begins the bid procurement and selection process.

There are two options for obtaining bids:

1. The Service Coordinator and participant select a waiver approved E-mod provider to be responsible for planning, oversight and supervision of the project. The provider is then responsible for obtaining three bids from skilled professionals and selecting the contractor; OR
2. The Service Coordinator and participant obtain three bids from providers who are responsible for planning, oversight and supervision of the project AND have the personnel and expertise to complete the E-mod.
 - For E-mods of less than \$1,000, only one bid is necessary.
 - For E-mods of \$1,000 or more, three bids are necessary.

Any combination of these two options can be used to obtain three bids. The lower bid must be selected, unless there is an indication that the contractor did not understand the full scope of the work or is unable to deliver the needed service. Every reasonable effort must be made to acquire the required three bids.

When the Service Coordinator determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare or is preventing an individual from leaving an institution, the Service Coordinator must contact the RRDS. The RRDS will consult with DOH and will notify the Service Coordinator if they can proceed without the required three bids.

STEP 5

The Service Coordinator submits the E-mod proposal using the E-mod Project Description and Cost Projection form (Appendix C-2) to the RRDS for review and approval along with the Service Plan. Information that must be submitted includes but is not limited to:

1. Justification for the E-mod.
2. All comprehensive assessments completed to determine the specifications of the E-mod.
3. Information regarding the residence where the E-mod is proposed, including the name of the home owner or landlord. The owner's approval for the renovations, including any lease or rental contract, must be included (DOH is not responsible for the cost of restoring a site to its original configuration or condition).
4. If the participant or family is having other renovations or repairs done to the house along with the E-mods, the scope of work should clearly delineate the waiver covered E-mods from modifications being funded by the family.

STEP 6 The RRDS reviews the E-mod proposal and may request more information. Approval is contingent upon available funding. The RRDS notifies the Service Coordinator of the approval.

STEP 7 The Service Coordinator notifies the E-mod provider of the approval and obtains a signed contract from the provider. The E-mod provider is responsible for coordination of the E-mod, including obtaining necessary permits, supervising the construction, beginning and ending dates, and satisfactory completion of the project.

Signed contracts must be forwarded to the RRDS and must be less than \$15,000 per 12 month period, unless approved by DOH waiver management staff. Any changes in cost must be prior approved by the RRDS through an Addendum to the Service Plan.

STEP 8 Upon completion of the E-mod, a summary of the work, with actual costs, is submitted to the RRDS on the Environmental Modifications Final Cost form (Appendix C-2).

STEP 9 The RRDS reviews the Final Cost form, approves the final cost of the E-mod and notifies the Service Coordinator.

STEP 10 The Service Coordinator notifies the E-mod provider to seek reimbursement.

Repairs

Repairs for home modifications which are cost effective may be allowed. Modifications that have worn out through normal use (faucet controls, ramps, handrails, etc.) may be replaced using the same E-mod approval process as for new E-mods. Repair and/or replacement may be contingent upon developing and implementing a plan to minimize repeated damage.

Reimbursement

E-mods must be provided by a DOH approved provider and included in the Service Plan to be reimbursed. E-mods initiated up to thirty days prior to the initial Notice of Decision are reimbursed after the Notice is issued.

This service is reimbursed according to the final cost of the project approved by the RRDS and must be less than \$15,000 per 12 month period, unless approved by DOH waiver management staff.

E-mods for Vehicles

Definition

Vehicle modifications provide the participant with the means to access services and supports in the community, increase independence and promote productivity. These modifications may include adaptive equipment and/or vehicle modifications.

Equipment that is available from the dealer by factory installation as standard or optional features of the car is not covered as a waiver service. These items, as well as ongoing maintenance and repair of the vehicle, are the responsibility of the participant.

The vehicle must be owned by the participant, a family member or an individual who provides primary long term support to the participant. Modifications will only be made to a vehicle if it is the primary source of transportation for the participant and it is available to the participant without restrictions.

All vehicles that are modified under the waiver must be insured and meet New York State inspector standards before and after the modifications are completed.

Vehicle modifications must be less than \$15,000 per 12 month period, unless approved by DOH waiver management staff.

Allowable E-mods for Vehicles

Adaptive equipment is designed to enable a participant to operate a vehicle or be transported but is not usually available through the vehicle's manufacturer.

Adaptive equipment includes:

- Hand controls
- Deep dish steering wheels
- Spinner knobs
- Wheelchair lock downs
- Parking brake extensions
- Foot controls
- Wheelchair lifts, including maintenance contracts
- Left foot gas pedals

Vehicle modifications include adaptations and/or changes to the structure and internal design of existing vehicle equipment.

Vehicle modifications include:

- Replacement of a roof with a fiberglass top
- Floor cut-outs

- Extension of steering column
- Raised door
- Repositioning of seats
- Wheelchair floor
- Dashboard adaptations

Adaptive equipment and vehicle modifications may only be provided if the following conditions are met:

- a. The participant is not eligible for these services through any other resource (e.g., VESID, Veterans Administration, Workers Compensation, insurances, etc.);
- b. There is an acceptable written recommendation and justification by a VESID approved evaluator that the services are essential for the participant to drive or be transported in a motor vehicle; and
- c. The participant and the owner of the vehicle must sign the statement, indicating that the vehicle is available to the participant without restrictions.

Limitations on adaptive equipment and vehicle modifications:

- a. The Service Coordinator will instruct the VESID approved evaluator to recommend the most cost effective and least complicated adaptive equipment and vehicle modifications(s) which will meet the participant's functional capabilities and safety needs while also meeting appropriate requirements/standards.
- b. A car may be considered for modification if the participant can independently transfer him/herself and a wheelchair into and out of the car, has the functional ability to drive the car, and does not have medical contraindications, which preclude the ability to transfer from and/or drive the car.
- c. A van can only be considered for modification if a car cannot be modified to meet the participant's needs.
- d. Modifications to a vehicle that the participant will not be driving are limited to modifications that are essential to insure safe transportation and access into and out of the vehicle.
- e. Modifications may not exceed the Blue Book on current market value of the vehicle.

Used Vehicles

The HCBS/TBI waiver may cover the modification of used vehicles or the cost of

modifications in a used vehicle only if the vehicle meets the following additional criteria:

- a. The vehicle must pass New York State inspection be registered and insured;
- b. The vehicle must be structurally sound and not in need of mechanical repairs;
- c. The vehicle must not have any rust or deficiencies in the areas to be modified or in the areas already modified; and
- d. The vehicle must be less than five years old or register less than 50,000 miles.

Used Adaptive Equipment

Used adaptive equipment and modification devices are sometimes available for purchase. To ensure the greatest safety and performance, DOH will only approve used equipment purchased from businesses dealing in the sale of vehicles or adaptive equipment. The equipment must be able to safely meet the participant's needs, as determined by an evaluation completed by a VESID approved evaluator, and be in good working condition as determined by the vehicle modifier.

Assessing the Value of Used Adaptive Equipment or Vehicle Modifications

- a. Determine the value of the used vehicle (as though no modifications had been made) from the Blue Book. Subtract this figure from the asking price of the previously modified vehicle. The difference will be the asking price of the modification or adaptive equipment.
- b. To determine the current value of the used modification or adaptive equipment, ascertain the original cost of the modification from the dealer. Adaptive equipment depreciates 10% each year. Calculate the current value of the modification based on the 10% depreciation. This figure is the current value of the modification or adaptive equipment. This is the amount that Medicaid may cover provided it does not exceed the vehicle modification limits specified in this Manual.

Repairs

Waiver services do not include general repairs or maintenance of a vehicle. All warranties and guarantees must be fully utilized. Requests for repairs to E-mods for the vehicle must follow the same procedure as initial vehicle modification applications.

Approval Process for E-mods for a Vehicle

- Step 1** The participant, Service Coordinator and anyone selected by the participant determine if any vehicle modifications are required during the development of any Service Plan.
- Step 2** A VESID approved evaluator completes an assessment of the participant's needs for adaptive equipment or comprehensive vehicle modifications.
- Step 3** The participant, the Service Coordinator and anyone selected by the participant must explore all other resources to pay for the modifications.
- Step 4** When all other resources have been utilized, the Service Coordinator and waiver participant select a HCBS/TBI waiver approved E-mod provider.
- Step 5** The E-mod provider obtains the needed bids for the modifications and selects one provider based on cost, comparability of services and professional skills.
- For modifications of less than \$1,000, only one bid is required.
 - For modifications of \$1,000 or more, three bids are necessary.
- Step 6** Bids are submitted to the Service Coordinator for selection.
- Step 7** The Service Coordinator submits the request for the adaptive equipment or vehicle modification, using the Vehicle Identification and Information form and the E-mod Project Description and Cost Projection form (Appendix C-2), to the RRDS along with the Service Plan for review and approval. Information that must be submitted includes but is not limited to:
- Justification for the vehicle adaptive equipment or modification;
 - All comprehensive assessments including the assessment and recommendations of the approved VESID evaluator; and
 - A copy of the selected bid and the projected costs.
- Step 8** The RRDS reviews the proposal and may request more information. Approval is contingent upon available funding.
- Step 9** The RRDS approves the proposed E-mod for the vehicle and notifies the Service Coordinator. The Service Coordinator notifies the E-mod provider to complete the approved modifications and obtains a signed contract from the provider.
- Step 10** The VESID approved evaluator who recommended the adaptive equipment and/or modifications must check work done by E-mod provider(s). The evaluator must submit a statement to the E-mod provider indicating compliance with the original recommendations before the participant picks up

the vehicle. Documentation must be included verifying that the vehicle is insured and inspected by New York State following the modifications.

- Step 11** The Service Coordinator submits to the RRDS: (a) the E-mod Final Cost form (Appendix C-2) and (b) the VESID statement indicating that the completed E-mod complies with the original recommendations.
- Step 12** The RRDS reviews the E-mod Final Cost form and VESID statement, approves the final cost of the vehicle E-mod and notifies the Service Coordinator.
- Step 13** The Service Coordinator notifies the E-mod provider to seek reimbursement.

Reimbursement

Vehicle modifications must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Vehicle modifications will be reimbursed on a cost basis and only if the procedures described in this section have been followed. The service is reimbursed according to the final cost of the project, after approval by the RRDS.

When the E-mod provider does not complete the actual construction but is responsible for management and oversight of the project, the provider may add 10% to the actual cost of the construction for project management.

Assistive Technology Services

Definition

Assistive Technology Services supplements the State Plan Medicaid Service for Durable Medical Equipment and Supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other resources must be utilized before considering Assistive Technology Services.

This service will only be approved when the requested equipment and supplies directly contribute to the participant's level of independence, ability to access needed supports and services in the community or maintain or improve the participant's safety.

Assistive Technology may be obtained at the time the individual becomes enrolled as a participant, no more than thirty days prior to the initial Notice of Decision, or during the development of any Service Plan. Requests for Assistive Technology must be less than \$15,000 per 12 month period, unless approved by DOH waiver management staff.

Provider Qualifications

Assistive Technology Services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of Assistive Technology must be:

1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers to the HCBS waiver administered by OMRDD;
3. A licensed pharmacy; or
4. An approved provider of Personal Emergency Response Systems (PERS). These providers are limited to only providing PERS.

Providers of Assistive Technology must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with FCC Regulations.

Approval Process for Assistive Technology Services

- Step 1** The participant, the Service Coordinator, and anyone selected by the participant determine if any Assistive Technology is needed during the development of any Service Plan. This must be done in conjunction with an assessment by either an ILST or other professional who is knowledgeable about the full range of options available for individuals with disabilities.
- Step 2** The participant and Service Coordinator explore and utilize all possible funding sources including: private insurance; community resources; non-waiver Medicaid funding; and/or other federal/State programs. These funding sources must be accessed prior to requesting Assistive Technology Services.

- Step 3** The Service Coordinator submits the Assistive Technology request to the RRDS, using the Assistive Technology Project Description and Cost Projection form (Appendix C-2) along with the Service Plan for review and approval. Information that must be submitted includes but is not limited to:
- Justification for the Assistive Technology, indicating how the specific equipment will meet the needs and goals of the participant in an efficient and cost effective manner.
 - Copies of all assessments made to determine the necessary Assistive Technology, including an assessment of the participant's unique functional needs and the intended purpose and expected use of the requested Assistive Technology. The assessment must include a description of the ability of the equipment to meet the individual's needs in a cost effective manner.
 - When the Assistive Technology will require modifications to the participant's residence, information must also include the name of the home owner or landlord.
 - Dates of the needed Assistive Technology.
- Step 4** The Service Coordinator obtains price quotes from approved Assistive Technology providers. The Service Coordinator must select an approved provider based on reasonable pricing and obtain a written price quote stating all terms and conditions of sale.
- For Assistive Technology costing up to \$1,000, only one bid is required.
 - For Assistive Technology costing \$1,000 or more, three bids are required.
- Step 5** The RRDS reviews the Assistive Technology Project Description and Cost Projection and may request more information. Approval is contingent upon available funding. The RRDS notifies the Service Coordinator of the approval.
- Step 6** The Service Coordinator notifies the Assistive Technology provider.
- Step 7** The Service Coordinator submits the Assistive Technology Final Cost form to the RRDS, including a detailed description of the Assistive Technology purchased and the final cost.
- Step 8** The RRDS reviews the Final Cost form and notifies the Service Coordinator of the approval.

Step 9 The Service Coordinator notifies the Assistive Technology provider to seek reimbursement.

Repairs

Repairs to Assistive Technology which are cost effective may be allowed. Items that have worn out through normal everyday use (keyboards, switches, etc.) may be replaced using the same procedures that were followed to initially acquire the item. There are situations where replacement or repair will be contingent on establishing a plan that would minimize repeated loss or damage. The Service Coordinator is responsible for working with the team to develop and implement a plan to prevent repeated loss or damage.

Reimbursement

Assistive Technology must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Assistive Technology is reimbursed based on the lower of two costs: wholesale plus 50 percent or the retail cost, and may include 10 percent administrative fee, based on the total, final cost payable, to the AT provider. Repairs and replacement of parts are reimbursed at the retail cost. Assistive Technology obtained no more than thirty days prior to the initial Notice of Decision are reimbursed after the Notice of Decision is issued.

Waiver Transportation

Definition

Waiver transportation supplements transportation provided by the Medicaid State Plan. It includes transportation for non-medical activities which support the participant's integration into the community.

All other options for transportation, such as informal supports, community services and public transportation, must be explored and utilized prior to requesting waiver transportation. Use of this service must be indicated in the Service Plan.

Provider Qualifications

A provider of transportation under the HCBS/TBI waiver must be an:

- (a) Approved provider of Medicaid State Plan transportation. Waiver transportation providers must also be approved by DOH waiver staff; or
- (b) Individual waiver transportation provider. Individual waiver transportation providers must:
 - Have a current New York State drivers license;
 - Drive a New York State registered, inspected and insured vehicle; and
 - Be identified in the Service Plan.

Approval Process and Record Keeping for HCBS/TBI Waiver Transportation

- (A) For approved waiver providers who are also approved for Medicaid State Plan transportation:
 - The type and amount of waiver transportation must be included in the approved Service Plan.
 - The participant selects the waiver transportation provider. If necessary, the advocate or Service Coordinator may request the service.
 - The Service Coordinator arranges for the transportation through the local department of social services (LDSS). In New York City, the New York City Transportation Prior Approval unit must be contacted.
 - After the transportation is provided, the provider bills the Medicaid Program.
 - The Service Coordinator maintains complete records including dates of transportation, destination, cost and reason for using waiver transportation.

(B) For individual waiver transportation providers:

- The participant selects the individual(s) to provide waiver transportation.
- The participant and Service Coordinator determine the destination and frequency of transportation.
- The Service Coordinator calls the LDSS or authorizing agency for authorization of the transportation.
- After the transportation is provided, the provider reports mileage and tolls to the Service Coordinator.
- The Service Coordinator completes a voucher received from the LDSS or authorizing agency and returns it to the appropriate party.
- The LDSS or authorizing agency processes the voucher and reimburses the waiver provider.
- The Service Coordinator maintains complete records, including the dates of transportation, destination, cost and reason for the waiver transportation.

Reimbursement

Transportation services must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Approved providers of Medicaid State Plan transportation which provide HCBS/TBI waiver transportation are reimbursed at the Medicaid rate.

Individual waiver transportation providers are reimbursed at the private vehicle reimbursement rate established by the LDSS.

Community Transitional Services (CTS)

Definition

Community Transitional Services (CTS) provide funding for the reasonable costs of one-time set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community. Reasonable costs are defined as necessary expenses for an individual to establish his/her living space.

These services must be included in the Initial Service Plan and may not exceed \$3,000, including the 10% administrative fee payable to the CTS provider. CTS assistance must be accessed by eligible individuals prior to applying for a rental subsidy and/or housing supports from the HCBS/TBI Housing Program.

Items eligible for CTS funding include reasonable costs for some or all of the following items:

- Security deposits that are required to obtain a lease on an apartment or home within Fair Market Rate as established by the federal Department of Housing and Urban Development (HUD)
- Essential furnishings: bed, table, chairs, eating utensils, window coverings
- One-time set up fees for services access including: electric, heat, telephone
- Broker's fee
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy
- Moving expenses

Items not eligible for CTS funding include but are not limited to:

- Televisions, cable TV access, VCRs, DVDs, music systems
- Air conditioners - if medically necessary these must be applied for as an Environmental Modification (E-mod) using the procedure outlined in this Manual
- Any items which are not necessary for establishing a living space
- Monthly rent

Provider Qualifications

All CTS providers must be approved providers of Service Coordination in the HCBS/TBI waiver. However, CTS must be available to waiver participants independent of their Service Coordination provider.

Approval Process for CTS

Step 1 The individual, Service Coordinator, and anyone selected by the participant, determine if any CTS are required prior to discharge from the nursing home into the community.

- Step 2** A comprehensive list of the items needed and anticipated costs is developed.
- Step 3** The individual and Service Coordinator explore all possible resources including informal supports and community resources.
- Step 4** After all other resources are utilized, the Service Coordinator compiles a detailed list of items and anticipated expenses using the CTS Project Description and Cost Projection form (Appendix C-2) and submits it with the Initial Service Plan to the RRDS.
- Step 5** The RRDS reviews and approves the costs detailed for CTS.
- Step 6** The Service Coordinator and individual select an approved CTS provider. Approved costs may be covered by CTS up to sixty days prior to the individual's discharge into the community.
- Step 7** The RRDS notifies the Service Coordinator of approval for CTS.
- Step 8** The CTS provider makes the approved payment directly to the broker, utility company and/or the landlord for a security deposit. Funds for essential furnishings are forwarded to the Service Coordination Agency.
- Step 9** The Service Coordinator and the individual purchase the approved essential furnishings with prior approval by the RRDS. All receipts and any remaining balance must be returned to the CTS provider.
- Step 10** As soon as the individual becomes a waiver participant, the Service Coordinator informs the CTS provider to seek reimbursement.

Reimbursement

Community Transitional Services must be provided by a DOH approved provider and included in the Initial Service Plan to be reimbursed.

This Service is reimbursed on a cost basis. Total one-time reimbursement for CTS must not exceed \$3,000, which may include a 10% administrative fee payable to the CTS provider.

Section VII

Record Keeping

Introduction

Record keeping is required both for clinical reasons and to document the expenditures of Medicaid funds. All records must be maintained for at least seven years after termination of waiver services.

Clinically, structured record keeping assists the participant and provider to document desired goals and the accomplishment of these goals. By setting goals, developing and implementing a strategy of intervention and then reviewing the effectiveness of the intervention, the participant and provider will better understand whether the established goals can be realized and identify when interventions and/or goals need to be revised.

Record keeping documenting Medicaid billing is required of all Medicaid providers. The need to maintain the necessary records is discussed in the Provider Agreement, the eMedNY Provider Manual and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all Medicaid claims.

The three major components of the record keeping responsibilities include:

1. Detailed Plans;
2. Documentation of Encounters; and
3. Individual Service Reports.

Detailed Plans

Each waiver provider must develop a Detailed Plan for each participant served. The Detailed Plan is an essential component of a participant's efforts to remain in his/her community of choice. The Detailed Plan identifies the participant's goals for each waiver service.

Information is gathered through interviewing the participant and anyone selected by the participant. It may also be necessary to talk with other providers to understand the participant's skills and abilities in a particular area of functioning. The method for gathering baseline information may vary according to the particular waiver service. For example, the CIC will use a different process than the ILST. An HCSS provider will often rely on the assessments of other providers, such as the ILST or PBIS, to understand the participant's level of skill and appropriate interventions. The HCSS develops a Detailed Plan, incorporating the information from other services and describing specific goals and interventions for HCSS.

Once the goals are established, the provider is responsible for completing a thorough evaluation of the participant's basic skills and abilities related to the selected goals.

The Detailed Plan should include three components:

a. **Milestones**

Milestones are defined as component, intermediate goals which must be

accomplished in order to achieve a larger goal. For example, a participant's goal may be to return to work. A Structured Day Program will establish milestones, such as punctuality or grooming, which need to be accomplished to meet the employment goal.

b. Interventions

Once milestones are established, the provider determines what interventions will assist the participant to achieve the milestones and, eventually, the selected goal. A thorough understanding of the participant's unique strengths, deficits, interests and abilities will help guide the provider in the development of interventions.

c. Timeframes

Timeframes include the frequency and length of the interventions and how long the participant and provider expect it will take for the participant to reach the selected goal. These timeframes must be reflected in the Service Plan. It is essential to set realistic timeframes to determine the success of an intervention and the stated goal. It can be just as important to assist a participant to recognize that a particular goal may not be obtainable but that the outcome of the goal can be accomplished through another means. For example, if a participant is not successful in being an independent cook, the preparation or securing of meals can be accomplished by other means.

Documentation of Encounters

The provider must document each encounter with the participant as required by Medicaid for reimbursement. Documentation must include the date, location, time and a description of the activities, which are related to the goals established in the Detailed Plan. This information must be recorded as soon as possible after each contact and reviewed for completeness each month. All records must be maintained for seven years following termination of services to a participant.

Individual Service Reports

Waiver service providers for the services listed below, must submit an Individual Service Report (ISR) to the Service Coordinator six weeks prior to the expiration of the current service plan:

- Independent Living Skills Training
- Intensive Behavioral Program
- Home and Community Support Services
- Community Integration Counseling
- Structured Day Program
- Substance Abuse Program
- Respite Services

The ISR is an opportunity for the provider to describe their activities during the past six months and to describe future goals.

The ISR is directly related to the Detailed Plan and ongoing documentation of encounters with the participant. The Detailed Plan sets the overall design of the interventions to be implemented. The notes regarding ongoing interactions with the participant provide the information necessary to complete the ISR.

The ISR identifies the following fundamentals:

1. What goals have been worked on?
2. What did staff do to assist the participant accomplish his/her goals?
3. How successful were the interventions?
4. What will be the goals for the next six (6) months?
5. Is there a need to change the amount of the service being provided?

The last three questions require review of the Detailed Plan – Is it working? Does it need to be changed? What are the participant's goals now? How can this service be used to assist the participant to reach these goals?

The ISR documents the progress of the participant in relation to provided services, justifies the continuation of the services and represents the provider's request for continued approval to provide the services. In order for the RRDS to justify reapproval/continuation of a service, the ISR must clearly describe how the continuation of this service will help to maintain the participant in the community. The ISR is reviewed and signed by the participant, the waiver provider and the Service Coordinator.

Record Keeping for Service Coordinators

It is imperative that the Service Coordinator maintains accurate and complete documentation. The Service Coordinator is responsible for distributing the approved Service Plans to all waiver providers and ensuring that each provider receives information that impacts the delivery of services.

The Service Coordinator shall maintain a file for each participant that includes:

1. The Application Packet (Appendix C-1). If the Service Coordinator was not involved in the development of the Application Packet, a copy must be obtained from the RRDS. For all other information, the Service Coordinator is responsible for maintaining information which was written during his/her period of involvement with the participant;
2. The most recent PRI/SCREEN and all PRI/SCREENS conducted during the time the agency provided service coordination to the waiver participant;
3. All Revised Service Plans, including all Individual Service Reports;
4. Completed Home Assessment Abstract
5. All Medicaid Verification forms

6. All Addendums;
7. All Notices of Decision;
8. Documentation of waiver transportation as described in the Program Manual;
9. Summaries of all Team Meetings;
10. Participant's Rights and Responsibilities original, signed and dated forms;
11. Current Provider Contact List;
12. Documentation of the provision of Service Coordination services;
13. Individual Service Reports, including the Service Coordinator's Individual Service Reports; and
14. Documentation of all contacts with:
 - a. The participant;
 - b. Family and informal supports;
 - c. Providers of waiver services;
 - d. Providers of non-waiver services;
 - e. Regional Resource Development Specialists; and
 - f. Any other significant contacts which affect the Service Plan or reflect a change in the participant's situation; and
 - g. Local Departments of Social Services.
13. Plan for Protective Oversight (PPO) (Appendix C-1)

Record Keeping for All Other Providers

All other waiver service providers shall maintain participant files, which include:

1. The Application Packet. Providers who begin after the initial approval was approved should obtain a copy of the Application from the Service Coordinator. For all other records, the provider is responsible for maintaining information which was written during his/her period of involvement with the participant;
2. All assessments they have performed or requested;
3. All Detailed Plans;
4. All Individual Service Reports submitted to the Service Coordinator for Revised Service Plans;
5. The most recent Service Plan and Notice of Decision;
6. Records of all contacts with the Service Coordinator;
7. Records of all contacts with other waiver providers, family and informal supports; and
8. Participant's Rights and Responsibilities original signed and dated forms.

Note: Structured Day Programs and Substance Abuse Programs must keep logs reflecting attendance.

All providers must maintain records which adequately support all billing for waiver services.

Documentation of Serious Reportable Incidents and Recordable Incidents, as defined in the HCBS/TBI Incident Reporting Policy, must be kept separately from participant files to ensure confidentiality.

Section VIII

Required Training for Waiver Service Providers

Introduction

There are three components of required training:

1. Basic Orientation Training
2. Service Specific Training
3. Annual Training

An approved provider agency is responsible for:

- Developing a written training curriculum to meet the requirements identified in this section;
- Ensuring that individuals providing the training meet the qualifications specified in this section;
- Providing Basic Orientation Training and the appropriate Service Specific training to all waiver providers prior to any unsupervised contact with a waiver participant;
- Providing required annual training to all service providers; and
- Documenting all training in the employee file, including all related HCBS/TBI training, seminars and conferences attended, whether offered by the provider or other entities.

Qualifications of Trainers

Training must be provided by individuals who are:

- Knowledgeable about the needs of individuals with TBI or knowledge regarding one of the specific areas of required training;
- Familiar with the philosophy, policies and procedures of the HCBS/TBI waiver; and
- Experienced in providing the waiver service in service specific training;

DOH waiver management staff and/or DOH Program Contractors may request to review any training materials used by a provider.

Documentation of Training

Required documentation includes:

1. Basic Orientation Training curriculum developed by the provider;
2. Curriculum for Service Specific training for each waiver service provided; and
3. Documentation in each employee's file of all HCBS/TBI related training provided by the provider or other entities. Documentation must include:
 - Name of the trainer and affiliation/qualifications
 - Record for all staff that attended training
 - Date and place of training
 - Goals and objectives of training
 - Evaluation tools

Agencies are responsible for ensuring that individuals providing waiver services complete Basic Orientation training and Service Specific training. Individuals with documented successful completion of prior training in the content areas specified in Basic Orientation training and/or Service Specific training may be exempt from such training at the discretion of the provider. The reason for the exemption must be documented in the employee file.

Basic Orientation Training

All qualified service providers must complete Basic Orientation training prior to any unsupervised contact with a waiver participant and within 30 days of initial employment.

Approved service providers who are exempt from this training requirement are limited to providers of E-mods, Assistive Technology, Transportation and Community Transition Services.

The training consists of one-on-one and/or group training to instruct new waiver providers regarding the specific needs of individuals with a TBI, the philosophy and policies of the HCBS/TBI waiver and waiver participant's rights and responsibilities.

Basic Orientation training for all service providers must include, at a minimum, instruction in the following areas:

- Traumatic brain injury (TBI): the range of physical, cognitive and behavioral effects of a TBI and the emotional impact on the individual and their significant relationships.
- The HCBS/TBI waiver philosophy, including:
 - Role of the RRDS
 - Role of the Service Coordinator
 - Role of other state contractors
- Overview of all waiver services, including the interaction and communication of all waiver service providers with the Service Coordinator.
- Review of Participants Rights and Responsibilities form in the Program Manual (Appendix C-1).
- HCBS/TBI Incident Reporting Policy, including recognition, prevention and reporting of Serious Reportable Incidents.
- Development and/or implementation of a written Detailed Plan of intervention for each service, including long and short-term goals and milestones for each goal.
- Basic safety and emergency procedures (e.g. choking, loss of consciousness, breathing difficulties).

- Effective interventions during crisis, including behavioral and medical crisis, natural disasters, severe weather, and lack of replacement staffing.
- Methods to provide support and supervision to maintain the health and welfare of the participant when in the community.
- Team Meeting requirements of attendance, roles and responsibilities of staff.

Service Specific Training

Service Specific training prepares the individual provider for the roles and responsibilities specific to the waiver service he/she is qualified to provide. This training must be completed prior to any unsupervised contact with a waiver participant and within 30 days of initial employment.

Service Specific training consists of one-on-one and/or group training to instruct individuals of their role as providers of a specific service and for which they have responsibility to interact with the Service Coordinator and other waiver providers. The instructor for this training must be a qualified, experienced provider of the specific service.

Training for Service Coordinators include, at a minimum, instruction in the:

1. Roles and responsibilities of the Service Coordinator, including a detailed job description;
2. Record-keeping responsibilities, including appropriate use of the standardized Service Plan forms (Appendix C);
3. Procedures for effective communication and coordination between all service providers, including coordination of Team Meetings with all service providers;
4. Procedures of the HCBS/TBI waiver Housing Program, using the HCBS/TBI Housing Guidelines, and procedures for completion of the Housing Standards Checklist;
5. Availability of approved HCBS/TBI waiver providers of other waiver services and non-waiver service providers in their region;
6. Local, state and federally funded programs such as Medicare, Medicaid, Food Stamps, HEAP, VESID and Social Security Administration and methods for securing these services and funds; and
7. Sources of potential informal supports available in the community.

Training for Independent Living Skills Trainers (ILST) must include, at a minimum, instruction in the:

1. Roles and responsibilities of the ILST, including a detailed job description;
2. Record keeping responsibilities;
3. Procedures for effective communication and coordination with the Service Coordinator and other service providers;
4. Conducting Functional Assessments of ADLs and IADLs, including an overview of available standardized instruments and strategies for assessing ADLs and IADLs; and
5. Training of other waiver providers and informal supports to ensure consistency in how they cue, support or assist the participant with ADLs and IADLs.

Training for Structured Day Program (SDP) Director and Program Staff must include, at a minimum, instruction in the:

1. Roles and responsibilities of the SDP, including a detailed job description;
2. Record-keeping responsibilities;
3. Procedures for effective communication with the Service Coordinator and other service providers;
4. Procedures for individual goal setting and assessment of changing skill levels within a group setting;
5. Orientation to program development and scheduling;
6. Methods of working with participants in a group setting;
7. Procedures for fire and safety;
8. Responsibilities of the Director including supervision and training of program staff; and
9. Responsibility of program staff to report to the Director.

Training for Substance Abuse Program Director and Program Staff must include, at a minimum, instruction in the:

1. Roles and responsibilities of the Substance Abuse Program, including a detailed job description;
2. Record-keeping responsibilities;
3. Procedures for effective communication with the Service Coordinator and other service providers;
4. Effects of abusing substances on individuals with a traumatic brain injury;

5. Procedures for supporting participants to make healthy life choices, such as proper nutrition, leisure activities, relationships, etc.;
6. Working with a participant who has experienced a break in sobriety;
7. Working with community-based self-help/support groups to provide technical assistance to community-based services to meet the needs of the participant; and
8. Responsibilities of the Director to supervise and train program staff; and
9. Responsibility of program staff to report to the Director.

Training for Community Integration Counseling (CIC) must include, at a minimum, instruction in the:

1. Roles and responsibilities of CIC, including a detailed job description;
2. Record-keeping responsibilities; and
3. Procedures for effective communication with the Service Coordinator and other service providers.

Training for the Director of Positive Behavioral Interventions and Support Services (PBIS) and the Behavioral Specialist must include, at a minimum, instruction in the:

1. Roles and responsibilities of the Director and the Behavioral Specialist, including a detailed job description;
2. Record-keeping responsibilities; and
3. Procedures for effective communication with the Service Coordinator and other service providers.

Directors without experience and/or training related to individuals with TBI must receive basic orientation training in TBI.

Training for Behavioral Specialists

Training for Behavioral Specialists must include, at a minimum, a curriculum developed and conducted by the Director of PBIS Services, at a minimum, which must include the:

1. Analysis of behaviors, with attention to assessing the events and circumstances contributing to the behavioral difficulties, as well as being able to understand and record the frequency and intensity of the behavior(s);
2. Implementation of an emergency intervention plan developed by the Director of PBIS;
3. Implementation of a comprehensive, clearly written Detailed Plan that provides

behavioral training to family members, informal supports and other providers who have significant contact with the participant receiving this service;

4. Responsibilities of the Director to supervise and train PBIS Specialists; and
5. Responsibility of the PBIS Specialist to provide feedback to the Director regarding the effectiveness of the PBIS Plan.

Training for Home and Community Support Services (HCSS) must include, at a minimum, instruction in the:

1. Roles and responsibilities of HCSS providers, including a detailed job description;
2. Record-keeping responsibilities;
3. Procedures for effective communication with the Service Coordinator and other service providers;
4. Role of the HCSS staff in relation to providers of ILST, PBIS, and other waiver and non-waiver service providers;
5. Observation and reporting to their supervisor any changes in diet and eating habits, behavior, sleep patterns, mood, physical abilities and cognitive abilities; and
6. Policies regarding participant self-administration of medication.

Training for Respite Services must include, at a minimum, instruction in the:

1. Roles and responsibilities of Respite Service providers, including a detailed job description;
2. Record-keeping responsibilities;
3. Procedures for effective communication with the Service Coordinator and other service providers;
4. Observation of and reporting to the Service Coordinator any changes in diet and eating habits, behavior, sleep pattern, mood, physical abilities and cognitive abilities; and
5. Policies regarding participant self-administration of medication.

Minimum Required Annual Training for All Waiver Service Providers

All HCBS/TBI waiver service provider agencies are required to provide to their staff annual training which includes, at a minimum, the following information:

1. HCBS/TBI Incident Reporting Policy;
2. Review of all new policies and/or procedures required by the HCBS/TBI waiver;
3. Review of HCBS/TBI Participant Rights and Responsibilities; and
4. Additional topics relating to findings of satisfaction surveys, incident reports and additional training.

Section IX

Quality Management Program

Introduction

This section of the Program Manual describes the various activities that comprise the Quality Management Program (QMP). Some of these activities have been described in earlier sections, while other activities, specifically developed to ensure that the QMP is comprehensive, are introduced. Many of the basic procedures, such as approving individuals to become participants in the waiver or the Service Plan document, have been developed so that quality is inherent in them.

The definition of quality continues to evolve as community-based services more fully embrace the person-centered approach. There must be quality assurance standards, by which the waiver can assure that providers are meeting their contractual agreements as described in the Provider Agreement and this Manual. That, however, is only a start. The Department, providers, advocates, and the participants and their families must work together to establish an ongoing process to strive to continually improve the quality of waiver services and participant satisfaction.

The primary measure of success of the QMP is whether the waiver participant has been able to achieve his/her desired outcomes. For the participant, as for anyone, these desired outcomes must be tempered by the reality of the person's skills and resource availability. The philosophy of the waiver, its policies and procedures has been developed to assure the greatest opportunity for participants to be successful in the pursuit of their desired outcomes. There must be various methods for all involved - the participant, advocates, providers and waiver management staff - to understand when the participant has or has not experienced success and what role did participation in the waiver have in this outcome.

In entering into the agreement with the Centers for Medicare and Medicaid Services (CMS) to operate the HCBS/TBI waiver, the State made the following assurances:

1. To guarantee the health and welfare of the participants;
2. That only qualified providers, as defined by the State, serve participants;
3. That level of care determinations are conducted on a regular basis (for this waiver, this is the determination that the individual is in need of a nursing home level of care);
4. That Service Plans are responsive to the participants' needs and goals; and
5. That the overall Medicaid costs for waiver and State Plan Medicaid services are less than or equal to the overall cost of providing nursing home care to a similar population.

These assurances represent the basis for the activities in the QMP.

In addition to measures of supervision that the Department engages in, providers are directed to examine their own Quality Management Programs in relation to this framework and to evaluate if they have the capacity to meet the assurances and desired outcomes for which they are responsible. In various parts of the description of the areas of focus, the word system is used. It is recommended that a provider envision their service delivery as a

system and review whether they have effectively dealt with these issues as the provider strives to assure quality in its performance.

Please note that the list of focus areas and the overall concept of this framework is taken from The National Quality Inventory Project sponsored by CMS, with additional language added, where noted*.

Framework for a Quality Management Program

Recently, CMS has increased its attention to the concept of quality. CMS has developed a Quality Framework which provides an excellent example for constructing a viable and practical approach to dealing with the quality aspects of a waiver. This Quality Framework contains three distinct functions: Discovery, Remediation and Improvement.

The Discovery function focuses on the ability and willingness to become aware of those events that may compromise the waiver's pursuit of meeting its assurances to the federal government. On a more concrete level, are there policies and procedures in place that will identify issues that may be of concern to the participant, provider, community or program?

Do we know when a participant experiences neglect? Do we know when waiver policies and procedures have a negative impact on the providers' ability to meet the standards established for hiring qualified staff? Do we have a way of documenting and sharing best practices? These are the types of questions that must be positively responded to if the HCBS/TBI waiver, under the Department, is to understand whether it is successful in fulfilling its primary goals.

Once discovery processes are in place, the QMP must respond to individual situations via Remediation and, when necessary, to initiate Improvements on a system-wide level. The Remediation processes established to provide amelioration of an individual's problem must be ones that can be carried out in a timely and efficient manner. Overwhelmingly, situations requiring Remediation would be considered Serious Reportable Incidents (see Incident Reporting Policy). Such events must be catalogued by both the State and provider to understand whether they are isolated events or if a pattern has developed. If patterns are identified, there must be improvement, which may result in program-wide policy changes.

Improvement on a system-wide basis is also essential in order for the waiver to respond to changes in the healthcare and other environments. Resource and reimbursement concerns, along with the shifting interests and needs of participants and providers, must be considered as the waiver continues to mature and grow. New barriers and concerns may evolve and must be managed. System-wide improvements, clarifications or changes to existing policies and procedures will impact the other two components of the QMP – Discovery and Remediation. These improvements may also be reflected in changes to the basic waiver design or to its policies and procedures. Often, the system-wide improvements being sought are based on the recognition that there are faults within the Discovery or Remediation functions that cannot be corrected in any other way. This type of self-correcting closed loop model of improvement, where feedback from the system is used to initiate changes in that system, provides the opportunity for an ongoing quality

improvement process.

By continuous evaluation of the HCBS/TBI waiver, we can meet our assurances to CMS as well as the requirements described in this Manual. There is a need to segment the activities associated with the waiver into specific focus areas to understand its effectiveness.

These focus areas are:

- I. **Participant Access - Desired Outcome:** Individuals have ready access to appropriate home and community-based services and supports in their communities.
- **Information/Referral - Desired Outcome:** Individuals and families can readily obtain information concerning the availability of the waiver and the application process. When necessary, additional referrals are made.

Process: Each RRDS is responsible for tracking information about referrals made to them within their region. It is expected that an appointment with the potential waiver participant will be scheduled within two weeks of receiving the referral. Information to be tracked includes the following:

Measure:

- a. Number of referrals received;
 - b. Appropriateness of referrals;
 - c. Reasons for a referral being inappropriate;
 - d. Source of referrals;
 - e. Referrals to other community resources for individuals not eligible for the waiver;
 - f. Follow-up response time from initial call; and
 - g. The time elapsed from time of request to time of appointment to meet the potential waiver participant. (It is expected that setting up this appointment will be accomplished within two weeks of receiving the referral.)
- **Intake and Eligibility - Desired Outcome:** Intake and non-financial eligibility processes are understandable and user-friendly to individuals and families and there is assistance available in applying for the waiver.

Process: The RRDS presents the potential waiver participants with the “Understanding of the HCBS/TBI Waiver Process” form during the initial interview. Signing this form indicates that the potential waiver participant understands the enrollment process, the philosophy of the waiver, and the services and supports available through the waiver.

Measure: An Understanding of the HCBS/TBI Waiver Process form, signed by the participant, is maintained in each participant file.

- **Eligibility Determination - Desired Outcome:** Each individual’s needs and non-financial eligibility for HCBS are assessed and determined promptly.

Process: THE RRDS will track whether, after being selected, the Service Coordinator submits an Application Packet within sixty (60) calendar days. The RRDS has 15 working days to review the application and determine if the request can be approved. If not approved the RRDS must provide written feedback regarding what must be changed in order to approve the application. It is expected that corrections required by the Service Coordinator will be submitted to the RRDS within 15 working days. Total turn-around time for waiver eligibility determination should be less than 90 days from the time a Service Coordinator is selected to the final RRDS approval.

Measure: Total turn-around time from Service Coordinator selection to approval.

- **Referral to Community Resources - Desired Outcome:** Individuals who need services but who are not eligible for the waiver are referred to other community resources.

Process: The RRDS is responsible for determining non-financial eligibility for the waiver and for referring ineligible individuals to other resources within the community. Referrals determined ineligible for the waiver must be tracked by each RRDS as noted above in the Information/Referral section.

Measure: Provision of referrals made within two days from initial call where it is immediately apparent the individual is not eligible, e.g., the individual is under age 18.

- **Individual Choice of HCBS - Desired Outcome:** Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.

Process: Service Coordinators are responsible for including a signed Freedom of Choice form in each Application Packet. This form confirms that the individual has chosen to live in the community and receive waiver services instead of residing in a nursing home.

Measure: A Freedom of Choice form, as well as the waiver application packet, signed by the participant, is maintained in each participant's file.

- **Prompt Initiation - Desired outcome:** Services are initiated promptly when the individual is determined eligible for and elects to participate in the HCBS waiver.

Process: Service Coordinators are responsible for assuring that each waiver service begins on the date specified in the Service Plan.

Measure: Date of service initiation matches the start date in the Service Plan.

II. Participant-Centered Service Planning - Desired Outcome: Services and supports are planned and implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

- **Assessment - Desired Outcome:** Comprehensive information concerning each participant's preferences, personal goals, needs, abilities, health status and available supports is gathered and used in developing an individualized Service Plan.

Process: The Service Coordinator is responsible for working with the waiver participant to develop a Service Plan, which contains the comprehensive information noted above. All Service Plans must include information related to health and welfare issues and this information must be considered in the development of the Service Plan.

Each waiver service provider is responsible for developing a Detailed Plan for his/her service which is also based on the waiver participant's goals and preferences. The Service Coordinator is responsible for reviewing the Service Plan with the participant each time they meet and each waiver service provider is responsible for reviewing the Detailed Plans with the waiver participant on an ongoing basis. A more formal review occurs prior to the development of the next Service Plan. By signing both the Service Plan and the Detailed Plans, each waiver participant is acknowledging that these Plans represent his/her desired outcomes.

Measure: Service Plans and Detailed Plans, signed by the participant, are maintained in each participant's file.

- **Participant Decision Making - Desired Outcome:** Information and support is available to help participants make informed selections among service options.

Process: Initially, the RRDS provides the waiver participant with a list of all approved Service Coordinators. The Service Coordinator is responsible for providing the waiver participant with objective information regarding the type of waiver services available and the approved providers of each service. Team Meetings must occur at every Service Plan revision to assure participant involvement.

Measure:

- A Service Coordinator Selection form and Participants' Rights and Responsibilities form, signed by the participant, are maintained in each participant's file.
 - Service Coordinator documentation of Team Meetings, occurring a minimum of every six months, is maintained.
- **Free Choice of Providers - Desired Outcome:** Information and support is available to assist participants in freely choosing among qualified providers.

Process: The RRDS is responsible for ensuring that participants sign a Service Coordinator Selection form during the application process, indicating that they have been informed of all approved providers within their region. In the Participant's Rights and Responsibilities form, which is signed annually by the waiver participant, is a

description of the participant's right to choose and change providers. The Service Coordinator is responsible for assuring that the participant knows about his/her ability to choose and/or change providers, and assists the waiver participant in doing so.

Measure: A Service Coordinator Selection form and Participants' Rights and Responsibilities form, signed by the participant, are maintained in each participant's file.

- **Service Plan - Desired Outcome:** Each participant's Plan comprehensively addresses his or her identified need for waiver, health care and other services in accordance with his or her expressed personal preferences and goals.

Process: Each Service Plan is signed by the waiver participant and anyone who participated in its development, indicating approval of its contents. Team Meetings must occur when a Revised Plan is submitted. The RRDS reviews all Service Plans for completeness, focusing on issues of health and welfare, the inclusion of the waiver participant's goals, continued eligibility for the waiver, and each service requested.

Measure: A Service Plan and Participants' Rights and Responsibilities form, signed by the participant, are maintained in each participant's file.

- **Participant Direction - Desired Outcome:** Participants have the authority to and are supported to direct and manage their own services to the extent they wish and are able.

Process: The Service Coordinator and other waiver providers include the waiver participant, and anyone he/she chooses, in the development of each Service Plan and each Detailed Plan. Throughout these processes the waiver participant is supported and encouraged to lead and fully participate in the process. The waiver participant attends Team Meetings when a Revised Service Plan is to be developed.

Measure:

- Service Plans and Detailed Plans, signed by the waiver participant, are maintained in each participant's file.
 - A participant's presence/absence at Team Meetings is documented in the Service Coordinator's notes.
- **On-going Service Delivery and Support Coordination - Desired Outcome:** Participants have continuous access to assistance as needed to obtain and coordinate services and to promptly address issues encountered in community living.

Process: In their meetings with participants, Service Coordinators are responsible for the ongoing review of all Service Plans to determine if the services are being delivered as set forth in the Service Plan and if these services are assisting the waiver participant to assure his/her health and welfare, and are meeting his/her goals. A more formal review occurs at the time of the development of a Revised Service Plan or Addendum.

It is the responsibility of the Service Coordinator to work with the waiver participant to make needed changes in the type and/or amount of services and to assure the services are on-time and received in a timely manner. The RRDS reviews all Service Plans to assure that the frequency of Service Coordination matches the participant's needs.

Measure:

- Participants complete participant satisfaction surveys documenting whether or not they are satisfied with their Service Coordinators.
 - Documentation of meetings, as specified in the Service Plan, is kept in Service Coordination notes.
- **Service Provision - Desired Outcome:** Services are furnished in accordance with the participant's Plan.

Process: All waiver service providers are responsible for monitoring service provision in the following areas: compliance with the Service Plan, amount and type of service approved; presence of staff as stated in Service Plan; activities mirror those outlined in the Detailed Plans; Plan for Protective Oversight is followed; documentation of interaction with the participant and other waiver providers as described in the Program Manual; and staff supervision is provided according to the Program Manual and in accordance with best practices.

Measure: Services provided to the participant match those outlined in the Service Plan.

- **Ongoing Monitoring - Desired Outcome:** Regular, systematic and objective methods - including obtaining the participant's feedback - are used to monitor the individual's well being, health status, and the effectiveness of the waiver in enabling the individual to achieve his or her goals.

Process: Service Coordinators meet with waiver participants as prescribed in the Service Plan. These meetings must occur in the participant's home on a quarterly basis. A Housing Standards Checklist must be completed by the Service Coordinator on an annual basis for individuals receiving a HCBS/TBI Housing subsidy. The RRDS reviews Service Plans when they are submitted. Each service provider reviews the Detailed Plan with the participant on an ongoing basis, and when an Individual Service Report for the Revised Service Plan or an Addendum is to be submitted. Providers are responsible for soliciting feedback from participants on no less than an annual basis, using standardized satisfaction survey tools and monitoring tools. If the participant needs assistance in completing the survey, someone other than the provider soliciting the feedback must provide this assistance.

Measure:

- Documentation of quarterly meetings in the participant's home is maintained.
- Service Coordinators complete a Housing Standards Checklist on an annual basis for individuals receiving a HCBS/TBI Housing subsidy.

- Analysis of participant satisfaction is completed on an annual basis.
- **Responsiveness to Changing Needs - Desired Outcomes:** Significant changes in the participant's needs or circumstances require prompt consideration of modifications to his or her Service Plan.

Process: Providers must record in the participant's chart that significant changes in participant needs have been addressed. When an Addendum is necessary, it is submitted in a timely manner. Revised Service Plans are developed at six month intervals, describing the changes in the participant's life during that period of time. The request for waiver services must reflect the participant's current and expected needs for the next six months.

Measure:

- A Revised Service Plan is developed every six months and signed by the participant, indicating his/her approval.
- Participant satisfaction surveys, completed annually, raise issues and complaints with service provision.

III. Provider Capacity and Capabilities- Desired Outcome: There are sufficient waiver providers, and they possess and demonstrate the capability to effectively serve participants.

- **Provider Networks and Availability - Desired Outcome:** There are sufficient qualified providers to meet the needs of participants in their communities.

Process: Sufficiency of providers is measured by each RRDS and reported in quarterly reports. The RRDS is responsible for raising issues with the Department of Health which directly relate to how policies and procedures impact the availability of a sufficient number of qualified providers.

Measure:

- Number of participants on provider waiting lists.
- Each RRDS submits required quarterly reports.
- **Provider Qualifications - Desired Outcome:** All waiver providers possess the requisite skills, competencies and qualifications to support participants effectively.

Process: Each provider maintains the documentation required by the Program Manual dealing with personnel records and training. Each RRDS will provide certificates of attendance to all providers who attend RRDS-organized training sessions, and providers will keep such documentation in personnel files. Providers will use pre and post testing to assure that the staff has acquired the information presented in any provider presented training. Supervision provides an opportunity for the supervisor to judge the staff members' level of skill and competence and need for additional training and support. Surveys and audits will be conducted by DOH to assure that only qualified providers are working with the waiver participants.

Measure: Documentation of staff qualifications and training attended are maintained in personnel files.

- **Provider Performance - Desired Outcome:** All waiver providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's Service Plan.

Process: Providers formally review the Detailed Plan prior to the submission of the next Individual Service Report or the Revised Plan, tracking the extent to which participants have met goals established in prior Service Plans (effectiveness), and that these goals have been met within established timeframes (efficiency). It is suggested that an 80% achievement rate for each of these measures (% goals met, timeframes met) be considered acceptable performance. In addition, participant satisfaction surveys, administered by the providers and DOH, provide information about the effectiveness of waiver services on both a micro and macro level.

Measure:

- Percentage of goals achieved and timeframes met.
- High rates of participant satisfaction with services.
- Provider response to the results of the participant satisfaction surveys.

IV. Participant Safeguards - Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

- **Risk and Safety Planning - Desired Outcome:** Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with the informed involvement of the participant.

Process: A Plan for Protective Oversight is prepared every time a Service Plan or Addendum is developed. The Service Coordinator and the waiver team are responsible for assuring that the activities outlined in the Plan for Protective Oversight promote independence and safety with the informed involvement of the participant.

Measure:

- A Plan for Protective Oversight, signed by the participant, is maintained in each participant's file.
 - Documentation of staff training on the Plan for Protective Oversight.
- **Critical Incident Management - Desired Outcome:** There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.

Process: Safeguards are outlined during Service Plan and Plan for Protective Oversight development. The Incident Reporting Policy describes procedures for the reporting, investigation, and response to critical events. Providers complete an Annual Incident Trend Report.

Measure:

- A Plan for Protective Oversight, signed by the participant, is maintained in each participant's file.
 - Documentation that staff is trained on incident reporting policies and procedures as well as emergency management.
- **Housing and Environment - Desired Outcome:** The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.

Process: The Service Coordinator completes a Housing Standards Checklist annually for each participant receiving a HCBS/TBI Housing subsidy. The Service Coordinator is required to meet with the waiver participant no less than on a quarterly basis in the participant's home.

Measure:

- A Housing Standards Checklist completed annually by the Service Coordinator for each participant receiving a HCBS/TBI Housing subsidy.
 - Documentation of Service Coordinator meetings, on a quarterly basis, with the participant in their home.
- **Behavior Interventions - Desired Outcome:** Behavior interventions - including chemical and physical restraints - are only used as a last resort and subject to rigorous oversight.

Process: Use of any restraint is a Serious Reportable Incident. Detailed Plans for an Intensive Behavior Program, signed by the participant, are included in all Service Plans or Addendums. These Plans contain crisis intervention methods. There is a Statewide Neurobehavioral Resource Project which is available for consultation and technical assistance in those situations with concern about the participant's health and welfare.

Measure:

- Documentation of staff training on Serious Reportable Incidents.
 - Evidence of detailed Behavior Plan with physical/chemical restraints as last resort.
 - Evidence of training on a participant's Behavior Plan.
 - Evidence of consultation with the Statewide Neurobehavioral Resource Project, when indicated.
- **Medication Management - Desired Outcome:** Medications are managed effectively and appropriately.

Process: The management of each waiver participant's medication is described in the Service Plan. Service Coordinators and RRDSs review Service Plans for changes in medications or overall health status. All waiver staff must be trained to observe changes in the participant's general health and cognitive status and to request a medical evaluation if

significant changes are noted. Serious Reportable Incidents are filed when the waiver participant is hospitalized due to a medication error.

Measure:

- The Service Plan, signed by the participant, is maintained in each participant's file.
- Evidence of staff training on the signs/symptoms of participants not taking their medication as directed.
- Evidence of staff noting concerns about a participant's change in medication taking practices.
- **Natural Disasters and Other Public Emergencies - Desired Outcome:** There are safeguards to protect and support participants in the event of natural disasters or other public emergencies.

Process: These are addressed during development of the Plan for Protective Oversight. In addition, provider agencies are responsible for creating/maintaining disaster plans.

Measure:

- A Plan for Protective Oversight, signed by the participant, is maintained in each participant's file.
- Provider agencies have written disaster plans in place.

V. Participant Rights and Responsibilities - Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities.

- **Civil and Human Rights - Desired Outcome:** Participants are informed of and supported to freely exercise their fundamental constitutional and federal or State statutory rights.

Process: Each provider is responsible for ensuring that participants sign a copy of the Participants' Rights and Responsibilities form on an annual basis. A copy of this form is located in the participant's file at each provider agency.

Measure: A Participants' Rights and Responsibilities form, signed by the participant, is maintained in the participant's file and is updated annually.

- **Participant Decision-Making Authority - Desired Outcome:** Participants receive training and support to exercise and maintain their own decision-making authority.

Process: All waiver staff must be trained to assist the participant to make key decisions about the goals for each waiver service, and this is reflected in the Detailed Plans. The participant's signature on the Service Plan, Plan for Protective Oversight, and Detailed Plan demonstrate consistency between the participant's stated goals and the interventions provided by staff. Participants' satisfaction, which is often a reflection of the level of control they have over their lives, is monitored through participant satisfaction surveys.

Measure: The Service Plan, Plan for Protective Oversight, and Detailed Plans, each signed by the participant, are maintained in the participant's file.

- **Alternate Decision Making Authority - Desired Outcome:** Decisions to seek guardianship, surrogates or other mechanisms that take authority away from participants are considered only after a determination is made that no less intrusive measures are or could be available to meet the participant's needs.

Process: All team members assist the waiver participant to maintain decision-making authority. In situations where there may be a need to seek alternative authority for decision-making, the waiver providers will meet with the RRDS to determine the appropriateness of pursuing such an action. If there is a person other than the participant who has decision-making authority, that individual is listed in the Service Plan and Plan for Protective Oversight.

Measure:

- Documentation is maintained of any discussion surrounding decision-making authority.
 - Indication that the participant was advised of his/her right to challenge guardianship and resources for appeal.
 - A Plan for Protective Oversight, signed by the participant, is maintained in the participant's file.
- **Due Process - Desired Outcome:** Participants are informed of and supported to freely exercise their due process rights.

Process: Fair hearing information is issued to the participant with each Notice of Decision. The waiver participant can request an Administrative Meeting to discuss programmatic decisions prior to moving to a more formal Fair Hearing.

Measure:

- Fair hearing information is given to the participant.
 - Documentation of notice of formal and informal right of appeal.
- **Grievances - Desired Outcome:** Participants are informed of how to register grievances and complaints and are supported in seeking resolution. Grievances and complaints are resolved in a timely fashion.

Process: Waiver provider agencies are responsible for informing participants of their own grievance policies and procedures, which is measured through the provider grievance process and monitored by a toll free complaint hotline report.

Measure:

- Provider agencies have a grievance policy and procedure and make the process known to participants.
- Toll-free complaint hotline report.

VI. Participant Outcomes and Satisfaction - Desired Outcomes: Participants are satisfied with their services and achieve desired outcomes.

- **Participant Satisfaction - Desired Outcome:** Participants and family members, as appropriate, express satisfaction with services and supports.

Process: Participant satisfaction surveys, part of the waiver provider's self monitoring process, are used by each provider on at least an annual basis for each participant receiving services. The Department reviews these surveys to identify potential issues. DOH also has a process for assessing participant satisfaction and tracks the following outcomes: hospitalizations; reasons a participant leaves the waiver program; and deaths.

Measure: Participant satisfaction survey completed on an annual basis.

- **Participant Outcomes - Desired Outcome:** Services and supports lead to positive outcomes for each participant

Process: Providers maintain documentation of participant outcomes. Such documentation may be in the form of standardized outcome measurements (e.g., Community Integration Questionnaire), or documentation of success in goal attainment from one Service Plan period to the next. Review of notes, Individual Services Reports and Detailed Plans are completed to determine if the participant's goals were met.

Measure:

- Goal attainment from one Service Plan or Detailed Plan to the next.
- Goals outlined in each Individual Service Report.

VII. System Performance - Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality.

- **System Performance Appraisal - Desired Outcome:** The service system promotes the effective and efficient provision of services and supports by engaging in systemic data collection and analysis of program performance and impact.

Process: RRDS meet regularly with provider groups and train the providers in the effective and efficient use of waiver services. RRDS review all Service Plans for appropriate and effective use of all services. Participant surveys provide data concerning the effectiveness of services, which is analyzed in order to assist in determining areas of needed intervention and training. Retrospective reviews of either

the participant's complete file or latest Service Plans assist the RRDS in evaluating the effectiveness of waiver services.

Measure:

- Number of calls to the Hotline.
 - Quarterly RRDS reports.
 - DOH review of the service system on an ongoing basis.
- **Quality Improvement - Desired Outcome:** There is a systemic approach to the continuous improvement of quality in the provision of waiver services.

Process: The RRDS meet with DOH to evaluate the waiver and identify ways to improve its efficiency and effectiveness. The RRDS, through calls and e-mails, provide DOH with information about barriers that prevent the waiver from reaching its goals. The feedback that RRDS provide to Service Coordinators with each Service Plan is a primary vehicle for quality improvement. The Serious Reportable Incident database assists the Department in understanding the types of incidents that most regularly occur and which providers are involved.

Measure: DOH reviews the system and waiver design on an ongoing basis.

- **Cultural Competency - Desired Outcome:** The waiver system effectively supports participants of diverse cultural and ethnic backgrounds.

Process: All populations regardless of culture/ethnicity are served by the waiver. The RRDS seeks to enroll providers who have cultural competencies. Where necessary, participants have access to services in other languages.

Measure:

- Documentation of staff training on cultural issues.
 - The Service Plan incorporates cultural practices and evidence of follow-through exists.
- **Participant and Stakeholder Involvement - Desired Outcome:** Participants and other stakeholders have an active role in program design, performance appraisal and quality improvement activities.

Process: RRDS receive feedback from providers and, in turn, inform DOH about concerns regarding the waiver's policies and procedures. DOH staff is accessible to participants, advocates, providers, and others. DOH staff visits regions each year. The toll-free complaint hotline provides an opportunity for participants and advocates to voice concerns. The participant satisfaction survey used by the waiver also provides feedback from participants.

Measure: DOH receives input from stakeholders on an ongoing basis.

- **Financial Integrity - Desired Outcome:** Payments are made promptly in accordance with program requirements.

Process: The eMedNY system pays providers who submit valid claims in a timely manner. The Department's fiscal agent, eMedNY, assists providers when they have concerns about payment processes.

Measure:

- Evaluation of claims payment records.
- DOH has a process to handle late payments and uses it effectively.

Self Monitoring

Under the waiver's QMP, it is incumbent upon waiver providers to understand their customers' (the participants, the RRDS and the State's waiver management staff) perception of the quality of services delivered. This feedback is essential if the provider is to consistently maintain or improve its ability to successfully serve participants. Self-assessment tools provide a base for gathering this information. The provider is responsible for obtaining the following information:

1. The participant's level of satisfaction regarding the services provided;
2. The success of a provider in delivering services that meet the agreement established in the Service Plan (staff is able to make appointments, be on time and provide services as agreed upon); and
3. An annual report, examining the number and types of incidents which occurred, including an analysis of these incidents and the provider's response to the incidents.

Each waiver service provider must develop and implement a policy for responding to complaints raised by participants, their families or advocates. This process must be clearly written and easy to navigate.

The complaint policy must include:

1. A description of how to register a complaint and who is responsible for receiving and responding to the complaint;
2. A time frame for providing a written response to the complainant (maximum 30 days from initial complaint);
3. An appeal process, including timeframes, if the person who registered the complaint is not satisfied with the response (to be completed in no more than 15 days from notice from the complaint); and
4. A further appeal process, in which all of the relevant information is forwarded to the RRDS, who will assist in resolving the difficulties (to be completed in no more than 15 days from receipt of the information).

If the RRDS is not able to resolve the difficulties, the matter will be forwarded to the DOH waiver management staff for review and final resolution.

There may be times when a complaint must be converted to a Serious Reportable Incident report. A provider must inform the individual filing the complaint that this has occurred and the decision to convert the complaint and the incident review process must be documented.

Quality Management Program Activities

There are many policies and processes associated with the HCBS/TBI waiver that are components of the QMP. Within these processes are embedded activities, which are essential for assuring quality within the waiver. Other policies are developed to meet the requirements for a comprehensive QMP.

The components of the QMP include:

1. HCBS/TBI Waiver Program Manual

The Manual includes the definitions of each waiver service, provider qualifications, required training, and policy and procedure standards for quality assurance and incident reporting. Any time revisions or additions are made to the waiver's policies or procedures; a copy is forwarded to all providers and RRDS. The original Manual was developed in 1995.

2. RRDS Interview with Potential Participants

The RRDS is responsible for meeting with all individuals in their region who are interested in receiving services through the HCBS/TBI waiver. During this interview the RRDS explains the philosophy of the waiver and the services available. An important part of the interview process includes a preliminary assessment of the potential participant to determine if the individual meets the established eligibility criteria of the waiver.

3. Participants' Choice of Waiver Services and Providers

Potential participants are informed by the RRDS of their right to choose between being a nursing home resident or participating in the waiver. Those selecting the waiver are provided with a list of approved Service Coordinators. It is the responsibility of the Service Coordinator to assist the individual in establishing goals and selecting service providers appropriate for accomplishing these goals. A list of selected services and providers is included in a detailed individualized Service Plan as part of the Application Packet submitted to an RRDS for acceptance into the HCBS/TBI waiver.

4. Participant Satisfaction Survey

All approved providers are required to conduct an annual survey of the waiver participants' satisfaction. This survey focuses on the satisfaction of the participant with the waiver services provided. Providers are required to review all surveys and address recommendations and concerns expressed by the participants. The RRDS or the Department may follow-up on any information included in the survey.

5. Provider Self-Monitoring Tools

All providers are required to implement a self-monitoring process to assess the provision of waiver services. This assessment serves as a basis for identifying areas where revisions to providers' policies and procedures may be indicated.

6. Fair Hearing Rights

Participants are informed of their Medicaid Fair Hearing Rights with any Notice of Decision, including denial of their application, denial of requested provider, reduction in services, or termination from the waiver. An informal discussion (Administrative Meeting) is offered to explain the reasoning behind a decision and negotiate an agreement prior to the Fair Hearing.

7. Participants' Rights Form

The Service Coordinator will inform each participant of his/her rights and responsibilities under this waiver. The list of Participants' Rights and Responsibilities will be provided to the participant at each Service Plan review and can be referred to when there are questions or concerns. Both the participant and Service Coordinator sign the form and the participant receives a copy.

8. Contact Sheets

Each participant is given a listing of names and phone numbers of staff, the staff's supervisor, the RRDS, and DOH waiver management staff in case any concerns arise.

9. RRDS Interview with Potential Waiver Service Providers

All potential waiver providers are interviewed by the RRDS using a standardized process to evaluate the qualifications of the provider and their ability to meet the needs of the participants. Each service to be provided is reviewed and approved separately. During the interview process, the RRDS provides information on the philosophy and services of the waiver. The RRDS makes recommendations to DOH, which is responsible for the final decision regarding approval of the potential provider.

10. Surveillance of Providers

Providers are surveyed by the Department on a regular basis. The survey focuses primarily on the providers' compliance with policies described in the Program Manual.

11. Suspension and Termination of Providers

DOH has the right to suspend providers from providing services to new participants or terminate the Provider Agreement if the provider is unable to fulfill its responsibilities and obligations.

12. Review of Service Plans

RRDSs review all Service Plans at least every six months to assure that adequate and appropriate services are provided to maintain the participants' health and welfare and meet the participants' goals.

13. Retrospective Review of Service Plans

Waiver management staff is responsible for the retrospective review of Service Plans. The Service Plans reviewed are selected either randomly or based on specific concerns regarding activities with a region, provider, or service. The percentage reviewed is based upon established agreements between the State and federal government

14. Participants' Signature On Service Plans

Participants must sign all Service Plans, assuring that the participant agrees with the information included in the Service Plan. This information includes the services requested and the providers of the services.

15. Plan for Protective Oversight

A Plan for Protective Oversight form is included in every Service Plan. This form outlines responsible individuals involved in the Service Plan.

16. Assuring Timely Submission of Service Plans

The waiver has a process to alert the Service Coordinator that a Service Plan is late. Continuous problems with the timely submission of Service Plans can lead to suspension or termination of the provider.

17. Addendum to Service Plan

This process provides the Service Coordinator an opportunity to request a change to an approved Service Plan, which reflects a need for a different mix of waiver services. The Addendum is used when a waiver service is to be increased, decreased, added or discontinued.

18. Incident Reporting Policy

This policy defines the various types of incidents, procedures, timelines and standardized forms for reporting these events, and outlines the providers' responsibilities for investigation and resolution of all incidents.

19. Housing Guidelines

The HCBS/TBI Housing Guidelines were established to ensure that participants who receive HCBS/TBI rental subsidies obtain affordable, accessible housing that is in good repair. The Guidelines describe the policies and procedures for locating and maintaining affordable and accessible rental housing for HCBS/TBI waiver participants and contain a complete set of HCBS/TBI housing application forms and instructions for completion. This policy is not included in the Program Manual, but is available as a separate document. Training regarding the guidelines and the application process are conducted in each region at least annually.

20. Examination of Claim Detail Reports

The Department has the ability to examine the Claim Detail reports of a participant. This report is an accounting of all Medicaid expenditures for services provided to a participant. This report may be compared to the Service Plan to identify

discrepancies between services approved, provided and billed to Medicaid.

21. Coordination with Other State Agencies

The Department and HCBS/TBI waiver staff have developed relationships with other State agencies and organizations that regulate or provide services and supports to HCBS/TBI waiver participants and other special needs populations in the community. Through communication with agencies such as the Office of Mental Retardation and Developmental Disabilities, Vocational and Educational Services for Individuals with Disabilities, and Office of Alcohol and Substance Abuse Services, the HCBS/TBI waiver is aware of available services and the quality of providers, and can facilitate coordination and promote the most effective and efficient use of all available services.

22. Neurobehavioral Training for Providers

DOH has a contract to provide consultation and training to any HCBS/TBI waiver provider needing assistance with intensive behavioral problems. Services include technical assistance, training and individual Service Plan review.

23. Best Practice Conferences

DOH presents Best Practice Conferences. Attendees include providers, participants, advocates and related State agencies. Conferences offer numerous training workshops and opportunities for networking and advocacy.

24. DOH Technical Assistance to RRDS

HCBS/TBI waiver management staff are available to the RRDS to address questions regarding the waiver, provision of services and management of participants.

25. RRDS Quarterly Meetings with DOH

All RRDS meet with HCBS/TBI waiver management staff on a quarterly basis. New policies or program changes are presented, training is provided, and common problems are discussed.

26. RRDS Technical Assistance to Providers, Waiver Participants and Family Members

All RRDS schedule at least eight (8) trainings per year with providers in their region. This is an opportunity for training and for the introduction and clarification of waiver policies. In addition, RRDS are available to provide technical assistance to individual agencies to address any problems or concerns that may arise. The RRDS is also available to participants and family members who have questions or concerns regarding the HCBS/TBI waiver and services.

27. Accessibility of DOH Waiver Management Staff

The waiver management staff visits regions regularly and are accessible to participants, advocates and providers via phone, e-mail or in person.

28. Policy Clarification Letters

When there is a change in statewide policy or procedure, letters are sent to

providers and RRDS to describe these new policies. Letters clarifying existing policies are also sent when necessary.

29. Coordination with Local Departments of Social Services

Through communication and collaboration with local departments of social services, the HCBS/TBI waiver can facilitate coordination and promote the most effective and efficient use of all available services. DOH sends the local Departments of Social Services directives regarding changes in policies related to the waiver.

30. Technical Amendment Requests to CMS

Any policy changes related to the agreement between the State and CMS must be submitted to CMS in a letter requesting a technical amendment to the waiver. These include the development of a new waiver service, modifying the definition of a waiver service, or amending the qualifications of a provider.

31. Clinical Consultant

DOH has a contract to provide consultant services which assist DOH with all aspects of quality management activities including investigations and RRDC and provider oversight.

32. Waiver Complaint Hotline

A toll-free number is available for waiver participants and others to lodge complaints and express concerns about the HCBS/TBI waiver.

Section X

Incident Reporting Policy for Waiver Providers

Background and Intent

This section describes waiver provider agency responsibilities for reporting, investigating, reviewing and tracking two categories of incidents involving individuals in the HCBS/TBI waiver. Serious Reportable Incidents, which must be reported to DOH in accordance with Section III of this Policy, and Recordable Incidents, which must be reported, investigated and tracked within the provider agency in accordance with Section VII. All HCBS/TBI waiver service providers are subject to this policy and reviews of their compliance.

The HCBS/TBI waiver staff must be informed of serious incidents and the providers' response to these incidents in order to:

1. Assist the HCBS/TBI waiver staff in their role as an external monitor to ensure the quality of care provided to participants and to maintain the participants' health and welfare as outlined in the State's agreement with the federal government.
2. Assist the HCBS/TBI waiver staff to establish a database that documents trends and identifies specific areas of concern. This information assists the HCBS/TBI waiver to identify and develop training and policies aimed at increasing provider skills in the prevention, identification, and investigation of incidents.
3. Assist providers to recognize trends in incidents within their agencies, take corrective measures to minimize the probability of a recurrence of the same or similar situations, and to develop and implement appropriate staff training programs.

Serious Reportable Incidents

Serious Reportable Incidents are defined as any situation in which the participant experiences a perceived or actual threat to his/her health and welfare or to his/her ability to remain in the community. These incidents must be reported to DOH via the appropriate RRDS using the process outlined in Section III of this policy. Some of these incidents must also be reported to Adult Protective Services and the police.

Serious Reportable Incidents include:

1. Allegations of Abuse and Neglect are defined as the maltreatment or mishandling of a participant which would endanger his/her physical or emotional well-being through the action or inaction on the part of anyone, including but not limited to, any employee, intern, volunteer, consultant, contractor, or visitor of any HCBS/TBI waiver provider, or another participant, family member, friend, or others, whether or not the participant is or appears to be injured or harmed.

Types of allegations of abuse and neglect must be classified as follows:

- a. Physical Abuse is defined as physical actions such as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of physical interventions, or other mishandling of a participant. Physical

contact that is not necessary for the safety of the person and causes discomfort to the participant or the use of more force than is reasonably necessary is also considered to be physical abuse.

Situations where physical intervention is used to assure the health and welfare of the participant or others must also be reported as a Serious Reportable Incident.

- b. Sexual Abuse is defined as any sexual contact between a participant and any employee, intern, volunteer, consultant, contractor or visitor of the HCBS/TBI waiver provider providing services to the participant. Sexual abuse may also occur with any other person living in the community if it is non-consensual or if, according to New York State law, the participant is not competent to consent. Sexual contact is defined as the touching or fondling of the sexual or other body parts of a person for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. Sexual contact also includes causing a person to touch someone else for the purpose of arousing or gratifying personal sexual desires. Forcing or coercing a participant to watch, listen to, or read material of a sexual nature is also considered sexual abuse. A situation in which one participant has a sexual contact with another participant, who is either not capable of consent to or did not agree to participate in the relationship, is considered to be a Serious Reportable Incident.
- c. Psychological Abuse is defined as the use of verbal or nonverbal expressions that subject the participant to ridicule, humiliation, scorn, contempt or dehumanization, or are otherwise denigrating or socially stigmatizing. Use of language and/or gestures and a tone of voice, such as screaming or shouting at or in the presence of a participant, may in certain circumstances constitute psychological abuse.
- d. Seclusion is defined as the placement of the waiver participant alone in a locked room or area from which he/she cannot leave at will, or from which his/her normal egress is prevented by someone's direct and continuous physical action.

The act of seclusion should not be confused with a limited quiet time procedure. Quiet time is a procedure in which a HCBS/TBI waiver participant is accompanied by staff away from an activity for a brief period of time to help the participant recompose him/herself. In removing the participant from ongoing activity, the objective is to offer a changed environment in which the individual may calm down. The use of quiet time is not considered to be an incident unless it is excessive or used as a punishment.

- e. Unauthorized or Inappropriate Use of Restraint is defined as:
 - The use of a mechanical restraining device to control a participant

without the written, prior authorization of a physician if the physician cannot be present within 30 minutes;

- The use of a mechanical restraining device without it being specified in a Service Plan;
- The use of restraint for medical purposes without a physician's order; or
- The intentional use of a medication to control a person's behavior that has not been prescribed by a physician for that purpose.

Inappropriate use of a restraint shall include, but not be limited to, the use of a device(s) or medication for convenience, as a substitute for programming, or for disciplinary (punishment) purposes.

- f. Use of Aversive Conditioning is defined as the use of unpleasant or uncomfortable procedures when trying to change the behaviors of a participant.
 - g. Violation of Civil Rights is defined as action or inaction that deprives a participant of the ability to exercise his or her legal rights, as articulated in State or federal law (e.g., the Americans with Disabilities Act).
 - h. Mistreatment is defined as a deliberate decision to act toward the participant in a manner that goes against that person's individual human rights, the Service Plan, or that is not generally considered acceptable professional practice.
 - i. Neglect is defined as a condition of deprivation in which a participant's health and welfare is jeopardized because of inconsistent or inappropriate services, treatment or care which does not meet their needs, or failure to provide an appropriate and/or safe environment. Failure to provide appropriate services, treatment or medical care through gross error in judgment and inattention is considered to be a form of neglect. For example, neglect occurs if a Service Coordinator is aware that an agency listed in a Service Plan cannot provide the requested services, but does not seek an alternate waiver provider to meet the participant's needs.
2. Missing Person is defined as unexpected absence of a participant from his/her home or scheduled waiver service. It is mandated that formal search procedures be initiated immediately upon discovery of the absence of a participant whose absence constitutes a recognized danger to the well being of that individual or others. For others, consideration should be given to the missing person's habits, deficits, capabilities, health problems, etc. in making the decision of when to begin a formal search, but this must be initiated no more than 24 hours after the participant has been missing.
 3. Restraint is defined as the act of limiting or controlling a person's behavior through the use of any device which prevents the free movement of any limb as ordered by

a physician; any device or medication which immobilizes a person, as ordered by a physician; any device which is ordered for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a physician which renders the participant unable to satisfactorily participate in services, community inclusion time or other activities.

NOTE: This does not preclude the use of mechanical supports to provide stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous fluids or other medically necessary procedures.

4. Death of a Participant is defined as any loss of life, regardless of cause. The follow-up report of the investigation submitted to the RRDS must include information concerning the death, medical records, death certificate, police reports, autopsy reports, EMS records, emergency room records and any other information deemed relevant.
5. Hospitalization is defined as any unplanned admission to a hospital.

NOTE: The planned overnight use of a hospital for any procedure is not considered a Serious Reportable Incident, but should be noted in the subsequent Revised Service Plan.

6. Possible Criminal Action is defined as any action by a participant that is or appears to be a crime under New York State or federal law.
7. Sensitive Situation is defined as any situation which needs to be brought to the attention of DOH, through the RRDS office, as expeditiously as possible, and does not fit within the categories described above. This includes any situation that would threaten the participant's ability to remain in the community or the health and welfare of the participant, such as the admission to a psychiatric facility/unit or substance abuse facility/unit.
8. Medication Error/Refusal is defined as any situation in which a participant experiences marked adverse reactions which threaten his/her health and welfare due to: refusing to take prescribed medication; taking medication in an incorrect dosage, form, or route of administration; taking medication on an incorrect schedule; taking medication which was not prescribed; or, the failure on the part of waiver staff to properly follow the plan for assisting the participant in self-medication.
9. Medical Treatment Due to Accident or Injury is defined as any medical intervention(s) which are the direct result of an accident or injury to the participant, regardless of whether hospitalization is required or not.

Incident Reporting Procedure

The RRDS is responsible for following this procedure whenever a notice of a Serious Reportable Incident is received from a waiver provider.

Procedure

1. When an RRDS is contacted by a waiver provider via phone, fax or e-mail that a Serious Reportable Incident has occurred, the RRDS must log the contact into their regional database of incidents and assign a reporting number to the incident. This number must be included in all future reports and correspondence relating to the incident. At the time of the initial contact, the RRDS must discuss the provider's plan for investigating the incident. The RRDS may provide technical support and may choose to involve DOH, if necessary.

Assigning a number to an incident:

Each incident number consists of four sets of numbers, each series being separated by a dash (-):

- A two digit number indicating the Recipient/Exception code;
- a two digit number indicating the year of the incident (e.g. 05);
- a two digit number indicating the RRDS region (e.g. 09); and
- a three digit number assigned to the specific incident.

Numbers start at 001 for each RRDS region and continue in consecutive order from January to December.

Example: An incident in the HCBS/TBI waiver is reported to the Lower Hudson Valley RRDS in 2006 and is the 7th incident reported to that region. The incident number is 81-06-04-007.

RRDS Region Code:

- 01 Long Island
- 02 New York City (Bronx, Queens, Manhattan, Brooklyn, Staten Island)
- 04 Lower Hudson Valley
- 05 Capital
- 06 Adirondack
- 07 Syracuse
- 08 Binghamton
- 09 Rochester
- 10 Buffalo

2. Within 24 hours, the RRDS must receive a copy of the reporting form from the investigating waiver provider (see Incident Reporting Policy). The RRDS must verify that the number assigned to the incident is correct on the report. The RRDS will review

the 24-hour report and determine if the incident has been adequately investigated and is considered closed, or if further investigation is warranted and the incident must remain open. The RRDS will notify the provider and the Service Coordinator the status of the Incident using the RRDS Serious Reportable incident Status Resolution form. The RRDS will notify DOH waiver management staff regarding Serious Reportable Incidents requiring DOH involvement.

- The incident is closed.
If the RRDS determines that the incident is closed, a letter is forwarded to the investigating provider and the participant's Service Coordinator. The resolution of the incident must be documented in the RRDS incident database.
 - The incident requires further investigation.
If the RRDS determines that the incident is to remain open pending further investigation, the provider is required to submit a report one week after the incident and then each month, starting on the anniversary date of the incident, until the RRDS determines that the incident is closed. The RRDS may indicate what further information is necessary for resolution of the incident.
 - The incident involves abuse, neglect or death.
If the incident involves the abuse, neglect or death of a participant, the RRDS must provide the DOH Clinical Consultant with copies of all communications related to the incident. The RRDS and the Clinical Consultant will review all reports and come to a mutual decision regarding the determination of the investigation prior to notifying the investigating provider.
3. When the incident is finally determined to have been adequately investigated and closed, the RRDS will forward a letter to the investigating agency and the Service Coordinator.

Reporting Time Frames

1. The local RRDS office must be notified ***immediately*** by phone/fax of any occurrence of a Serious Reportable Incident.
2. **Within 24 hours** of reporting the incident, a written report using the DOH Report of Serious Reportable Incidents form must be faxed or express mailed to the RRDS. **If the Service Coordinator is not the person reporting the incident, the investigating agency must also inform the Service Coordinator within 24 hours of the incident.**
3. The RRDS will provide the reporting agency with an identification number for the incident that must be used on all subsequent communications regarding the incident.
4. **Within one week** of the incident, the provider agency must submit a Serious Reportable Incident Follow-Up Report (Appendix B) to the RRDS describing

the investigation activities that have taken place to date. This report must include the following information:

- a. Who was interviewed or called in for consultation;
 - b. What is the conclusion of the investigation and the current status of the situation;
 - c. What actions were taken (e.g., behavior plan developed, staff changed, police called);
 - d. What was the outcome of these actions (e.g., HCBS/TBI waiver participant's behavior has changed, HCBS/TBI waiver participant is more satisfied with staff, safety of HCBS/TBI waiver participant has been secured); and
 - e. What, if any, long term activities the provider has initiated to decrease, either in frequency or intensity, the possibility of similar incidents occurring in the future.
5. **Within thirty days** following the initial reporting of the incident, a completed final report using the Serious Reportable Incident Follow-Up form must be sent to the RRDS. Such final report must cover the information described in #4 above.
 6. **Within two weeks** of receipt of the investigating agency's Final Report, the RRDS must send a written notice to the investigating agency and Service Coordinator indicating whether the incident is considered open or closed. If it is to remain open, the reasons for that decision must be identified by the RRDS on the Incident Resolution Status Report (Appendix B).
 7. If the incident is determined to require further investigation or resolution, continued follow-up and investigation by the investigating agency is expected. A Serious Reportable Incident Follow-Up Report must be submitted **monthly** to the RRDS on the date of the anniversary of the incident.
 8. The RRDS will continue to respond to each Follow-up Report using the Incident Resolution Status Report until the incident is considered closed by the RRDS.

Reporting Process

Any employee of a HCBS/TBI waiver provider witnessing any actions or lack of action that constitutes a Serious Reportable Incident as described in this policy must notify the RRDS and the Service Coordinator **immediately** by phone, followed by a fax and following the timeframes described above. It is understood any employee may need to notify their supervisor and the supervisor may be the person to notify the RRDS and the Service Coordinator. However, the staff that witnesses the Serious Reportable Incident must complete the Report of Serious Reportable Incidents Form.

- In situations where no HCBS/TBI waiver provider has witnessed the Serious Reportable Incident, the employee who first became aware of the incident is responsible for filling out the reporting form. Again, the supervisor may report the incident to the RRDS and Service Coordinator.
- When a provider's employee reports a Serious Reportable Incident that he/she did not directly witness, the RRDS will assign the responsibility for the investigation to the agency whose employee was allegedly involved. If the incident does not involve a provider's employee, the RRDS has the discretion to assign the responsibility of the investigation to any of the participant's HCBS/TBI waiver providers.
- If the RRDS is concerned that the provider responsible for investigating the Serious Reportable Incident is not in a position to conduct an objective, thorough investigation, the RRDS has the discretion to involve DOH in conducting the investigation.

Notification of the Waiver Participant, Legal Guardian and Others

Any Serious Reportable Incident must be reported by the provider to the participant or the waiver participant's court appointed legal guardian within 24 hours. The waiver participant has the right to decide whether or not other individuals are to be notified.

Notification of Other HCBS/TBI Waiver Providers

It is the responsibility of the HCBS/TBI waiver provider agency originating the incident report to notify any other program or waiver provider when there is visible evidence of injury to the HCBS/TBI waiver participant or when the incident or response to the incident may impact services or activities. Consideration of the individual's privacy should be balanced against the need to notify other service providers.

Investigation of Serious Reportable Incidents

Investigations by the Provider

The provider must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations. A provider may choose to contract with another agency to perform the investigation. However, the contracted agency must not have any involvement or stake in the outcome of the investigation. The decision of the contracted agency is binding. The results of the investigation are presented to the Incident Review Committee, which will determine if the investigation is complete, the appropriate action and necessary follow-up.

People conducting the investigation must not include:

- Individuals directly involved in the incident.
- Individuals whose testimony is incorporated in the investigation.

- Individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigation.

An investigation of a Serious Reportable Incident must contain the following information:

1. A clear and objective description of the event under investigation. This must include a description of the people involved in the alleged incident, the names of all witnesses and the time and place the incident occurred;
2. Identification of whether this was a unique occurrence or if this is believed to be related to previously reported incidents;
3. Details of structured interviews with all individuals involved in the events and all witnesses;
4. The investigator's conclusions if the allegation is substantiated, unsubstantiated or whether no definitive conclusions can be reached. The reasoning behind this decision must be included; and
5. The investigator's recommendations for action. This action may be directed towards individual employers or the participant, or may address larger program concerns such as training, supervision or agency policy.

If a participant is alleged to have abused another participant or member of the community (including staff), it is necessary for the investigation to take into consideration the aggressor's cognitive abilities to make a judgment as to the interventions that should follow the investigation of the incident.

Investigations by DOH

As described in the HCBS/TBI waiver Provider Agreement, the Department and its representative(s) (i.e., the RRDS or others identified as such by the HCBS/TBI waiver staff) have the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any agency or individual serving as a HCBS/TBI waiver provider. This level of intervention will occur when there are concerns that the provider has not followed the procedures described in this policy. If the provider is found to be noncompliant with these policies, the State will take appropriate action that may include terminating the Provider Agreement.

DOH works cooperatively with other State agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous Serious Reportable Incidents.

Any employee under investigation for Serious Reportable Incidents by DOH or another State agency is not permitted to provide service to any HCBS/TBI waiver participant.

Provider's Serious Incident Review Committee

1. Organization and Membership of the Serious Incident Review Committee

- The Committee may be organized on an agency-wide, multi-program or program-specific basis. Independent HCBS/TBI waiver providers must also form a committee to review serious incidents. One way to accomplish this is to partner with other independent providers or existing agencies for this purpose.
- The Committee must contain at least five individuals. Participation of a cross section of staff, including professional staff, direct care staff and at least one member of the administrative staff is strongly recommended.
- The Executive Director of the agency shall not serve as a member of the Committee, but may be consulted by the Committee in its deliberations.
- The Program Administrator may be designated as a member only if the Committee is an agency-wide or multi-program committee.
- The Committee must meet at least quarterly, and always within one month of a report of a Serious Reportable Incident involving a HCBS/TBI waiver participant.

2. Responsibilities of the Serious Incident Review Committee

This Committee is responsible for reviewing the investigation of every Serious Reportable Incident. The Committee will evaluate whether the investigation has been thorough and objective. It will determine if the conclusions and recommendations of the investigator are in line with best clinical practices and are in compliance with the guidelines of the HCBS/TBI waiver.

In addition, the Committee will:

- a. Assure that the providers' Incident Reporting Policies and Procedures comply with DOH HCBS/TBI Incident Reporting Policy.
- b. Review all Serious Reportable Incidents and Recordable Incidents (discussed in Section VII) to assure that incidents are appropriately reported, investigated and documented.
- c. Ascertain that necessary and appropriate corrective, preventive, and/or disciplinary action has been taken in accordance with the Committee's recommendations. If other actions are taken, the Committee must document the original recommendations and explain why these recommendations were revised.

- d. Develop recommendations for changes in provider policy and procedure to prevent or minimize the occurrence of similar situations. These recommendations must be presented to the appropriate administrative staff.
- e. Identify trends in Serious Reportable Incidents (by type, client, site, employee, involvement, time, date, circumstance, etc.), and recommend appropriate corrective and preventive policies and procedures.
- f. Report, at least annually, to the HCBS/TBI waiver staff regarding reportable incidents and allegations of HCBS/TBI waiver providers and corrective, preventive and/or disciplinary action pertaining to identified trends. This report must include the name and position of each of the members of the committee and documentation of any changes in the membership during the reporting period. This report will be submitted to the RRDS in the agency's region between January 1 and January 31 of each year for the prior year. The RRDS will review and submit these reports to DOH. In addition, DOH may request reports at any time.

3. Documentation of Serious Incident Review Committee Activity

- The chairperson shall ensure that minutes are kept for all meetings and collected in one location.
- Minutes addressing the review of Serious Reportable Incidents shall state the identification number of the incident (provided by the RRDS), the waiver participant's name and CIN number, a brief summary of the situation that caused the report to be generated (including date and type of incident), Committee findings and recommendations, and actions taken on the part of the agency/program as a result of such recommendations.
- Minutes are to be maintained in a manner that ensures confidentiality.
- DOH may request to review minutes at any time.

All information regarding Serious Reportable Incident reports, including but not limited to the information collected to complete the investigation and the investigation report and minutes of the standing Serious Incident Review Committee, must be maintained separately from the participant's records.

Recordable Incidents

Recordable Incidents are defined as incidents that do not meet the level of severity as described in Section II, Serious Reportable Incidents, but which impact the participant's life in the community. An example of these incidents is a fall that does not require medical attention. These Recordable Incidents do not need to be reported to DOH. However, DOH reserves the right to review these incidents at any time.

Agency policies and procedures regarding Recordable Incidents must include an explanation or identification of the:

- (1) Title or position of the individual(s) responsible for implementing these policies;
- (2) Process for reporting, investigating and resolving Recordable Incidents within the agency;
- (3) Process for identifying patterns of incidents which involve a specific participant or patterns within the agency that threaten the health and welfare of participants in general;
- (4) System for tracking the reporting, investigation and the outcome of all Recordable Incidents; and
- (5) Criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident to be reported to DOH.