

The HCBS Waiver Primer and Policy Manual



DEPARTMENT OF DEVELOPMENTAL SERVICES

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APRIL 2008

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CHAPTER 1: CALIFORNIA'S HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Background

Medicaid, known as Medi-Cal in California, is a jointly-funded, federal-state health insurance program for certain low income and needy people that includes long-term care benefits. Before 1981, the long-term care benefits were limited to care provided in an institutional setting such as a hospital, nursing home, or intermediate care facility for the developmentally disabled (ICF-DD¹). In 1981, President Reagan signed into law the Medicaid Home and Community-Based Services Waiver program, section 1915c of the Social Security Act to expand long-term care options for eligible individuals. The legislation provided a vehicle for states to offer long-term Medicaid funded services and supports in community settings.

The Social Security Act lists specific services that may be provided in Home and Community-Based Services (HCBS) Waiver programs, including: case management (service coordination), homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. The array of services may be expanded when requested by states and approved by the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to include such services as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care.

For additional information on the Centers for Medicare and Medicaid Services' Home and Community-Based Services Waiver Program, visit:

[CMS HCBS Waiver Program](#)

California's first Home and Community-Based Services Waiver for Individuals with Developmental Disabilities (referred to throughout this manual as the HCBS Waiver) was approved in November 1982, effective retroactively to July 1, 1982 with a total enrollment cap of 3,360 participants. The State's current approved HCBS Waiver has an enrollment cap of 75,000, progressing to 95,000 in fiscal year 2010-2011. Through this HCBS Waiver certain federal Medicaid rules are "waived," allowing the State to provide services to people with developmental disabilities in ways that are not available to other people enrolled in Medicaid (Medi-Cal in California). One federal condition of the HCBS Waiver is that the services and supports are different than those available through Medi-Cal.

States have great flexibility in the way they implement their HCBS Waivers. In many states, the HCBS Waiver is used to expand service and support alternatives for individuals found eligible to participate. In these states, HCBS Waiver participants have access to a broader array of

¹ The term ICF-DD used throughout the document includes ICF-DD, ICF-DD Habilitation, and ICF-DD Nursing facilities.

services and supports than individuals whose services are financed solely with state funds. However, this is not the case in California. In California, the HCBS Waiver provides funding for services and supports provided through regional centers. HCBS Waiver participants have access to the same array of services and supports as available to all regional center consumers.

Administrative Structure of California’s HCBS Waiver

The purpose of this section is to explain the administrative structure of the California HCBS Waiver and the roles and responsibilities of the federal, state and local organizations; and to summarize the requirements of the HCBS Waiver.

Centers for Medicare and Medicaid Services

The HCBS Waiver program is administered on the federal level by CMS. As with any federal program, the HCBS Waiver imposes administrative requirements on states. States are required to provide six assurances to CMS, as a condition of HCBS Waiver approval. CMS considers the six assurances to be “*the backbone of the quality assurance responsibilities of the State vis-à-vis its 1915(c) Waiver program*”² and expects states to incorporate them into their day-to-day operations. The assurances are:

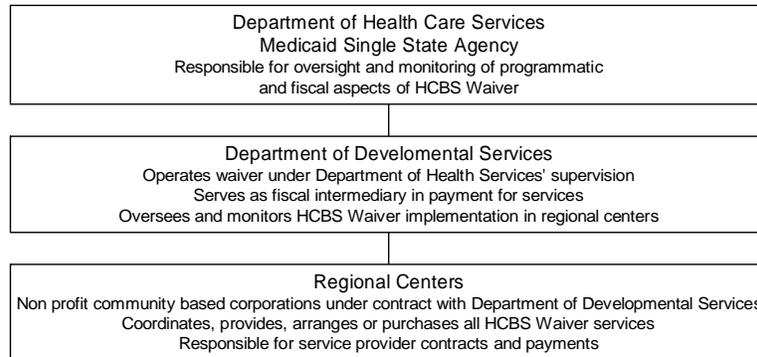
1. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under the HCBS Waiver;
2. Plans of Care are responsive to HCBS Waiver participant needs;
3. Only qualified providers serve HCBS Waiver participants;
4. Level of Care need determinations are consistent with the need for institutional care;
5. The state Medicaid Agency retains administrative authority over the HCBS Waiver program; and,
6. The state provides financial accountability for the HCBS Waiver.

States are required to submit an HCBS Waiver application to CMS spelling out their administrative structure and quality assurance plan to meet these six assurances. Approval is generally for a five-year period. CMS verifies compliance with the approved HCBS Waiver through review of periodic required reports, an ongoing dialogue with States, and a compliance review conducted 18-12 months prior to the HCBS Waiver’s expiration date. The purpose of these reviews is to assess the quality of care and services provided through the HCBS Waiver

² CMS Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs, Version 1.2, p. 1

and to ascertain if the state is in compliance with its approved HCBS Waiver application and the federal regulations governing Medicaid and the HCBS Waiver.

State of California



Role and Responsibilities of the Department of Health Care Services

Medicaid regulations require states to designate a Medicaid Single State Agency that is responsible for overseeing all Medicaid funded programs. The Department of Health Care Services (DHCS) is the Medicaid Single State Agency in California. DHCS administers the HCBS Waiver through an Interagency Agreement (IA) with the Department of Developmental Services (DDS). DHCS exercises its administrative and oversight responsibilities through:

1. Ensuring technical compliance and correctness of the IA;
2. Maintaining information appropriate to the fiscal and programmatic requirements delineated in the IA;
3. Reviewing, negotiating and approving amendments to the IA;
4. Reviewing DDS' HCBS Waiver related policies, procedures, rules or regulations for consistency with the HCBS Waiver, Medicaid statutes and regulations;
5. Approving DDS' HCBS Waiver Policy Manual, HCBS Waiver program advisories, HCBS Waiver technical letters, and other policies, procedures, rules or regulations that are related to the HCBS Waiver or any other Medicaid related issues;
6. Operating and maintaining an invoice tracking payment and reconciliation process;
7. Reviewing and approving required reports;
8. Participating in collaborative DDS/DHCS biennial monitoring reviews of regional centers with follow-up audits in alternate years;
9. Performing independent focused reviews to investigate significant special incident reports;
10. Performing monitoring reviews as needed; and,
11. Providing fiscal oversight for the HCBS Waiver program.

Role and Responsibilities of the Department of Developmental Services

DDS is responsible for the provision of services and supports to persons with developmental disabilities in California including those funded through the HCBS Waiver. DDS has been delegated the responsibility for operation of the HCBS Waiver through an IA with DHCS. The DDS role and responsibilities for operating the HCBS Waiver are defined in the approved HCBS Waiver and the IA with DHCS. The role and responsibilities of DDS include:

1. Serving as the fiscal intermediary for DHCS in the payment for HCBS Waiver services provided to persons with developmental disabilities through the regional centers;
2. Ensuring, with the oversight of DHCS, that the HCBS Waiver is implemented by regional centers in accordance with Medicaid statute and regulation by:
 - a. Performing fiscal audits of each regional center no less than every two years with follow-up audits in alternate years;
 - b. Participating in collaborative DDS/DHCS biennial *program* monitoring reviews of regional centers with follow-up audits in alternate years;
 - c. Performing ongoing training and technical assistance; and,
 - d. Performing, as needed, unannounced visits to a regional center or provider.
3. Overseeing the overall design and operation of a quality assurance program, which allows it to continually plan, assess, assure, and improve the quality and effectiveness of services and the level of satisfaction of consumers.

Role and Responsibilities of the Regional Centers

The 21 regional centers are charged with the responsibility to coordinate, provide, arrange or purchase services and supports for persons with developmental disabilities in California. The regional centers were created under the Lanterman Act and receive their funding through contract with DDS. DDS has delegated responsibility to the regional centers for assuring the following HCBS Waiver requirements are met:

1. Ensuring that HCBS Waiver participants meet the level of care criteria for eligibility for HCBS Waiver services;
2. Developing and implementing a written Plan of Care (also known as Individual Program Plans, or IPPs) that assures the health and welfare of HCBS Waiver participants;
3. Ensuring that adequate safeguards exist for the protection of the health and welfare of consumers through the use of standards for service providers;
4. Ensuring that eligible consumers are given a choice between receiving care in an institutional or a home and community-based setting;
5. Ensuring HCBS Waiver participants are notified of their appeal rights;

6. Ensuring a system for monitoring provider standards, IPPs, and quality of care and service;
7. Providing HCBS Waiver services in accordance with the service definitions and provider qualifications contained in the approved HCBS Waiver application; and,
8. Ensuring that HCBS Waiver services, except crisis intervention, have prior regional center authorization and are paid in the manner specified by DDS.

CHAPTER 2: ESTABLISHING AND MAINTAINING ELIGIBILITY FOR THE HCBS WAIVER

Federal statute and regulation, and CMS directives set the eligibility criteria for participation in the HCBS Waiver. Establishing and maintaining eligibility is one aspect of the HCBS Waiver where additional requirements are placed upon regional centers over those that are required to establish and maintain ongoing eligibility for regional center services. The purpose of this chapter is to explain the process to establish and maintain eligibility for participation in the HCBS Waiver.

California has implemented the HCBS Waiver as a part of its larger developmental disabilities service delivery system. The HCBS Waiver requirements are met, in large part, by applicable law and the policies and procedures that apply to the total population served by regional centers, including those consumers receiving HCBS Waiver services. These requirements are found in the Lanterman Act, Titles 17 and 22 of the California Code of Regulations, and the contract between DDS and regional centers. Additional policies or requirements specific to the HCBS Waiver are found in the approved HCBS Waiver, in contracts between DDS and regional centers, and in program directives issued by the State to the regional centers. The HCBS Waiver requirements and their application to HCBS Waiver participants and all ongoing regional center consumers are shown in the following table.

HCBS Waiver Participation Requirements	Applies to	
	HCBS Waiver Participants Only	All Regional Center Consumers
Eligibility		
Meet the Lanterman Act definition of developmental disability	X	X
Be an active regional center consumer	X	X
Have or be eligible for full scope Medi-Cal benefits or meet the requirements for institutional deeming	X	
Meet the level of care for ICF-DD services as documented on Medicaid Waiver Eligibility Record (DS 3770)	X	
Not be concurrently enrolled in another HCBS Waiver	X	
Choose to participate in the HCBS Waiver and live in the community as documented on Consumer Choice of Service/Living Arrangement Statement (DS 2200)	X	
HCBS Waiver initial eligibility determination and annual recertification is reviewed by a Qualified Mental Retardation Professional (QMRP)	X	
Plans of Care (Individual Program Plans - IPPs)		
IPPs are responsive to consumer's needs and preferences	X	X
IPPs are developed by a planning team [as defined in Welfare and Institutions Code § 4512, subd. (j)] that includes the consumer, and where appropriate his/her legal representative, using a person-centered approach	X	X

HCBS Waiver Participation Requirements	Applies to	
	HCBS Waiver Participants Only	All Regional Center Consumers
IPPs specify the type and amount and provider of services and supports	X	X
IPPs must contain at least one HCBS Waiver funded service	X	
IPPs must be reviewed at least annually and documented through the development of a new IPP or the Standardized Annual Review Form (See Appendix 6)	X	
Fair Hearings		
Have a right to a fair hearing when eligibility is denied or terminated or when services are suspended, reduced or terminated without the agreement of the consumer	X	X
Necessary Safeguards to Protect Health and Welfare		
Service coordinators monitor implementation of IPPs to assure that services and supports are delivered	X	X
Quarterly face-to-face meetings with consumers who live in CCFs, FHA, independent and supported living settings	X	X
Two unannounced visits to CCFs annually	X	X
Scheduled annual CCF facility visit	X	X
Quality assurance monitoring of CCFs every three years	X	X
Monthly face-to-face contact for the first 90 days after moving from a developmental center to the community	X	X
Special incidents are reported in accordance with Title 17	X	X
A review of the general health status of the consumer including a medical, dental, and mental health needs shall be conducted, as agreed to by the consumer or the consumer's authorized representative.	X	X
Qualified Providers		
Services and supports are provided in accordance with service definitions and provider qualifications specified in Title 17	X	X
Consumers are given a choice of qualified providers	X	X
Quarterly or semiannual progress reports from CCFs and day programs documenting progress toward achieving IPP objectives	X	X

Eligibility Criteria

As shown in the matrix above, there are six criteria that the individual must meet for participation in the California HCBS Waiver as mutually agreed upon by CMS and the State of California. In order to be eligible a person must:

1. Meet the Lanterman Act definition of developmental disability (**See Chapter 3, page 3**);
2. Be an active regional center consumer;
3. Have full-scope Medi-Cal benefits, i.e., be eligible to access all services available through Medi-Cal, or meet the requirements for institutional deeming (**See Chapter 3, page 6**);
4. Have substantial limitations in his or her present adaptive functioning (**See Chapter 3, page 3**) which qualifies the consumer for the level of care provided in an ICF-DD, intermediate care facility for the developmentally disabled-Habilitation (ICF/DD-H) or intermediate care facility for the developmentally disabled-Nursing (ICF/DD-N). Evaluation of each consumer's level of care needs is based on his/her ability to perform activities of daily living and community participation. This qualification is important, not because a person will be admitted to such a facility, but because the HCBS Waiver provides funding for services only to individuals who, but for the provision of these services, would require the level of care provided in an ICF-DD;
5. Not be concurrently enrolled in another HCBS Waiver; and,
6. Choose to participate and receive services through the HCBS Waiver and to reside in a community setting.

Regional Center Role in Establishing Initial HCBS Waiver Eligibility

Regional centers are responsible for determining level of care eligibility for the HCBS Waiver and determining consumer choice. The HCBS Waiver eligibility process can be separated into three components:

- Verification that the person has been found eligible for regional center services and either receives full scope Medi-Cal or may be eligible for Medi-Cal through institutional deeming (**See Chapter 3 for more information**).
- A determination that the consumer has substantial limitations in his or her present adaptive functioning that would qualify the consumer for the level of care provided in an ICF-DD (**See Appendix 2 for more information**). This determination must be documented by the regional center on the Medicaid Waiver Eligibility Record (form DS 3770) and reviewed annually.
- The consumer chooses to participate in the HCBS Waiver and the IPP is developed that includes the services and supports needed to maintain him or her in the community (**See Chapter 4 for more information**).

The consumer or authorized representative must indicate their choice of receiving HCBS Waiver Services and living in a community setting by signing the Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement DS 2200 (**See Appendix 4 for more information**). The consumer's choice to participate in the HCBS Waiver must be documented at the time of:

- Determination of initial eligibility of HCBS Waiver funding;
- Reactivation of eligibility for HCBS Waiver funding after a person's termination from participation in the HCBS Waiver; or,
- Transition from minor to adult status.

There is a federal requirement that the regional center staff person who makes the determination meet the educational and professional qualifications to be a Qualified Mental Retardation Professional (QMRP). A QMRP has one-year experience working with persons with developmental disabilities, and is either a doctor of medicine or osteopathy, a registered nurse, or an individual who holds at least a bachelor's degree in one or more of a number of professional categories including social worker and human services professional.

For additional information about the professional qualifications of a QMRP, visit:

[QMRP Professional Qualifications](#)

Regional Center Role in Recertification of HCBS Waiver Eligibility

Every person who receives funding through the HCBS Waiver must have his or her HCBS Waiver eligibility reviewed by the regional center at least annually. The regional center must re-evaluate the consumer's level of care and needs. A recertification of eligibility must be determined by a regional center QMRP.

Regional Center Denial of Initial or Ongoing HCBS Waiver Eligibility

A person must be terminated from the HCBS Waiver if he or she no longer meets the HCBS Waiver eligibility criteria. Specifically, individuals must be terminated from the HCBS Waiver if:

1. The consumer loses Medicaid (Medi-Cal) eligibility.
2. The consumer elects, in writing, to terminate HCBS Waiver services.
3. The consumer's condition changes to the point that he/she no longer meets the level of care criteria for the HCBS Waiver.
4. The consumer does not meet the criteria in the HCBS Waiver, excluding Medi-Cal eligibility and level of care.
5. Death of the consumer.

A Notice of Proposed Action and the Fair Hearing forms must be forwarded to the consumer or their authorized representative by the regional center when:

1. HCBS Waiver services are denied or reduced; and/or,
2. The consumer is terminated from the HCBS Waiver for failure to meet the level of care criteria.

The consumer or authorized representative may choose to voluntarily disenroll from the HCBS Waiver in which case a Notice of Proposed Action from the regional center is not required.

The Effects of Transfer Between Regional Centers on HCBS Waiver Eligibility

Under federal regulations, Medi-Cal funding is “portable” within a state. Thus, an individual may move from one location to another within the same state and retain his or her eligibility for Medi-Cal and the HCBS Waiver as well as access to the services identified in his or her IPP. Since HCBS Waiver eligibility is valid throughout California, a person transferring between regional centers continues to be eligible for the HCBS Waiver funding. **Appendix 5** contains the technical rules and procedures for regional centers to use in certifying, recertifying and terminating an individual's HCBS Waiver eligibility.

CHAPTER 3: ELIGIBILITY FOR REGIONAL CENTER AND MEDI-CAL SERVICES

Participation in the HCBS Waiver requires a person be: 1) found eligible to receive regional center services; 2) have full scope Medi-Cal or be eligible for institutional deeming; 3) have conditions that would qualify him or her for care in an ICF-DD; and, 4) choose to participate in the HCBS Waiver and receive services in the community. The purpose of this chapter is to explain the eligibility criteria for regional center services and Medi-Cal. It should be noted that the eligibility requirements for regional center services and Medi-Cal apply to all Californians.

Regional Center Eligibility

Overview

Regional centers, as established by the Lanterman Developmental Disabilities Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, families, a representative of the vendor community, and other defined community representatives.

Regional centers are funded through contracts with DDS. They are responsible for the direct provision of outreach, intake and assessment, evaluation and diagnostic services, preventive services, and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports to implement the IPPs for the consumers in their caseloads. The IPPs are developed using a person-centered planning approach. Regional centers also conduct quality assurance activities in the community, and maintain and monitor a wide array of qualified service providers.

Regional centers implement the HCBS Waiver by conducting individualized assessments to establish eligibility, developing, monitoring and updating IPPs in response to changing needs, monitoring the delivery of services, and ensuring the health and safety of HCBS Waiver participants.

For additional information about services provided by regional centers, visit:

[Services Provided by Regional Centers](#)

For additional detailed information about various day, residential and support program options and the early intervention program, visit:

[Information about Programs and Services](#)

Outreach

Regional centers are required to conduct outreach activities to inform their communities of their services and to actively pursue individuals in need of services. Outreach and other information developed and used by regional centers must be available in English and other languages that

are reflected in the populations they serve. Outreach activities lead to persons with developmental disabilities finding or being referred to regional centers for intake and assessment and a determination of eligibility for services.

In California, the intake and assessment process is guided by timelines and expectations that are defined through the Lanterman Act (§ 4641 et seq.) and Title 17 regulations. As with all regional center processes and decisions that touch consumers and applicants, there is an appeal or fair hearing process to protect the rights of the individual against erroneous or arbitrary decisions (Lanterman Act § 4700 et seq.). The fair hearing process is discussed in Chapter 4.

Intake and Assessment Timelines

The Lanterman Act establishes a right to initial intake, diagnostic and counseling services and a determination regarding the need for assessment to any California resident believed to have a developmental disability or to be at high risk of parenting an infant with a developmental disability. People who are at high risk of parenting an infant with a developmental disability are not eligible to receive ongoing regional center services unless they are found to meet the California definition of developmental disability.

Section 4642 of the Lanterman Act defines the intake timelines and expectations. The Act provides that initial intake (the provision of “*information and advice about the nature and availability of services provided by the regional center and other agencies...*”) shall be performed within 15 working days following the request for assistance. The regional center must make a decision whether to provide an assessment as a part of the initial intake decision.

Assessments are performed to determine whether the person meets the California definition of having a developmental disability (Lanterman Act Section 4512). An assessment can take many forms. It can include a psychological history, psychological evaluation, medical evaluation, and/or review of records obtained from schools, physicians, hospitals, psychologists, speech and language specialists, vocational services, and other agencies. The sole purpose of the assessment process is to gather enough information for the regional center to make an informed decision regarding eligibility. Qualified professionals are required to perform the assessments. There is no cost to the applicant or his or her family for the assessments performed by regional centers.

If an assessment is needed, it must be performed within 120 days following the initial intake. The timeframe is reduced to 60 days if a delay would expose the person to unnecessary health and safety risk or a significant further delay in mental or physical development; or if the person is at imminent risk of placement in a more restrictive environment.

For more information about the intake and assessment process for people seeking services and supports through the regional centers, visit:

[Lanterman Act, Section 4642](#)

Determining Eligibility For Regional Center Services

An interdisciplinary team makes a determination of eligibility for ongoing regional center services after the intake and assessment process is complete. The determination must meet all of the California requirements for eligibility specified in Section 4512(a) of the Lanterman Act, and Sections 54000, 54001, 54002, and 54010 of the Title 17 regulations.

A “developmental disability” means a disability which begins before age 18, is expected to continue indefinitely, presents a substantial disability for the individual, and is due to mental retardation, cerebral palsy, epilepsy, autism or a disabling condition closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation. The definition expressly excludes other handicapping conditions that are solely learning disabilities, psychiatric disorders or physical in nature.

The criteria for determination of a substantial disability are defined in Section 54001 of Title 17, California Code of Regulations: A substantial disability is defined as:

1. A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
2. The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person’s age:
 - a. Receptive and expressive language
 - b. Learning
 - c. Self-care
 - d. Mobility
 - e. Self-direction
 - f. Capacity for independent living
 - g. Economic self-sufficiency

Title 17 regulations require a group of regional center professionals of differing disciplines to make the assessment. There is a requirement that the assessment include consideration of similarly qualified appraisals performed by other interdisciplinary bodies of the Department(s) serving the potential client. Title 17 goes on to say, “*The regional center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.*” If there is a reassessment of substantial disability for the purposes of continuing eligibility, the same criteria that were used in the original determination of eligibility must apply.

Other Regional Center Eligibility Categories

Infants and toddlers (age 0 to 36 months) who are at risk of a developmental disability or who have a developmental delay may also qualify for early intervention services. The criteria for determining the eligibility of infants and toddlers are specified in Section 95014 of the California Government Code.

Individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling, and other prevention services.

For more information about the intake and assessment process for people seeking services and supports through the regional centers, visit:

For additional information about who is eligible to receive Regional Center services, visit:

[Eligibility for Services in California](#)

Medi-Cal Services

Medi-Cal is a jointly funded federal and state Medicaid program that pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is available to all California residents who meet the eligibility criteria. Once eligibility is established, Medi-Cal continues as long as the person meets the eligibility requirements. However, eligibility is re-determined every 12 months as required by Title 22, California Code of Regulations, Section 50189.

DHCS, as the single state Medicaid agency, administers the Medi-Cal program. The program provides a variety of services to different groups of individuals, including those served by California's six federal HCBS Waivers. The Departments of Aging, Mental Health, Social Services and Developmental Services play prominent roles in ensuring the needs of eligible individuals are met. The basic eligibility requirements for Medi-Cal are consistent across all of the involved programs and departments.

Medi-Cal is a requirement for participation in the HCBS Waiver. It is not a requirement for regional center services, though many consumers receive Medi-Cal.

For more information about California's Home and Community Based Services Waivers, visit:

[CMS Website--California's Waivers](#)

Eligibility for Medi-Cal

County social services offices make Medi-Cal eligibility determinations. California residency is a basic eligibility requirement. In addition, a California resident must meet other specified criteria, (i.e., SSI/SSP beneficiary) or have been made eligible for the HCBS Waiver through institutional deeming (see below). Regional centers are authorized to apply for Medi-Cal on behalf of their adult consumers who do not have a legal guardian or conservator.

Cash Assistance Program Eligibility

A California resident may automatically be eligible for Medi-Cal if he or she receives cash assistance under one of the following programs:

- a. Supplemental Security Income/State Supplemental Program (SSI/SSP);
- b. California Work Opportunity and Responsibility to Kids (CalWORKs), formerly known as Aid to Families with Dependent Children (AFDC);
- c. Refugee Assistance;
- d. Foster Care or Adoption Assistance program; or,
- e. In Home Supportive Services.

Other Specified Criteria

A California resident may be eligible for Medi-Cal if he or she meets one of the following criteria:

- a. 65 or older;
- b. Blind;
- c. Disabled;
- d. Under 21;
- e. Pregnant;
- f. Diagnosed with breast or cervical cancer;
- g. In a skilled nursing or ICF-DD;
- h. Refugee status during a limited period of eligibility. Adult refugees may or may not be eligible depending on how long they have been in the USA;
- i. Parent or caretaker relative of a child under 21 and:
 - 1. The child's parent is deceased or doesn't live with the child, or
 - 2. The child's parent is incapacitated, or
 - 3. The child's parent who is the primary wage earner is unemployed or underemployed.

Institutional Deeming

California amended its HCBS Waiver in 1993 to allow waiver of spousal and parental deeming of income and resources if the consumer lives at home. It also allowed the application of spousal impoverishment provisions as if the HCBS Waiver beneficiary were institutionalized even if he or she lives at home or in a community setting. To be eligible for institutional deeming through the HCBS Waiver, an individual must be referred to a County social service office by a regional center.

The individual must meet all regular Medi-Cal eligibility rules including exemptions and deductions for a disabled person except that:

- Spousal impoverishment rules apply, if appropriate, as if the applicant were institutionalized and has a spouse living at home.
- Parental income and resources are not considered even if the child lives at home.
- The maintenance need or income limit is determined by the particular program limit for which the applicant is eligible.
- The county determines eligibility based upon the criteria for the HCBS Waiver.

For more information about Medi-Cal services and eligibility, visit:

[Medi-Cal Services and Eligibility](#)

A Notice of Action is sent to the applicant and the regional center to inform them that the application has been approved or denied. If the applicant is approved, the Notice of Action includes the actual effective date.

CHAPTER 4: DEVELOPING PLANS OF CARE (INDIVIDUAL PROGRAM PLANS)

The CMS expects states to have policies and procedures in place to define the development and approval of participant Plans of Care (IPPs), and review mechanisms to assure that services on the plan are delivered and are satisfactory to the consumer. The purpose of this chapter is to delineate California's and the CMS approved HCBS Waiver requirements for the development and review of IPPs. It should be noted that the requirements in this chapter apply to all IPPs developed for regional center consumers and are not specifically targeted at those who participate in the HCBS Waiver with one exception: federal law requires an annual review of the plan of care for HCBS Waiver participants and that the plan is revised as necessary to reflect the changing needs of the individual. California law specifies that IPPs shall be reviewed and revised by the consumer's planning team as necessary, in response to the person's achievement or changing needs, and no less than once every three years.

Background

The Lanterman Developmental Disabilities Services Act (Welfare & Institutions Code Section 4500 et.seq.), also known as the Lanterman Act, is the foundational legislation for California's developmental disabilities service delivery system. The Act is highly prescriptive and sets forth the policy that defines and guides processes for the system. One such process is the development of IPPs for all individuals served by the system, including HCBS Waiver participants. For HCBS Waiver participants, the terms "IPP" and "Plan of Care" are synonymous.

The 1992 amendments to the Lanterman Act require a person-centered approach to individual program plans. The basic requirements related to IPPs are:

1. IPPs will be centered on the person and family;
2. The DDS will prepare a standard format for IPPs with instructions. The format and instructions will embody an approach centered on the person and family;
3. DDS will prepare training materials to implement a person-centered approach;
4. To ensure a person-centered approach to IPPs, each regional center shall use the standard format, instructions, and training materials prepared by DDS;
5. All public or private agencies receiving state funds for the purpose of providing the services and supports selected through the IPP process shall respect choices made by consumers;
6. Information needed by consumers and families to exercise their right to make the choices necessary for person-centered IPPs will be provided in an understandable form;
7. The activities of employees of the regional centers and service providers related to person-centered IPPs shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and family;
8. Individuals receiving regional center services have an IPP, or individual family services plan (IFSP) in the case of children birth through two years of age, developed with their participation. The IPP a tool for ensuring the health and welfare of the people receiving

HCBS Waiver supports and services funded under the HCBS Waiver are addressed;
and,

9. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the IPP and purchased by the regional center, or obtained from generic agencies, shall be made jointly by the planning team at the program plan meeting.

IPP Development

A consumer's IPP is developed through a process of individualized needs determination that includes efforts to identify and address potential and perceived risks (example: health risks, behavioral risks, or risks to personal safety). The planning process includes gathering information and conducting assessments (by qualified individuals) to determine the life goals, capabilities, strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. Information is gathered from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The individual with developmental disabilities, and, where appropriate, his or her family, legal guardian or conservator or authorized representative, shall have the opportunity to actively participate in the development of the plan. The IPP includes a schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic resources or other resources, and identification of the provider or providers of service responsible for each objective. For HCBS Waiver beneficiaries, the IPP must address the conditions that qualify the person for the level of care required in an ICF-DD. Federal law requires the delivery of plan of care services by "qualified providers." To qualify as a potential HCBS Waiver provider, regional center vendorization is required (**See Chapter 5**). The Lanterman Act provides that a person's choice of service provider should be based on:

1. The consumer's choice of providers;
2. A provider's ability to deliver quality services or supports that can accomplish all or part of the person's program plan;
3. A provider's success in achieving the objectives set forth in the person's IPP;
4. Where appropriate, the existence of licensing, accreditation, or professional certification;
5. The cost of providing services or supports of comparable quality by different providers, if available;
6. The eligibility of the consumer for the same, or similar, services and supports from any publicly funded agency that has a legal responsibility to serve all members of the general public;
7. The cost effective use of public resources.

By signing the IPP, the person or person's designated representative is formally documenting their agreement with the services, supports and service providers reflected in their plan and agreed to in the planning meeting. The Lanterman Act provides that no service or support provided by any agency or individual shall be continued unless the consumer or their

designated representative is satisfied and agree that planned supports and services have been provided, and reasonable progress toward objectives has been made.

IPP Review Process for HCBS Waiver Participants

Regional centers are required to develop a new IPP for all consumers at least every three years. However, by federal law, regional centers are required to review the IPPs of HCBS Waiver participants at least once every 12 months. As such, the IPPs of HCBS Waiver participants are reviewed at least annually to determine the appropriateness and adequacy of the supports and services, and to ensure that the services and supports are consistent with the person's preferred future. The planning team conducts the annual IPP review, which is then documented as follows:

1. If a new IPP is developed as a part of the annual review, completion of the Standardized Annual Review Form (**Appendix 6**) is not required.
2. If a new IPP is not developed as the existing IPP is found to be complete and reflective of the current preferences and needs of the consumer, this must be documented on the Standardized Annual Review Form (**See Appendix 6**). The planning team participants must sign this form.
3. If the existing IPP is amended to reflect changes in services and supports, this must be documented on the Standardized Annual Review Form. The planning team participants sign the form to document that the remainder of the IPP is appropriate in meeting the needs and preferences of the consumer.

HCBS Waiver participants (as are all consumers) and their families and service/support providers, as appropriate, are directly involved in IPP reviews. Through the planning team process and scheduled periodic reviews they provide feedback to the regional center as to whether the supports and services identified in the IPP are being delivered in accordance with the IPP, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the IPP's implementation.

IPPs may be reviewed more often if there are changes in the consumers needs or if the consumer's planning team has determined that more frequent reviews are necessary. In addition, the Lanterman Act requires that an IPP review be conducted within 30 days after the request has been submitted by a consumer (Welfare and Institutions Code Section 4646.5(b)).

For additional information about the Lanterman Act requirements for IPP development and review, visit Welfare and Institutions Code Section 4646:

[Lanterman Act Requirements for IPP Development and Review](#)

Service Coordination

Every regional center consumer is assigned a service coordinator. Service coordinators are also referred to as case managers, counselors and client program coordinators. Service coordination is among the most important services and supports provided by regional centers.

There is a provision in the Lanterman Act section 4647 that no individual shall continue to serve as the consumer's service coordinator unless all parties, including the person, agree with the assignment of service coordinator.

The service coordinator has many responsibilities including: working in concert with the consumer and others in developing the consumer's IPP; ensuring that needed supports and services are available to the person; referral and linkage; advocacy; and implementing and monitoring a person's IPP to ascertain that objectives are met. The service coordinator is also responsible for informing the person of feasible alternatives for obtaining necessary supports and services.

The service coordinator, or other appropriate regional center personnel, ensures that the consumer, his or her legal representative(s), parents, relatives or involved persons, are informed of the choice of either participating or not participating in the HCBS Waiver program.

IPP Service Disagreements: Fair Hearing Process

CMS requires states to provide an opportunity for a fair hearing to any person when Medicaid eligibility or covered services are denied, suspended, reduced, or terminated. The fair hearing process must include the opportunity for a hearing before the agency that suspends, reduces or terminates the eligibility or services with a right to appeal the decision of the agency to a state agency hearing. The agency must issue and publicize the hearing procedures and inform every applicant or recipient in writing of his or her right to a hearing, the method by which he or she may obtain a hearing, and that they may represent themselves, have legal counsel or be represented by any other person. The information must be given to the individual at the time of application and at the time of any action affecting them. There is a requirement that the agency send a notice detailing the proposed action at least 10 days before the date of the action with information on the fair hearing process. If a fair hearing is requested, the agency cannot terminate or reduce services until a decision is rendered after the hearing (42 CFR Part 431, Subpart E).

The fair hearing procedure in the Lanterman Act satisfies the CMS requirement (Welfare and Institutions Code Sections 4700-4731). The fair hearing procedure applies to all consumers. With respect to the IPP, a notice of fair hearing must be given to a consumer when the regional center reduces, terminates or changes services that are on the IPP without mutual consent of the consumer and/or authorized representative.

It is important that consumers, family members, and others feel free to voice their complaints. The State issued a policy prohibiting reprisals against individuals who make a complaint against a service provider or regional center. See **Appendix 7** for the full text of this policy.

The Lanterman Act also provides a complaint process by which each consumer or representative acting on behalf of any consumer or consumers, who believes that any right to which a consumer is entitled has been abused, punitively withheld, or improperly or unreasonably denied by a regional center or service provider, may pursue a complaint as provided in section 4731. The complaint is first filed with the regional center director, who will review the complaint and propose a resolution. If the consumer or authorized representative is not satisfied with the proposed resolution of the regional center director, then the complainant may forward the complaint to the Director of DDS, who will issue a written administrative decision.

For additional information about how the fair hearing process works, how to file for a fair hearing, and forms to file for a fair hearing, visit:

[Fair Hearing Process](#)

Additional information on the fair hearing process can also be found by visiting:

[Fair Hearing Procedure in Lanterman Act](#)

For information about complaint process specified in Welfare and Institutions Code Section 4731, visit:

[4731 Complaint Process](#)

IPP Resource Materials

DDS, in cooperation with individuals with developmental disabilities, families, and organizations who represent important components of the service delivery system, developed a resource manual entitled “*Individual Program Plan Resource Manual, A Person-Centered Approach*” and a pocket guide to person-centered planning. The resource manual sets forth the policies, values, expectations, and outcomes for developing an IPP using a person-centered approach. The manual explains the planning conference, the written IPP, values, roles and responsibilities within the system, and presents the format and instructions for developing and monitoring the IPP. The manual also contains training material. The pocket guide excerpts portions of the resource manual and presents the information in simplified language. The resource manual and pocket guide are incorporated into this policy manual by reference and serve as California’s policies and procedures that define the development and approval of plans of care. The manual also references the role of the service coordinator in monitoring the implementation of the IPP. A copy of this manual is available on the DDS website.

For a copy of the “Individual Program Plan Resource Manual, A Person-Centered Approach”, visit:

[IPP Resource Manual](#)

CHAPTER 5: VENDORIZATION, SERVICE PROVIDER ACCOUNTABILITY AND RATES

CMS expects states to have policies and procedures in place to ensure providers of HCBS Waiver services are qualified. The purpose of this chapter is to delineate California's policies and procedures to ensure that providers are qualified. It should be noted that the policies and procedures apply to all providers vendored by the regional center to provide consumer services and are not specifically targeted at those who participate in the HCBS Waiver. This includes the requirement that vendors (approved providers) sign a Medicaid Provider Agreement as a condition of approval.

Title 17, California Code of Regulations

In California, all of the policies and procedures that govern provider qualifications, expectations, rates, the process to become eligible to provide services and supports, receive funding from regional centers and the provider appeal procedure are found in Title 17, California Code of Regulations. Therefore, Title 17 is incorporated in this manual by reference. The procedures are briefly described below.

Vendorization and Provider Qualifications

Vendorization encompasses the entire approval process to enable an individual or agency to provide services to people with developmental disabilities funded through a regional center. Regional centers are responsible for the Title 17 vendorization process in their catchment areas. Service providers must be vendored by a regional center before they can provide and be reimbursed by the regional center for the provision of services and supports included in a consumer's IPP.

The vendorization process allows regional centers to verify that a vendor applicant meets all of the requirements and standards specified in Title 17 regulations, determine the appropriate vendor category for the service to be provided, and approve or disapprove vendorization based upon their review of the documentation submitted by the applicant. Applicants who meet all specified requirements and standards are assigned a unique vendor identification number and service code.

To become a vendor, a Vendor Application Form (DS 1890) (**See Appendix 8**), must be submitted along with the documentation specified in Title 17, Section 54310. Once a potential service provider has obtained all necessary licenses, submitted a complete application and all necessary documentation to the vendoring regional center, the regional center has 45 days to approve or disapprove vendorization. Once vendored, the service provider may be utilized by other regional centers, known as "user" or "utilizing" regional centers, as well as the vendoring regional center. The vendor identification number assigned by the vendoring regional center must be used by all regional centers purchasing the vendored service.

Approved service providers are required to sign a Home and Community Based-Services Provider Agreement (**See Appendix 9**). The Agreement is a requirement of the HCBS Waiver and is subject to review in DDS' fiscal audits and the CMS reviews.

Although a regional center must vendor an applicant who meets all the requirements for the service to be provided, vendorization in no way obligates that regional center to purchase services from that vendor.

Title 17 sets the provider qualification standards for all services and support categories. To become a qualified HCBS Waiver Provider, one must be vendorized by the regional center and providing services and supports included in the state’s HCBS Waiver. See Appendix 9 for a list of all services funded through the HCBS Waiver.

For additional information about the vendorization process, including how to become a vendor, vendor application requirements, general requirements for vendors and regional centers, and a description of service codes, visit:

[Vendorization and Rates home page](#)

Direct Support Professional Training

Community Care Facilities (CCFs) licensed by the Department of Social Services are the backbone of DDS’s community residential system, serving over 75 percent of people with developmental disabilities living in licensed facilities. Direct support professionals are employed by CCFs to provide the day-to-day care and supervision for the consumers who reside in the facilities. Trained and competent direct support professionals are the key to the provision of quality care.

DDS has implemented a two-year, 70-hour standardized statewide competency-based training program, which is mandatory for all CCF direct support professionals and CCF administrators who provide direct care. The 70 hours of training are divided into two equal parts of 35 hours each to be completed in successive years. Those required to take the training have the opportunity to take a challenge test for each of the 35-hour segments. Those who pass the challenge test for either of the 35-hour training segments are not required to take that segment. Testing and training are based upon core competencies or skills necessary for satisfactory direct support professionals’ job performance.

The training is provided by local Regional Occupational Centers and Programs (ROPs) in communities throughout the state. The ROPs use instructors who have practical work experience in the provision of services to people with developmental disabilities.

For additional information about the Direct Support Professional training provided by ROPs, visit:

[Direct Support Professional Training](#)

Service Provider Program and Administrative Accountability

Various sections of Title 17 focus on service provider and/or regional center accountability for the health and safety for people with developmental disabilities receiving services and the provision of the highest quality services by service providers/vendors. These sections of Title 17 are summarized below:

1. Service provider accountability (Chapter 1, Subchapter 6, Article 1, Sections 50601-50612);

2. General requirements for vendors and regional centers (Chapter 3, Subchapter 2, Article 2, Section 54326);
3. Special incident reporting requirements for vendors and long term care health facilities (Chapter 3, Subchapter 2, Article 2, Section 54327);
4. Termination of vendorization for noncompliance (Chapter 3, Subchapter 2, Article 4, Section 54370);
5. Residential service provider orientation by regional centers (Chapter 3, Subchapter 4, Article 2, Section 56003);
6. Residential facility program design requirements (Chapter 3, Subchapter 4, Article 3, Section 56013);
7. Contract and vendorization with a family home agency (Chapter 3, Subchapter 4.1, Article 3, Section 56082);
8. Service contract between a regional center and community-based day program vendor (Chapter 3, Subchapter 9, Article 4, Section 57540);
9. Regional centers purchasing transportation services (Chapter 3, Subchapter 18, Article 2, Section 58510); and,
10. Contract with supported living vendors (Chapter 3, Subchapter 19, Article 8, Section 58671).

Rates and Billing Procedures

DDS operates as the fiscal agent for the HCBS Waiver through an interagency agreement with DHCS as the single state Medicaid agency. The regional centers in turn operate under contract with DDS. Regional centers purchase services for consumers, pursuant to their IPP through providers who have been vendored by the regional center in accordance with applicable Title 17 regulations. The regional centers pay the providers for the authorized services then bill DDS for services provided.

The amount that a regional center pays for any support or service is determined either through contract negotiations between the regional center and the vendor or through rate methodologies established by the DDS. These methods apply to all services financed by the DDS.

For each service that involves a rate rather than a contract negotiation, Title 17 identifies the methodologies that are used by DDS to set these payment rates. Title 17 also describes the conditions under which a regional center is able to negotiate payment levels through contractual agreements. These regulatory parameters (as described in Title 17) apply to supports and services that can be billed to the federal government through the HCBS Waiver as well as those services that cannot be billed to the federal government.

For additional information on the rate setting methodology and actual rates of reimbursement for Community-Based Day Programs and Respite Programs, Community Care (residential) Facilities, Long-Term Care Facilities, and for services covered by the Medi-Cal Schedule of Maximum Allowances (SMA), visit:

[Reimbursement Rates](#)

This site also presents frequently asked questions regarding reimbursement rates for services provided to people with developmental disabilities.

CHAPTER 6: MONITORING THE HCBS WAIVER

The foremost responsibility of any service system is to ensure the health, welfare and safety of individuals being served. Within California's developmental disabilities service delivery system, protocols are in place to ensure that health and welfare standards are continuously met and that Medicaid services, including those funded through HCBS Waiver are implemented in accordance with Medicaid statute, HCBS Waiver requirements and programmatic standards.

Components of the local quality assurance system include:

- a. Development and review of IPPs;
- b. Quarterly monitoring of each person living in a licensed residential health and community care facility, an independent living setting or receiving services from supported living or adult family home agencies;
- c. Enhanced service coordination for individuals moving from developmental centers to community living arrangements;
- d. Annual regulatory required programmatic reviews of each community residential care facility and adult family home agency to assure services are consistent with program design and applicable law;
- e. Not less than two unannounced visits annually to community residential care facilities, family home agency homes and licensed long-term health care facilities;
- f. Quality assurance reviews of community care residential facilities every three years;
- g. Review and investigations of health and safety complaints by protective agencies;
- h. Training and technical assistance;
- i. Review and follow-up on special incident reports;
- j. Collection and analysis of special incident data to identify trends and initiate quality improvement strategies;
- k. Regional Center Risk Management/Mitigation Planning Committees.

The regional centers' performance of these activities is monitored through the State's onsite HCBS Waiver programmatic reviews.

HCBS Waiver Monitoring Protocol

Overview

It is DDS' responsibility to ensure, with the oversight and collaboration of DHCS that the HCBS Waiver is implemented by regional centers in accordance with Medicaid statute and regulation. DDS carries out this responsibility through the existing HCBS Waiver Monitoring Protocol.

Under the Protocol, monitoring reviews are a collaborative effort between DDS and DHCS. The review team includes DHCS staff, with specific duties assigned to prevent duplication of effort by the two departments. The review cycle for the 21 regional centers is completed over a two-year period. The collaborative reviews of the 21 regional centers are conducted over a two-year period. Each review has three phases, pre-review, on-site review and post review.

Pre-review phase - Include notification of the regional center, sending out the regional center self-assessment tool and selecting a stratified random sample of HCBS Waiver participants.

On-site review phase - Includes the review of consumer records at the regional center, residential facilities and day programs; interviews with consumers, regional center service coordinators, clinical services staff, and quality assurance staff; interviews with service providers and direct support staff; program/facility reviews; and a review of special incident reports.

Post review phase - Includes developing the report of the review that delineates areas regional centers need to address, and receiving and reviewing a plan of action from the regional center. Follow-up reviews are conducted when warranted by findings in the review.

Regional Center Self Assessment

The purpose of the regional center self-assessment is to gain assurance from the regional center that it has written policies, procedures and practices and a system to assure compliance in 24 areas associated with the HCBS Waiver assurances. The 24 regional center assurances are limited to areas on which DDS does not routinely collect information from the regional centers, which includes information on their risk management system. The report to the regional center on the results of the review will contain comments and recommendations for those regional center assurances where there is a need for improvement.

Regional Center Consumer Record Review

The consumer record is one of the primary tools used to monitor regional center compliance with the HCBS Waiver requirements. It is a document that is reviewed by the DDS/DHCS monitoring team as well as CMS during compliance audits. In the DDS/DHCS review, the consumer record establishes the baseline for the consumer interview, the service coordinator interview, the service provider interview, the direct support staff interview, the community care facility record review, the day program record review, and the Special Incident Report (SIR) review. The record review consists of 31 criteria associated with Waiver eligibility certification and recertification, choice, fair hearings, health status, IPP development and implementation, and monitoring of services.

Community Care Facility Consumer Record Review

The HCBS Waiver review follows consumers into the community to assure that they are living in safe environments, receiving the services identified on their IPPs and being treated with respect and dignity, and that their health is safeguarded. The 19 review criteria for CCF consumer records associated with documentation requirements relative to IPP implementation, consumer

health and safety, medication safeguards, quarterly and semiannual reports, and special incident reporting.

Day Program Consumer Record Review

The HCBS Waiver review follows consumers into the community to assure that they are receiving day services in safe, productive environments that will assist in achieving the goals and objectives documented on their IPPs. The 17 review criteria address the day program requirements associated with documentation relative to maintaining consumer records and preparing written reports of consumer progress toward achievement of IPP services for which the program is responsible.

Interviews with Consumers

Consumers are interviewed and observed by the monitoring team at the day programs, residential homes or other locations. The purpose of consumer interviews and observations is twofold. First, the interviews are conducted with consumers who are willing to participate to capture the consumer's own feelings about his or her life. The interview format is designed to elicit information about consumer satisfaction with living arrangements and the staff who assist them in the residences, school or day program and respective assisting staff, choice, time spent with friends, food, recreation, interactions with the regional center, safety, and health. Secondly, the observations are conducted to verify that the consumers appear to be healthy and clean. A standardized checklist is used to document the observations.

Interviews with Regional Center Staff

Service Coordinator Interview

The service coordinator has a critical role in the life of the consumer. Among other things, he or she is responsible for assessing the needs of the consumer, facilitating the development of a person-centered IPP, linking the consumer to services and supports identified in the IPP, monitoring progress and service delivery, monitoring health and safety, and advocating for the consumer. The purpose of the interview is to determine how well the service coordinator knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of their participation in the plan, how the plan was developed, how services are monitored, how health issues are addressed and monitored, and how safety is monitored.

Clinical Services Interview

Regional center clinical services staff and contractors provide support to consumers and service coordinators on matters affecting the health, safety and medical needs of consumers living in the community. An informational interview is conducted with the clinical staff to ascertain how the regional center has organized itself to provide the support. The interview questions ask what processes the regional center has in place for routine monitoring of consumers with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health services, improvements in access to preventive health care resources, and the role of clinical services in special incident reporting and the Risk Management Committee.

Quality Assurance Staff Interview

Quality Assurance (QA) is an important component in assuring the health and safety of consumers in the community and provider competence. An informational interview is conducted with QA staff to gain an understanding of how the regional center has organized itself to conduct: Title 17 monitoring of community care facilities (CCFs); two unannounced visits to CCFs annually; QA evaluations of CCFs; and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and to ascertain what is done to assure quality among programs and providers.

Interviews with Service Providers and Direct Support Staff

Service Provider Interview

The service provider plays a significant role in the life of the consumer. The service provider is responsible for assessing the needs of the consumer, participating in the development a person-centered IPP, providing services and supports identified on the IPP, fostering consumer progress, ensuring the health and safety of the consumer, and reporting special incidents and taking action to assure consumer health and safety. The purpose of the interview is to determine how well the service provider knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how the accuracy of documentation is ensured, communication, how medications are safeguarded, how health issues are addressed and monitored, emergency preparedness, and how safety is monitored.

Direct Support Staff Interview

Direct support staff are the individuals who work with and assist the consumers in day programs and residential settings. Direct support staff play an important role in the implementation of the IPP. The purpose of the interview is to determine the direct support staff's familiarity with the consumer, understanding of the IPP and service delivery requirements, special incident reporting requirements, communication, level of preparedness to address safety issues, understanding of emergency preparedness, and knowledge about safeguarding medications.

Vendor Monitoring Review

Residential programs and day programs are reviewed by the monitoring team utilizing a vendor monitoring review form consisting of 25 review criteria. The purpose of the vendor review is to ensure the consumers are served in safe, healthy, positive environments where their rights are respected. The 25 criteria are divided into five categories: environment and safety; health and medications; services and staff; money (applies to residential programs); and rights. Each review criterion has interpretive guidelines to clarify the expectations and to provide a framework to promote effective and efficient provisions of services and supports to enable the consumers to reach their goals. The review is conducted through an inspection of the physical environment of the program and observations.

Special Incident Reports (SIRs)

The purpose of this section is to verify that special incidents have been reported within the timelines, that the documentation meets the requirements of Title 17, and that the follow-up was complete and appropriate action was taken to safeguard consumers. Special incidents are discussed in the next section.

Other Health and Safety Monitoring

Special Incidents

Special incidents are unplanned events that threaten the health and/or safety of consumers. Title 17 California Code of Regulations defines the categories of reportable special incidents, assigns responsibility for reporting for vendors, long-term health care facilities and regional centers, and establishes reporting timeframes. Special incident reporting applies to all consumers served by regional centers.

Vendors

Title 17 Section 54327 sets forth the special incident reporting requirements for vendors and long-term health care facilities. Vendors and long-term health care facilities are required to report special incidents to regional centers immediately but not more than 24-hours after learning of the occurrence, with a written report due within 48-hours of the occurrence. The required contents of the reports include: identification of the vendor; date, time and location of the special incident; name and date of birth of consumers involved in the incident; a description of the special incident; a description of the alleged perpetrator, if any; treatment provided to the consumer, if any; names and addresses of witnesses, if any; actions taken by the vendor, consumer or any other agency(ies) or individual(s) in response to the incident; other agencies notified, including law enforcement, licensing and/or protective services agencies; and family members or authorized representatives who were contacted and informed of the incident. The definition of reportable special incidents is divided into two broad categories, those that have to be reported regardless of when or where they occurred and those that have to be reported if they occurred during the time the consumer was receiving services and supports from a vendor or long-term health care facility.

Incidents that must be reported by the vendor to the regional center regardless of when or where they occur:

1. The death of any consumer, regardless of the cause;
2. The consumer is a victim of robbery, aggravated assault, larceny, burglary, or rape (including attempted rape).

The following types of incidents must be reported by the vendor to the regional center if they occurred during the time the consumer was receiving services and supports from the vendor:

1. The consumer is missing and a missing persons report has been filed with a law enforcement agency;
2. Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental or physical and/or chemical restraint;
3. Reasonably suspected neglect, including failure to:
 - a. Provide medical care for physical and mental health needs;

- b. Prevent malnutrition or dehydration;
 - c. Protect from health and safety hazards;
 - d. Assist in personal hygiene, or the provision of food, clothing or shelter; or
 - e. Exercise the degree of care that a reasonable person would exercise in the position of having care and custody of an elder or a dependent adult.
4. A serious injury/accident including:
- a. Lacerations requiring sutures or staples;
 - b. Puncture wounds requiring medical treatment beyond first aid;
 - c. Fractures;
 - d. Dislocations;
 - e. Bites that break the skin and require medical treatment beyond first aid;
 - f. Internal bleeding requiring medical treatment beyond first aid;
 - g. Any medication errors;
 - h. Medication reactions that require medical treatment beyond first aid; or
 - i. Burns that require medical treatment beyond first aid.
5. Any unplanned or unscheduled hospitalizations due to the following conditions:
- a. Respiratory illness;
 - b. Seizure-related;
 - c. Cardiac-related;
 - d. Internal infections;
 - e. Diabetes;
 - f. Wound/skin care;
 - g. Nutritional deficiencies; or
 - h. Involuntary psychiatric admission.

Regional Centers

The regional centers have overall responsibility to follow up on Special Incident Reports (SIRs). The follow-up includes verification of the facts reported by the vendor or long-term health care facility and appropriate actions to ensure the immediate health and safety of the consumer as well as to mitigate future risk.

The regional centers are responsible for reporting to DDS special incidents that fall in the definitions listed on pages 29 and 30 of this chapter. The reports are made utilizing DDS' electronic special incident reporting system.

Title 17 Section 54327.1 sets forth regional center responsibilities with respect to reporting special incidents to DDS. Initial reports of special incidents as defined on the previous pages must be submitted to DDS within two working days following receipt of the report from the vendor or long-term health care facility or within two working days of learning of an incident that was not reported by the vendor or long-term health facility. The initial report includes: the name, date of birth and UCI number of the consumer; identification of the vendor or long-term health care facility; identification of a regional center contact person; name of the consumer's conservator or guardian, if any; date, time and location of the incident; date incident was reported to the regional center; identification of the person preparing the report; date the report of the incident was prepared; type of incident; medical care or treatment required as a result of the incident; relationship of the alleged perpetrator to the consumer, if any; identification of persons or entities notified of the incident; a description of the special incident; if the incident was a death, indication if it was disease related, non-disease related or unknown; a description of any actions or outcomes taken by the regional center, vendor or long-term health care facility, or other protective agencies in response to the special incident; and any other information that the regional center determines is necessary to describe the incident.

Any required information that is not submitted with the initial report shall be submitted to DDS within 30 working days, or thereafter following receipt of the report of the special incident from the vendor or long-term health care facility.

For additional information on the regulations pertaining to Special Incidents and Special Incident Reporting, visit:

[Special Incident Reporting Requirements for Vendors](#)

[Special Incident Reporting Requirements for Regional Centers](#)

Risk Mitigation and Management System

The size, complexity, and diversity of California pose unique challenges with respect to implementing a risk management system. Among these challenges are communication, coordination, data analysis, reporting, training, resources, standardization, and monitoring. Beginning in fiscal year 2001-2002, the Legislature appropriated funds to DDS and regional centers to develop a comprehensive risk management system to enhance consumers' health, safety, and/or well-being and to implement preventive strategies and interventions to mitigate such risks. The level of funding has increased each subsequent fiscal year as the number of consumers served by the regional centers has increased. The system contemplated in fiscal

year 2001-2002 is now fully implemented statewide and applies to all regional center consumers.

This risk management system addresses the challenges of California, while respecting the basic roles and responsibilities of the State's protective service and developmental disabilities services system structures. The overall risk management system for the State involves numerous entities; however, the three key entities involved in risk management and risk mitigation activities within the developmental disabilities services system are the regional centers, DDS and the independent contractor retained by DDS.

Regional Centers

The 21 regional centers have local-level responsibility for planning, coordinating, and implementing the risk management program by:

- a. Developing and implementing a regional center risk management and prevention plan;
- b. Recording medical and other health-related care received by the consumer for his or her significant medical conditions in the period prior to the special incident;
- c. Reviewing medical records and coroner reports to ensure appropriate medical attention was sought and/or given;
- d. Coordinating with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, long-term care ombudsman, etc.) to gather and review the results of their investigations and using this information to prevent the recurrence of similar problems;
- e. Conducting onsite and chart review activities to gather and report initial and follow-up special incident information;
- f. Preparing and transmitting special incident reports (SIR) to DDS, investigative agencies, and local licensing offices, as appropriate;
- g. Integrating risk mitigation strategies into person-centered planning;
- h. Providing training and technical assistance to staff, providers, and others on: legal obligations in abuse reporting; documentation requirements; the definition of 'special incident'; using the automated SIR reporting system; developing and implementing an incident prevention plan; best practices for identifying consumer abuse; risk assessment; proactive risk management planning through the individualized program planning process; etc.;
- i. Annually reviewing the regional center's internal SIR reporting and control systems;
- j. Monitoring providers to ensure compliance with SIR-related corrective action plans;
- k. Maintaining the automated SIR reporting system, including verifying data integrity and related reports;

- I. Producing data runs and reports from the SIR database to identify unusual patterns and trends by provider(s) requiring follow-up.

Regional centers are expected to use their local SIR data to identify trends requiring local intervention and to effectively mitigate consumer risk through the individual person-centered planning process and development of IPPs.

Department of Developmental Services

DDS has overall state-level responsibility for planning, coordinating, and overseeing implementation of the state's risk management program for persons with developmental disabilities by:

- a. Developing, implementing and maintaining a uniform, statewide, automated special incident report (SIR) database system;
- b. Reviewing daily all individual SIRs transmitted by the regional centers to identify issues or concerns requiring additional follow-up;
- c. Revising regulations related to special incident reporting requirements to address new system requirements;
- d. Conducting periodic, on-site monitoring visits to review regional center and provider compliance with SIR regulatory requirements, as well as ensuring consistent and accurate reporting;
- e. Aggregating and analyzing SIR data by regional centers, risk indicators, client characteristics, programs, type of incidents, corrective actions, residence, and other relevant factors. Providing such data to the risk management contractor for further analysis and to regional centers for follow-up, as appropriate;
- f. Providing training and technical assistance to regional centers on: legal obligations in abuse reporting; documentation requirements; the definition of 'special incident'; best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process;
- g. Developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died, and conducting studies to educate and inform the service system so as to improve quality of life outcomes for consumers;
- h. Preparing, implementing and managing the risk-assessment and mitigation contract;
- i. Reviewing, on-site, highly unusual, suspicious and/or very sensitive individual incidents where DDS headquarters' involvement is indicated;
- j. Reviewing system trends and formulating statewide intervention strategies.

Risk Management Contractor

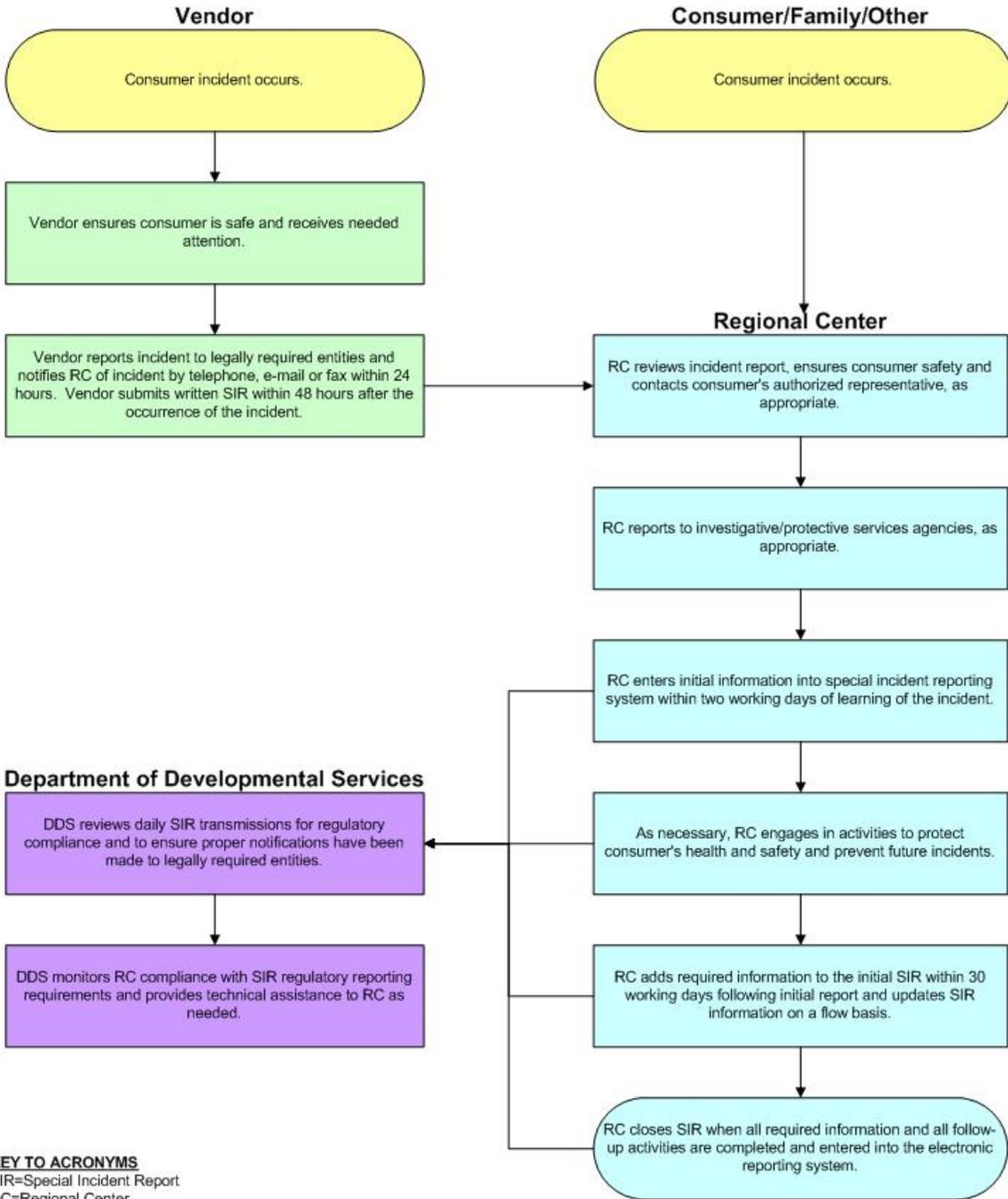
The state has engaged the services of an independent, specialized risk-management and mitigation contractor, possessing a multidisciplinary (clinical, research, data analysis, training, clinical, business) capacity to perform the following activities:

- a. Reviewing and analyzing DDS SIR data to identify statewide, regional and local trends requiring action. This includes defining indicators of problems requiring further inquiry;
- b. Based on data analyses and as directed by the DDS, conducting reviews (may include one or more regional center service areas and/or providers) to obtain qualitative health and safety risk data on incident trend pattern(s);
- c. Providing recommendations to DDS on actions that should be taken to strengthen the state's SIR system, including the need for regulatory, policy, organizational, resource and other changes that will improve consumer outcomes related to health, safety and well-being;
- d. Performing ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries and other adverse incidents;
- e. Developing and disseminating periodic reports and materials to the field (providers, regional centers, families, disability organizations, etc.) on best practices related to protecting and promoting the health, safety and well-being of consumers;
- f. Developing and maintaining a website (www.ddssafety.net) for consumers and their families, providers, professionals, and regional center staff. This website is dedicated to the dissemination of information on the prevention and mitigation of risk factors for persons with developmental disabilities. The site includes information from across the nation on current research and best practices and practical information directed towards improving consumers' health and safety;
- g. Assisting DDS in planning, coordinating and providing statewide training related to risk management and other related topics;
- h. Providing on-site technical assistance to regional centers related to local risk management plans and activities;
- i. Conducting mortality reviews.

Graphic Illustration of the Risk Mitigation and Management System

The flow charts on the following pages illustrate the processes and procedures implemented as part of California's risk mitigation and risk management system to enhance consumer health and safety.

Special Incident Reporting Process

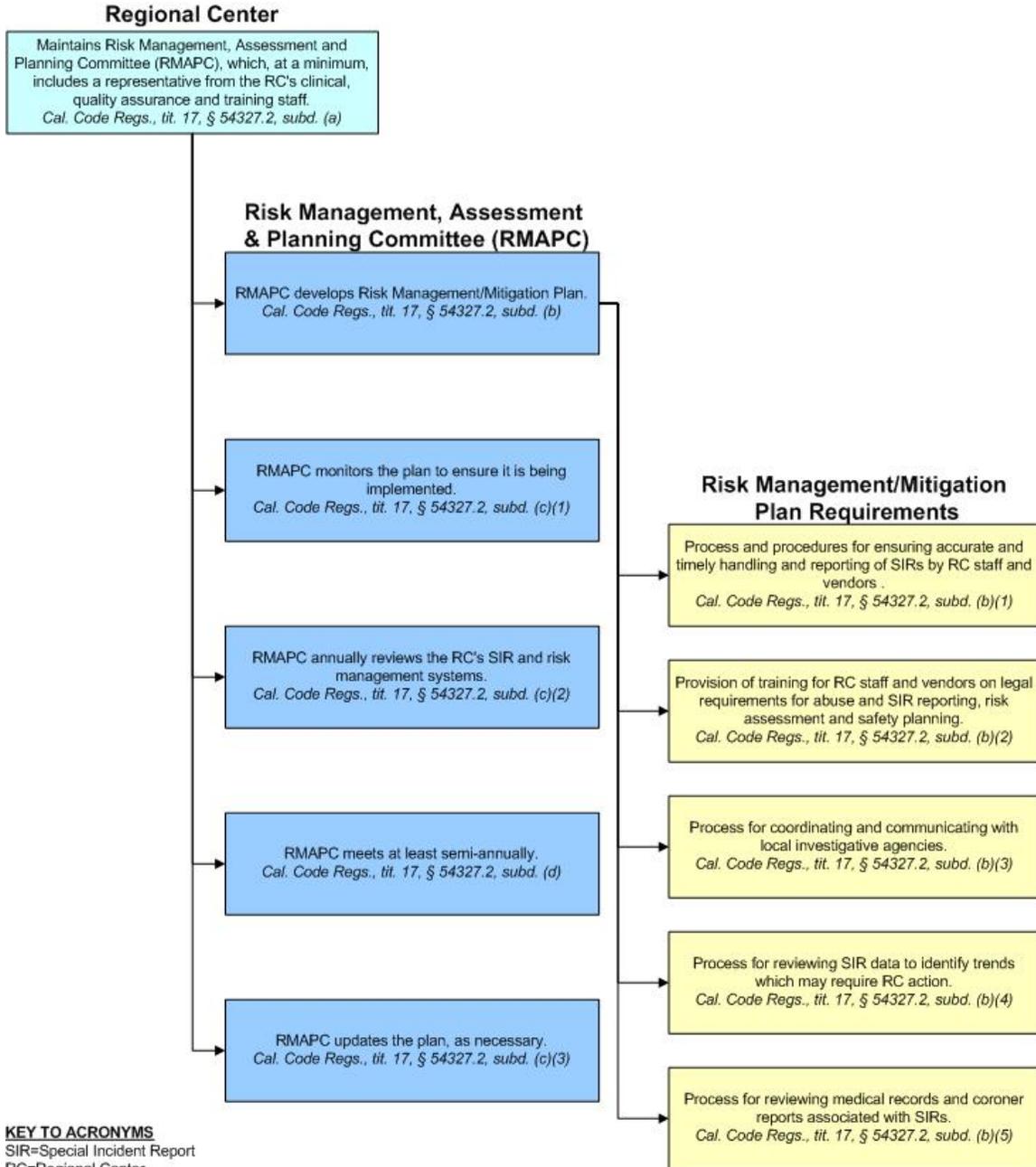


KEY TO ACRONYMS

SIR=Special Incident Report
 RC=Regional Center
 DDS=Department of Developmental Services

January 2003

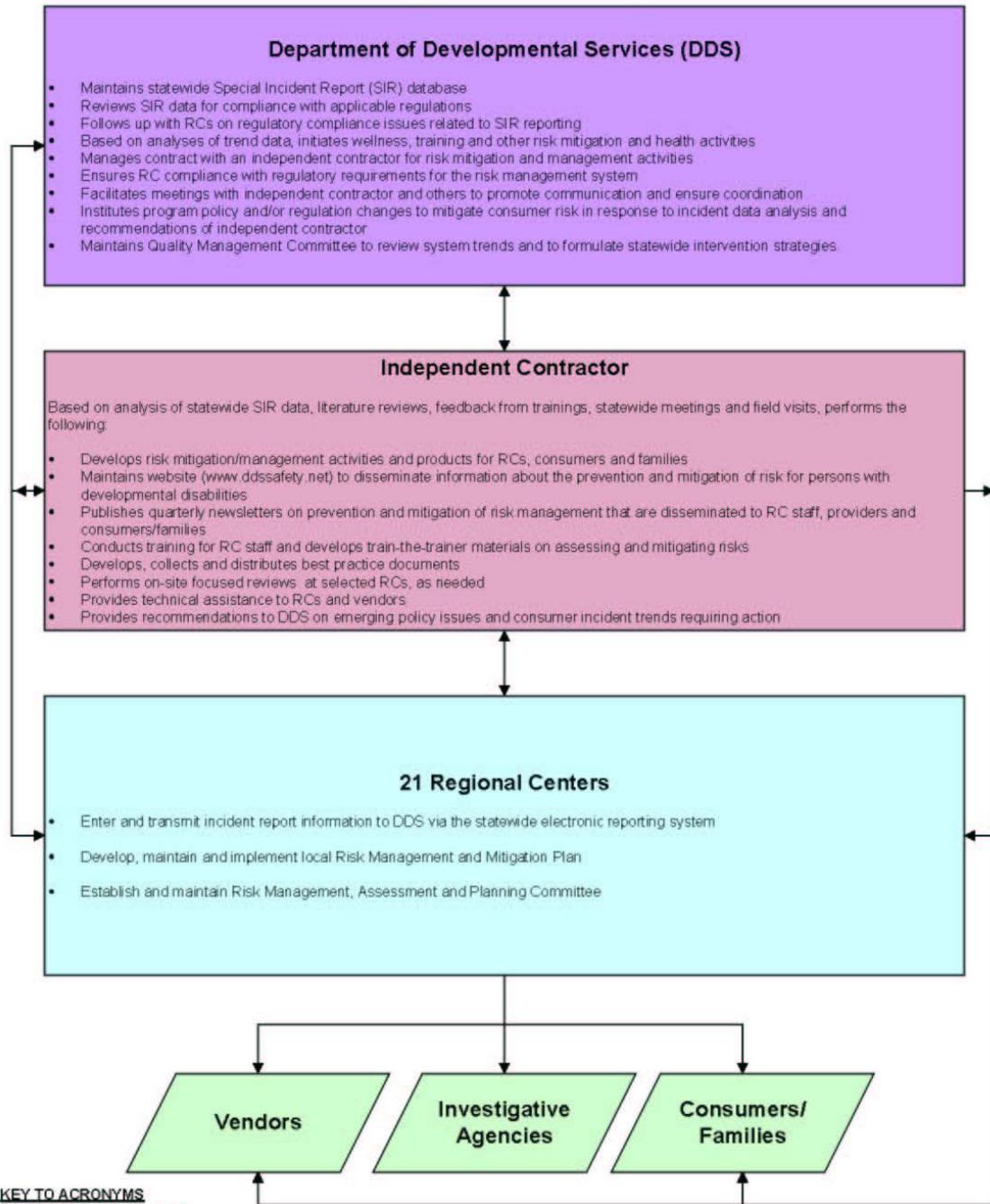
Regional Center Risk Management and Mitigation Planning Process



KEY TO ACRONYMS
 SIR=Special Incident Report
 RC=Regional Center
 DDS=Department of Developmental Services

January 2003

Statewide Risk Mitigation and Management System for Persons with Developmental Disabilities Living in the Community



KEY TO ACRONYMS
 SIR=Special Incident Report
 RC=Regional Center
 DDS=Department of Developmental Services

January 2005

CHAPTER 7: ENSURING QUALITY

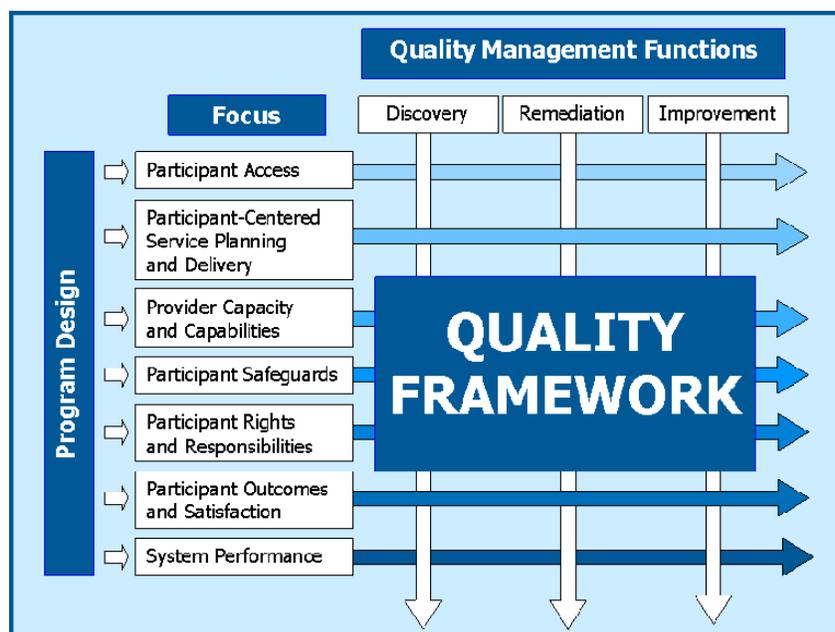
This chapter describes DDS' "Quality Management Model (QMM)" and discusses the CMS Quality Framework and how California's developmental disabilities system currently matches up with the quality framework. Lastly, it will describe in some detail the monitoring and accountability systems that are specific to the HCBS Waiver.

CMS Quality Framework

In August 2002, CMS issued a "Quality Framework" which was intended to serve as a national platform for states' quality management systems for home and community-based services. According to CMS, "The Framework focuses on participant centered desired outcomes along seven dimensions. Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring, participant health and welfare, and critical safeguards (e.g. incident reporting and management systems). The CMS Quality Management Processes are:

- **Design**
- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement;
- **Remediation:** Taking action to remedy specific problems or concerns that arise; and,
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

"Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes (from CMS)".



The DDS Quality Management Model

For years, the Lanterman Developmental Disabilities Services Act, departmental policies and procedures, and special initiatives have defined quality assurance for California's developmental disabilities services system. A wide variety of measures have been employed for quality assurance and improvement, ranging from licensing requirements, consumer face-to-face monitoring, periodic system monitoring, special incident reporting to individual life quality assessment, satisfaction surveys and direct service professional training. Each of these activities fulfills an important function and each continues in the system today.

However, the focus on quality in human service systems has shifted from monitoring and policing activities to producing outcomes for people and managing performance. Programs will not be judged solely on whether they conduct compliance reviews and track special incidents, but rather on whether they have comprehensive systems in place which produce desired consumer outcomes, establish performance expectations, measure both performance and outcomes, and take action based upon information and analysis.

The quality management model seeks to balance achieving consumer outcomes ("doing the right thing") with maintaining structures and processes to ensure cost-effectiveness and accountability ("doing things right"). At the core of the model is the consumer and family; all remaining system structures revolve around the center goal of "doing the right thing" for the people we serve. The basic concept is simple: the system should be based on values, establishing clear expectations for performance, collecting and analyzing data to determine if the expectations are met, and, finally, taking steps to correct deficiencies or improve processes and services.



Setting Performance Expectations for the California Service Delivery System

The first step in the process is to achieve consensus on values. In California, the following values have been established either by law or by stakeholder process:

Values for Individuals	Values for Service Delivery
<ul style="list-style-type: none"> ▪ Choice ▪ Relationships ▪ Lifestyle ▪ Health and Well-being ▪ Development ▪ Rights ▪ Satisfaction 	<ul style="list-style-type: none"> ▪ Person-centered ▪ Outcome-focused ▪ Availability & accessibility of needs-based services ▪ Service effectiveness ▪ Equitable delivery/non-discrimination ▪ Accountability ▪ Information dissemination ▪ Cost-effectiveness ▪ Continuous quality management and improvement

The second step is to establish performance expectations. For consumers and families, this is all done through the IPP process. For the regional center system, the Regional Center Performance contracts now establish “public policy indicators” and “compliance indicators” as noted below.

Public Policy Indicators	Compliance Indicators
<ul style="list-style-type: none"> ▪ Utilization of DCs ▪ Minors living with families ▪ Adults living in home settings ▪ Minors in facilities over 6 beds ▪ Adults in facilities over 6 beds ▪ Adults with earned income ▪ Average wages ▪ Adults in supported living ▪ Adults in competitive employment ▪ Access to medical and dental services 	<ul style="list-style-type: none"> ▪ Fiscal audits ▪ Fiscal projections ▪ Fiscal management ▪ HCBS Waiver compliance ▪ CDER currency ▪ Intake/assessment timelines ▪ IPP/IFSP development

Expectations for providers are established by regulation, accreditation, and contract.

Managing to Expectations

In order to achieve performance expectations, the system must marshal and direct resources where they are needed (e.g., allocations, contracts, rates, etc.), conduct monitoring and oversight, provide training and technical assistance, develop and disseminate resource materials and continually devise strategies and innovations to build capacity and capability. Examples of existing strategies are the HCBS monitoring protocols, life quality assessment, direct service professional training, the wellness initiative, the statewide risk mitigation contract, housing development consortia, and so forth.

Measuring Achievement of Expectations

Data and information are fundamental to the Quality Management Model. The system maintains a significant amount of information; the following types of information is available:

Consumer-based Information	Provider-specific Information	Compliance Information
<ul style="list-style-type: none"> ▪ Demographics ▪ Diagnostic ▪ Service Utilization ▪ Special incidents 	<ul style="list-style-type: none"> ▪ Vendor demographics ▪ Rates 	<ul style="list-style-type: none"> ▪ Fiscal /audits ▪ Regulatory ▪ Risk management ▪ Complaints ▪ Fair hearings ▪ Monitoring reports

From among the data sources, the department has selected specific performance measures that can show whether the performance expectations of regional centers have been met. Performance is measured and reported on a routine basis. In addition, the department will utilize its information sources to (a) report facts, (b) analyze trends and correlations and (c) issue special reports.

Remediation and Improvement (Closing the Loop)

The final critical step in the quality management process is acting upon the information received in order to correct deficiencies or promote continuous improvement. A number of strategies can be employed:

- Corrective action;
- Contract re-negotiation;
- Training and technical assistance;
- Public policy changes (e.g. legislation or regulation);
- Budget change proposals;
- Administration initiatives;
- Changes in the strategic plan.

The specific strategies need to be determined based upon the type of problem and the level of governance (state or local). The important thing is to close the loop.

California’s Performance and the CMS Quality Framework

DDS participated in a “National Inventory of Quality Assurance and Improvement Systems”; an extensive survey conducted by the National Association of State Directors of Developmental Disability Services. The following analysis demonstrates how California’s system meets CMS expectations for quality within the assurance areas States must address in their HCBS Waiver application:

Quality Framework Focus Area #1: Participant Access

Desired Outcome: Individuals have ready access to home and community based services and supports in their communities.

Systems and activities in place:

- Single point of entry through regional centers;
- Mandated information and outreach activities by regional centers;
- Mandated intake and eligibility procedures and timelines for regional centers;
- Targeted activities for diverse ethnic and cultural backgrounds in place through regional centers.

Quality Framework Focus Area #2: Participant-Centered Service Planning and Delivery

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

Systems and activities in place:

- Comprehensive, person-centered planning process involving the consumer and family, with training and technical assistance provided, resulting in an IPP that is reviewed for effectiveness;
- Comprehensive case management provided on a 24/7 basis, with a mandated caseload ratio of 1:62 for HCBS Waiver consumers;
- Face-to-face monitoring of implementation of consumer IPPs, including health and welfare;
- Health status reviews conducted annually as part of the IPP meeting;
- Additional health care strategies include physician consultation; wellness initiative grants, and medical school training programs for community health care providers;
- External case reviews conducted on a periodic basis by state agency personnel.

Quality Framework Focus Area #3: Provider Capacity and Capabilities

Desired Outcome: There is a complete array of HCBS providers that possess and demonstrate the capability to effectively serve participants.

Systems and activities in place:

- Resource development mandated by law and funded through the Community Placement Plan process, the regional center annual allocation, and special initiatives such as the Wellness and Facility Downsizing initiatives;
- Mandated two-year training program for all residential care providers and staff;
- Criminal history/background check for residential providers and staff;

- Core competencies established for residential care providers and staff;
- Licensing program for residential and day programs, with annual reviews and sanctions;
- Accreditation program for employment programs;
- Minimum expectations for all providers established by DDS through Title 17 regulations, and monitored by regional centers;
- Authority for unannounced visits of residential homes given to regional centers;
- Quality assurance reviews by regional centers with follow-up activities;
- Periodic monitoring of residential and day programs by state agency staff during HCBS Waiver monitoring reviews.

Quality Framework Focus Area #4: Participant Safeguards

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

Systems and activities in place:

- Automated “Risk Management and Mitigation” system in place statewide that includes special incident reporting, individualized risk management, regional and statewide trend analysis, and remediation and mitigation activities;
- Mortality reviews and studies at regional center and state levels;
- Medication administration protocols and provider training;
- Behavior Intervention protocols.

Quality Framework Focus Area #5: Participant Rights and Responsibilities

Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities.

Systems and activities in place:

- A “Bill of Rights” is posted in all service locations. DDS maintains an Office of Human Rights and Advocacy Services to ensure rights are protected;
- An impartial administrative due process system (fair hearings) is in place statewide, with data collected and tracked by regional center;
- Complaint procedures are in place that allow for any individual to file a complaint with the DDS Office of Human Rights and Advocacy Services.

Quality Framework Focus Area #6: Participant Outcomes and Satisfaction

Desired Outcome: *Participants are satisfied with their services and achieve desired outcomes.*

Systems and activities in place:

- “Life Quality Assessments” are conducted for everyone in out-of-home care by individual volunteers recruited by the area boards. A rapid response system is in place that provides for immediate follow-up if indicated;
- Early Start Satisfaction Survey of families conducted in 2001-2002; to be conducted periodically;
- Regional Center Performance Contracts, which include statewide public policy and compliance measures and outcomes;
- Consumer Outcome Data - a consumer outcome element is included on the Revised CDER. This allows for statewide measurement and tracking of consumer outcomes.

Quality Framework Focus Area #7: System Performance

Desired Outcome: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

Systems and activities in place or planned:

- A comprehensive “Quality Management Model” has been designed which reflects the desired outcomes, values and principles of the system, integrates all data systems and incorporates all existing processes.

This analysis shows that California’s system design addresses each of the CMS focus areas with specific activities and strategies. Work still needs to be done to fully implement the newly designed “Quality Management Model” statewide. Success in achieving the consumer and system performance outcomes will depend upon the dedication and collaboration of all who desire to secure a better future for California’s citizens with developmental disabilities and their families.

APPENDICES

- Appendix 1 DDS Waiver Referral Form (DHS 7096)
- Appendix 2 Community Operations Division Program Advisory 02-02-Level of Care Determination and IPP Requirements for HCBS Waiver Consumers
- Appendix 3 Medicaid Waiver Eligibility Record (DS 3770)
- Appendix 4 Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement (DS 2200)
- Appendix 5 Technical Instructions and Rules for Regional Center Staff Regarding HCBS Waiver Eligibility, Recertification and Termination.
- Appendix 6 Standardized Annual Review Form
- Appendix 7 Community Services Division Program Advisory 99-5 –Department of Developmental Services' Policy on Reprisals
- Appendix 8 Vendor Application Form (DS 1890)
- Appendix 9 Home and Community Based-Services Provider Agreement Form
- Appendix 10 Services Available Through the HCBS Waiver
- Appendix 11 DDS/DHCS Collaborative HCBS Waiver Monitoring Review Protocol

**DEPARTMENT OF
DEVELOPMENTAL SERVICES
WAIVER REFERRAL**

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

CALIFORNIA REGIONAL CENTER—Please complete this portion and forward to the appropriate County Waiver Contact Person.

Name of applicant _____

Address (number, street)	City	State	ZIP code
Social Security number	Date of birth	Telephone ()	
Parent/Guardian (if applicable)			
Address of parent/guardian (if different)	City	State	ZIP code

STATUS

- New Medi-Cal applicant.
- Currently receives Medi-Cal with a share of cost. Reevaluate under special institutional deeming rules.

LIVING ARRANGEMENT

- The applicant is currently in an institution. Please determine Medi-Cal eligibility based on his/her anticipated return to the home. Anticipated date of discharge _____
- The applicant is currently living in the home.
- Other: _____

This is to certify that the individual named above has met the admission criteria for an intermediate care facility for the developmentally disabled as defined in the California Health and Safety Code, Chapter 2, Section 1250.

Signature of Regional Center contact person _____

➤

Printed name of Regional Center contact person	Title	Telephone ()
Regional Center address (number, street)	City	State ZIP code

NOTE TO COUNTY: The eligibility determination waives parental and spousal income and resources even if the applicant lives in the home. See Section 19D of the Medi-Cal Eligibility Procedures Manual. If the applicant/beneficiary is entitled to zero share of cost Medi-Cal under regular eligibility rules, no waiver is required.

Please send a copy of the Notice of Action to the Regional Center when the determination is completed.

White: County copy

Yellow: Regional Center Copy



DEPARTMENT OF DEVELOPMENTAL SERVICES

COMMUNITY OPERATIONS DIVISION PROGRAM ADVISORY

COD 07-02

December 2007

LEVEL-OF-CARE DETERMINATION USING THE REVISED CDER For Home and Community-Based Services (HCBS) Waiver Consumers

INTRODUCTION

The purpose of this program advisory is to provide regional center staff with information on making level-of-care determinations for the HCBS Waiver program using the revised Client Development Evaluation Report (CDER).

BACKGROUND:

The HCBS Waiver provides funding for services to individuals who, but for the provision of these services, would require the level-of-care provided by an intermediate care facility for the mentally retarded (ICF/MR). To be eligible for the HCBS Waiver, the consumer must have substantial limitations in his or her present adaptive functioning which qualify the consumer for the level-of-care provided in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for Developmentally Disabled-Habilitation (ICF/DD-H), or Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N). (See CCR, Title 22, Sections 51343, 51343.1 and 51343.2). The CDER is used to assist in determining level-of-care needs. A program advisory dated March 27, 2002, discussed how to make and document level-of-care determinations.

IMPLEMENTATION:

The revised CDER combines some of the current evaluation elements and eliminates or re-names others. For instance, the personal care element of the revised CDER combines personal hygiene and bathing skills, whereas these are separate criteria under the current CDER. The updated "Criteria for HCBS Waiver Level-of-Care Eligibility" (Attachment I)

summarizes the qualifying conditions that can be used by regional centers in determining consumers' HCBS Waiver level-of-care eligibility. This update reflects changes in wording and organization of evaluation elements contained in the revised CDER.

As outlined in the March 27, 2002, program advisory (Attachment II), evaluation of each consumer's level-of-care is based on his/her ability to perform activities of daily living and community participation, not strictly on CDER scores. Using the revised CDER does not change the process of making level-of-care determinations nor does it restrict Waiver eligibility. When assessing level-of-care, the regional center Qualified Mental Retardation Professional (QMRP) should review the revised CDER data including the diagnostic, special conditions and personal outcomes sections as well as other pertinent information in the consumer's record. The Waiver qualifying conditions that significantly affect the consumer's adaptive function and community participation identified in this analysis should be documented on the "Medicaid Waiver Eligibility Record" (DS 3770). The consumer must have a minimum of two qualifying conditions in any one area or a combination of areas.

SANDIS will have the capability to automatically populate the DS 3770 with information from the revised CDER based on the responses, or scores assigned to applicable evaluation elements. However, this automation does not take the place of the QMRP's professional judgment in determining that the identified issues are qualifying conditions for HCBS Waiver level-of-care eligibility. As stated above, information in the consumer's record, such as the Individual

Program Plan (IPP), progress reports, medical and psychological evaluations and Title 19 notes, should be reviewed to ensure that the issues identified in the CDER and DS 3770 significantly affect the consumer's ability to perform activities of daily living and/or participate in community activities. The services and supports in place for these needs must be addressed in the IPP. Evaluation elements automatically entered by SANDIS that the QMRP determines are not qualifying conditions, must be removed from the DS 3770. Likewise, any elements the QMRP determines are qualifying conditions should be added to the DS 3770, if they were not automatically entered.

If you have any questions regarding level-of-care determinations, please contact Jim Knight, Waiver Monitoring Section, at (916) 653-7710.

Attachment I

**CRITERIA FOR HCBS WAIVER LEVEL-OF-CARE ELIGIBILITY DETERMINATIONS
USING THE REVISED CDER**

To be eligible for the HCBS Waiver program, the consumer must have substantial limitations in his or her adaptive functioning which could require the level of care provided in an ICF/DD, ICF/DD-H and/or ICF/DD-N as defined in Title 22, California Code of Regulations (§§51343, 51343.1 and 51343.2). The consumer must have, at a minimum, two qualifying conditions in any one area or a combination of areas listed below. These areas are organized below to correspond with the revised CDER and to provide additional detail regarding the CDER revisions.

Determination that a qualifying condition exists is based on an evaluation that the condition **significantly** affects the consumer's ability to perform activities of daily living and/or participate in community activities.

1) Elements in the revised CDER:

a) Skills Demonstrated in Daily Life

- Walking
- Using a Wheelchair
- Taking prescription medication
- Eating
- Toileting
- Bladder and Bowel control
- Personal care
- Dressing
- Safety awareness

b) Challenging Behaviors

- Disruptive social behavior
- Aggressive social behavior
- Self-injurious behavior
- Emotional outbursts
- Destruction of property
- Running or wandering away

2) Elements eliminated in the revised CDER

Consistent with the Title 22 standards for admittance to an ICF, substantial limitations in the following areas may also be considered as qualifying conditions when determining Waiver eligibility:

- Rolling and sitting
- Crawling and standing
- Smearing

3) Elements that have been combined in the revised CDER

The following qualifying conditions are combined into broader elements in the revised CDER. For example, bathing and hygiene skills are combined as part of the personal care element in the revised CDER.

- Bladder and bowel control are now a single element
- Bathing and hygiene are now part of the personal care element

The areas listed above may be considered as individual qualifying conditions. For example, bathing and hygiene may be considered as two qualifying conditions for the purpose of determining Waiver eligibility. However, bathing and personal care cannot be counted as separate qualifying conditions.

4) Health Related Conditions

Medical or physical conditions that require nursing care or observation on an ongoing intermittent basis to meet the consumer's needs can also be considered qualifying conditions. Examples include:

- Seizures controlled by medications
- Diabetic testing on a daily and regular basis.
- The consumer has a medical condition that requires at least daily or weekly injections.
- The consumer has a medical condition that requires daily medications to control the progression of the disease.
- Apnea monitoring
- Oxygen therapy includes continuous positive airway pressure (CPAP) with or without artificial airway.
- Colostomy/ileostomy care. The consumer has colostomy or ileostomy that requires direct care and treatment by another person or close supervision in situations where the consumer is able to perform some of the tasks.
- Gastrostomy feeding and care. The consumer requires at least one or all of his or her dietary needs via gastric tube or gastrostomy tube or oral feedings supplemented with nasal/gastric tube feedings.
- Naso-gastric feeding

- Tracheostomy care and suctioning
- The consumer needs special feeding assistance. (Special eating utensils)
- Sensory deprivation (deaf and /or blind). The degree of auditory and visual perception should be such that consumers require constant reminders, supervision or partial assistance in completing independent living/self-help domain activities and safety awareness of his/her environment.



DEPARTMENT OF DEVELOPMENTAL SERVICES

COMMUNITY OPERATIONS DIVISION PROGRAM ADVISORY

(COD) 02-02

March 27, 2002

LEVEL OF CARE DETERMINATION AND IPP REQUIREMENTS For Home and Community-Based Services (HCBS) Waiver Consumers

INTRODUCTION

This program advisory supersedes the program advisory dated March 30, 1999, on the level-of-care determination eligibility requirements for the HCBS Waiver program, including how special conditions and specified behavioral challenges (Attachment A, page 3) can be considered a qualifying condition when there are other conditions that significantly affect the consumers' ability to perform activities of daily living (ADL) and/or participate in the community. This advisory also specifies the requirements for addressing HCBS Waiver consumers' qualifying conditions in the individual program plan (IPP). This information is consistent with the training on these topics provided in January 2002.

BACKGROUND:

The HCBS Waiver provides funding for services to individuals who, but for the provision of these services, would require the level of care provided by an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

The Client Development Evaluation Report (CDER) is the written instrument used to evaluate the individual's level of care needs.

The flexibility afforded under the HCBS Waiver program has allowed the State to develop and implement strategies to provide an array of services to consumers who wish to reside in the community with appropriate supports and services. The HCBS Waiver program requires that consumers have an individualized plan of care that details the services and supports in place to: meet the consumer's needs, ensure their safety, and protect their health and

welfare.

IMPLEMENTATION:

I. Level of care determinations

Effective February 1, 2002, revised "Criteria for HCBS Waiver Level of Care Eligibility" (Attachment A) was implemented. Evaluation of each consumer's level of care is now based on his/her ability to perform activities of daily living and community participation and not strictly on the basis of CDER scores.

To be eligible for the HCBS Waiver, the consumer must have substantial limitations in his or her present adaptive functioning which qualify the consumer for the level of care provided in an intermediate care facility for the developmentally disabled (ICF DD), intermediate care facility for habilitation (ICF/DDH) and intermediate care facility for nursing (ICF/DD-N). (See CCR, Title 22, Sections 51343, 51343.1 and 51343.2)

The CDER Summary Profile may be used as a worksheet (Attachment B) to identify the qualifying conditions (Attachment A) that affect the consumer's adaptive functioning and community participation. The consumer must have a minimum of two qualifying conditions in any one area or a combination of areas. The Medicaid Waiver Eligibility Record (form DS 3770) must contain a summary of the qualifying conditions.

II. HCBS Waiver IPP Requirements

All qualifying conditions identified on the CDER Summary Profile must be addressed in the consumer's IPP. Therefore, the IPP document must include the

Attachment II

services and supports in place that address the identified conditions. This includes identifying the service provider/individual(s) responsible for providing the identified services and supports.

Qualifying conditions from the same area (e.g., multiple behaviors from the CDER emotional domain or multiple health related conditions or needs) do not need to be addressed individually if the support for these conditions is from the same source(s).

At times, a consumer or his/her authorized representative may choose not to address one or more qualifying conditions in the IPP. In this instance, the consumer's record must contain documentation that the consumer has chosen not to include the information in the IPP and what support is being provided or offered for the excluded conditions.

If you have any questions regarding level of care or IPP requirements, please contact Jim Knight, Federal Programs Operations Section, at (916) 653-7710.

Attachment-A

**CRITERIA FOR HCBS WAIVER LEVEL OF CARE ELIGIBILITY USING THE
CDER SUMMARY PROFILE**

Federal regulations state that the primary purpose of the ICF/MR is to furnish health or rehabilitative services and active treatment (42 CFR, §440.150 and §438.440). For Home and Community-Based Services Waiver consumers, while there is no requirement for active treatment, there is a requirement that a program of activities meeting the individual's needs be made available to protect his or her health and welfare (42 CFR §441.302(a) and Medicaid Letter Number 97-10).

To be eligible for the HCBS Waiver program, the consumer must have substantial limitation in his or her present adaptive functioning which require the level of care provided in an ICF/DD, ICF/DD-H and/or ICF/DD-N as defined in Title 22, California Code of Regulations (§§51343, 51443.2 and 51343.1). The consumer must have, at a minimum, two qualifying conditions. The qualifying conditions can be in any one area or a combination of areas specified below.

Determination that a qualifying condition exists is based on an evaluation that the condition **significantly** affects the consumer's ability to perform activities of daily living and/or participate in community activities.

AREAS:

1) Motor Domain:

- Rolling and sitting
- Crawling and standing
- Ambulation
- Wheelchair mobility

2) Independent Living Domain/Self-Help Skill:

- Eating
- Toileting
- Bladder control
- Bowel control
- Personal hygiene
- Dressing skill task
- Bathing

3) Cognitive Domain:

- Safety awareness and compliance

Attachment-A

4) Social Domain:

- Unacceptable social behavior-positive social participation is impossible unless closely supervised or redirected.

5) Emotional Domain:

- Aggression
- Self-injurious behavior
- Smearing feces
- Destruction of property
- Running or wandering away
- Depressive-like behavior
- Reaction to frustration
- Repetitive body movement
- Inappropriate undressing
- Hyperactivity
- Temper tantrums
- Resistiveness

6) Health Related Conditions:

Medical or physical conditions that require skilled nursing care or observation on an ongoing intermittent basis and 24 hour supervision to meet the consumer's needs should be considered in the eligibility process. Examples include:

- Seizures controlled by medications
- Diabetic testing on a daily and regular basis.
- The consumer has a medical condition that requires at least daily or weekly injections.
- The consumer has a medical condition that requires daily medications to control the progression of the disease.
- Apnea monitoring
- Oxygen therapy includes continuous positive airway pressure (CPAP) with or without artificial airway.
- Colostomy/ileostomy care. The consumer has colostomy or ileostomy that requires direct care and treatment by another person or close supervision in situations where the consumer is able to perform some of the tasks.
- Gastrostomy feeding and care. The consumer requires at least one or all of his or her dietary needs via gastric tube or gastrostomy tube or oral feedings supplemented with nasal/gastric tube feedings.

Attachment-A

- Naso-gastric feeding
- Tracheostomy care and suctioning
- The consumer needs special feeding assistance. (Special eating utensils)
- Sensory deprivation (deaf and /or blind). The degree of auditory and visual perception should be such that consumers require constant reminder, supervision or partial assistance in completing independent living/self-help domain activities and safety awareness of his/her environment.

OTHER CONSIDERATIONS:

The following special conditions or behaviors be considered during level-of-care determinations only as part of other areas that significantly impact the consumer's functioning abilities:

- Maladaptive sexual behavior
- Assaultive behaviors
- Attempted suicide in the past five years
- Habitual theft
- Vandalism or other acts of property damage
- Conviction of substance abuse or alcohol abuse related offense
- Recent history of abusing drugs or alcohol
- History of habitual lying
- History of behavior that could result or has resulted in fire setting.

MEDICAID WAIVER ELIGIBILITY RECORD
DS 3770 (Rev. 5/2001) (Electronic Version)

Print

<p>Eligible _____ Termination _____ Reactivation _____ Recertification _____</p> <p style="text-align: center; font-size: small;">Date Date Date Date</p> <p>ALL LEVEL OF CARE QUALIFYING DEFICITS: (Includes special health care requirements.)</p> <p>Short Term Absences: Yes <input type="checkbox"/> No <input type="checkbox"/> (Specify dates.)</p> <p>Comments:</p> <p> _____ _____</p> <p style="font-size: small;">Signature and Title (QMRP) Date</p>	<p>STATE VERIFICATION:</p>
---	-----------------------------------

<p>Eligible _____ Termination _____ Reactivation _____ Recertification _____</p> <p style="text-align: center; font-size: small;">Date Date Date Date</p> <p>ALL LEVEL OF CARE QUALIFYING DEFICITS: (Includes special health care requirements.)</p> <p>Short Term Absences: Yes <input type="checkbox"/> No <input type="checkbox"/> (Specify dates.)</p> <p>Comments:</p> <p> _____ _____</p> <p style="font-size: small;">Signature and Title (QMRP) Date</p>	<p>STATE VERIFICATION:</p>
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Eligibility Group	UCI	Social Security Number	Birthdate	Consumer Name
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**MEDICAID WAIVER CONSUMER CHOICE
OF SERVICES/LIVING ARRANGEMENT STATEMENT**

DS 2200 (Rev. 2/2000) (Electronic Version)



The consumer, parent/legal guardian, or legal representative, or involved other person has been informed of the feasible alternative of services available. The consumer has been offered a choice of receiving such services in a community care residential facility, in an in-home living arrangement, or in a long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N).

Consumer Identification Information/Date of Choice

Consumer's Name	Date of Choice (date form completed)
UCI	DOB

Choice of Services/Living Arrangement

I. MINORS

The consumer is a minor. The choice of living arrangement has been made by the parent, legal guardian, or legal representative as indicated in Section III below:

_____ Date _____
 Signature Date

II. ADULTS

a. The consumer is an adult and has chosen the living arrangement as indicated in Section III below:

_____ Date _____ _____ Date _____
 Client's signature/mark ("X") Witness' signature

The consumer is an adult but is unable to make such choice. The choice of living arrangement has been made by:

- b. The consumer's legal representative; or, if the client has no legal representative
- c. The consumer's parents, relatives or other persons actively involved in the development of the consumer's plan of care;

_____ Date _____
 Signature Date

III. SERVICES/LIVING ARRANGEMENT

- A. A long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N)
- B. A community care residential facility, or
- C. Consumer's choice of living arrangement other than above (please specify): _____

IV. DISENROLLMENT FROM MEDICAID WAIVER

- A. I choose/my legal guardian/representative chooses to terminate my Medicaid Waiver participation. Since this is my choice, I will not be requesting a fair hearing.

_____ Date _____
 Signature Date

V. COMMENTS:

**INSTRUCTIONS FOR MEDICAID WAIVER
CONSUMER CHOICE OF SERVICES/LIVING ARRANGEMENT STATEMENT**

Under the terms of the Title XIX Medicaid Waiver Program, each consumer must be informed of any feasible alternative services under the Waiver and be given a choice of receiving those services in a community care residential facility, in-home living arrangement, or long-term health facility. If those services are not offered or available, the consumer or his or her representative must be apprised of his/her right to a fair hearing.

The DS 2200 Medicaid Waiver Consumer Choice of Services/Living Arrangement is to be completed as follows:

Consumer Identification Information/Date of Choice

Enter the consumer's first and last name.

Enter the date the choice is offered which should be concurrent with the date the consumer is either initially enrolled in the Medicaid Waiver program or the date of reenrollment in the Medicaid Waiver program after a period of ineligibility greater than 120 days.

Enter the consumer's unique identifier (UCI).

Enter the consumer's date of birth.

Choice of Services/Living Arrangement

The following persons are responsible for making the Medicaid Waiver choice of services/living arrangement determination. The signature of such persons must be consistent with the signatures for other consent forms, release of information forms, etc. contained in the consumer's record.

Minors

The parent/legal guardian/legal representative must make the choice by marking the box indicating who is making the choice, signing, and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Adults

- a. The consumer indicates his/her choice by signing his/her name or making his/her mark. The consumer's mark must be witnessed. A representative of the interdisciplinary (ID) team may be a witness. The choice form must be dated. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

- b. The consumer has a legal representative. The legal representative must make the choice by marking the box indicating who is making the choice, signing and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

The ID Team

- c. Parents, relatives, or others involved in the development of the consumer's plan of care who represent the ID team for those consumers who are not able to indicate their choice and do not have a legal representative must make the choice by marking the box indicating who is making the choice, signing, and the dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Consumer Choice to Disenroll from the HCBS Waiver Program

Should an HCBS consumer or his/her parent, legal guardian, representative wish to voluntarily terminate enrollment, the consumer or his/her parent, legal guardian, representative should mark the box and sign and date the form to document his/her/their choice.

Comments

Use this section to provide any clarification or explanation with either the choice of services/living arrangement, the signatures, or dates provided.

NOTE: In those instances when services or choice of living arrangement (community or health facility) cannot be provided, the consumer/parent/legal guardian or legal representative/other involved person must be apprised that they are entitled to a fair hearing.

**Technical Instructions and Rules for Regional Center Staff Regarding HCBS
Waiver Eligibility, Recertification and Terminations.**

Determination of Eligibility

1. Regional center eligibility: A regional center has found the person to be eligible to receive ongoing regional center services (Status 2).
2. Medi-Cal eligibility:
 - a. County welfare offices are responsible for making all determinations regarding eligibility for Medi-Cal benefits using eligibility criteria that are applied uniformly throughout the State (This applies to all Medi-Cal beneficiaries, not just HCBS Waiver participants). The eligibility criteria for the HCBS Waiver include low income families with children as described in Section 1931 of the Social Security Act, Supplemental Security Income (SSI) recipients, optional state supplement recipients, the special HCBS Waiver group that qualifies for institutional deeming, medically needy, and all other mandatory and optional groups.
 - b. Regional centers are authorized to apply for Medi-Cal on behalf of consumers who are adults and do not have a legal guardian or conservator.
 - c. If a regional center cannot obtain documentation that a person is currently eligible for Medi-Cal benefits, a verification of Medi-Cal eligibility request can be sent to DDS Federal Programs Operations Section for action. When Medi-Cal eligibility has not been established, the regional center should take the following steps to see if the person is eligible for the HCBS Waiver and then assist the individual to seek enrollment in Medi-Cal:
 - I. Determine that the person qualifies for HCBS Waiver funding (has a developmental disability, meets the ICF level of care requirements, chooses to live in a community setting and receives at least one HCBS Waiver funded service a year);
 - II. Assist the person, or where appropriate his or her family or legal representative to take steps to apply for Medi-Cal including,
 - III. Complete and send a DDS Waiver Referral Form (DHS 7096) (**See Appendix 1**) to the County Welfare Office for review and determination of Medi-Cal eligibility. Medi-Cal rules allow up to three months retroactive eligibility for new applications.
3. Level of care determination: Qualified Mental Retardation Professionals (QMRPs) are responsible for making level of care determinations. The criterion for level of care determinations is spelled out in Community Operations Division Program

Advisory 02-02: *Level of Care Determination and IPP Requirements for HCBS Waiver Consumers*. (See **Appendix 2** for a copy of this Program Advisory) The steps in making and documenting the determination include:

- a. Determination of the person's needs and qualifying conditions by the QMRP through review of both historical and current documents to ensure the person has at least two qualifying conditions as described in the Community Operations Division Program Advisory 02-02. This review should include the Client Development Evaluation Report (CDER), the Early Start Report, IPP, annual and/or quarterly progress reports, clinical evaluations, medical information and any other documents that indicate the person's needs;
 - b. The CDER Consumer Summary Profile (See **Appendix 2**) may be used as a worksheet to identify or clarify qualifying conditions that affect a person's adaptive functioning and community participation. The identified qualifying conditions for HCBS Waiver eligibility should be consistent with the CDER and other assessments.
 - c. Completion of the Medicaid Waiver Eligibility Record (form DS 3770) (See **Appendix 3**). This form serves as a continuous log for all actions taken relative to eligibility determinations and re-evaluations. The QMRP is required to complete, sign (including the title QMRP) and date the DS 3770. The date of the signature must be within the same month as the date that eligibility was determined;
 - d. The QMRP signature, title and date are critical steps in the process. They are used as measures of timeliness in meeting the requirements for initial determination and re-certifications of eligibility and as proof that the determinations/re-certifications were made by a QMRP as required.
4. Choose to participate in the HCBS Waiver: The person or his or her legal representative must indicate their choice of receiving HCBS Waiver services and living in a community setting by signing the Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement (DS 2200) (See **Appendix 4**).
 5. Developing an Individual Program Plan: The planning team develops an IPP using a person-centered planning approach. The IPP must address the needs and preferences of the consumer including, but not limited to those to be addressed through generic resources, Medi-Cal or HCBS Waiver services. The completed document includes the amount of services and supports to address all qualifying conditions, the service provider(s)/individual(s) responsible for providing the services and supports and an approximate start date for new services. The consumer or, where appropriate, his or her legal representative, and the regional center representative must sign the IPP prior to implementation. Since HCBS Waiver funded services are intended to prevent the need for institutional care, it is important that the IPP identify at least one HCBS Waiver funded service to be provided

annually. If a consumer does not need or utilize one of these services, the consumer is not eligible for the HCBS Waiver.

6. **Establishing initial eligibility dates:** The initial eligibility date must be established after the QMRP has determined that the person is eligible for HCBS Waiver services (has a developmental disability, meets the ICF level of care, chooses to live in a community setting, receives at least one HCBS Waiver funded service a year, and is eligible for Medi-Cal).
 - a. The initial eligibility date is usually the first day of the month the person's record is reviewed by the QMRP and the determination is made, except in cases where a person applies for Medi-Cal through institutional deeming or other date specific events described below. The signature date (the date the record is reviewed) on the Medicaid Waiver Eligibility Record (DS 3770) (**See Appendix 3**) must be within the same month as the eligibility date.
 - b. When Medi-Cal eligibility has not been determined, the DDS Waiver Referral form (DHS 7096) (**See Appendix 1**) is completed and sent to the county Medi-Cal office. If the person will not be eligible for Medi-Cal due to parental or spousal income or property levels, the county will then determine the person's Medi-Cal eligibility as if the person were residing in an institution, often referred to as institutional deeming. This option for regional center consumers to be institutionally deemed for Medi-Cal eligibility is only available through the HCBS Waiver. As such, the consumer must have been determined to meet the HCBS Waiver level of care requirement prior to the referral to the county Medi-Cal office and must remain a HCBS Waiver consumer in order to continue the Medi-Cal benefit. This allows for the resources of a spouse or parents to be ignored and only the applicants resources will be considered in making the Medi-Cal eligibility determination. Medi-Cal rules allow for up to three months retroactive eligibility for new applications. Therefore, HCBS Waiver eligibility can be retroactive up to three months prior to the month the application was submitted to the county.

Examples:

A person currently residing in the community was determined eligible on 3/18/07, making their initial HCBS Waiver eligibility date 3/1/07.

When a person is discharged from a State Developmental Center, nursing facility, or an acute hospital on 5/12/07 their HCBS Waiver eligibility date can be no earlier than 5/12/07.

An institutionally deemed person who applied for Medi-Cal in April could have an HCBS Waiver initial eligibility date that is retroactive back to January 1.

Re-Certification of HCBS Waiver Eligibility

Every person who receives funding through the HCBS Waiver must have his or her HCBS Waiver eligibility reviewed by a QMRP at least annually. The re-certification must be documented on the Medicaid Waiver Eligibility Record (DS 3770) (**See Appendix 3**). The DS 3770 must be signed by the QMRP and be dated within the anniversary month of the initial or latest certification.

Example:

If the initial eligibility date is 12/1/06, the recertification must be completed on or prior to 12/1/07, and have a signature date within that same month.

A re-certification may occur prior to the 12-month interval, but exceeding the 12-month period will cause the person to become ineligible for the HCBS Waiver. If this were to occur the QMRP must terminate Waiver eligibility as of the end of the recertification year (anniversary date). The QMRP may then reactivate eligibility effective the date all eligibility conditions were met.

Steps in the Re-Certification of Eligibility

In re-certifying the person's eligibility, the QMRP must evaluate the person's needs and level of care by reviewing all current information and progress reports. As with initial eligibility determinations, the person must be eligible for full scope Medi-Cal, reside in a community setting and have at least two qualifying conditions that are addressed in the IPP by at least one billable HCBS Waiver service each year.

1. If not done previously, all short-term absences from the HCBS Waiver that occurred during the previous year must be recorded on the Medicaid Waiver Eligibility Record (DS 3770). (**See Appendix 3**) By reporting short-term absences, regional centers suspend HCBS Waiver billing for periods when a person is not in HCBS Waiver approved and/or Medi-Cal funded settings.

A short-term absence is a period of ineligibility of at least 1 day but less than 120 days due to hospitalization, incarceration, etc. To accurately reflect the time of the absence, the beginning date of the short-term absence must be recorded as the day before the absence begins and the ending date of the short-term absence is the day the consumer is either discharged from the non-HCBS Waiver funded setting or returns home.

Example:

A person was admitted to a hospital on 7/28 and was discharged on 7/31. Since Medi-Cal will pay for 7/28 – 7/30 (charge is based on number of nights), the short-term absence must be recorded as starting 7/27 and ending 7/31.

2. A person must be terminated from the HCBS Waiver if he or she no longer meets the HCBS Waiver eligibility criteria. Causes for termination are:
 - a. When a person is no longer eligible because of an event specific reason, (such as move out of state, move to an institutional setting, voluntary dis-enrollment, or death) the termination date will be the date the event occurred.
 - b. Other reasons for termination from the HCBS Waiver, including no longer meeting the level of care criteria, Medi-Cal ineligibility, etc, result in the termination date being the last day of the month when the determination was made.
3. A person whose HCBS Waiver eligibility is terminated because he or she no longer meets the level of care requirements for the HCBS Waiver must either be sent a notice of action or sign the Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement (DS 2200) (**See Appendix 4**) indicating he or she has voluntarily disenrolled from the HCBS Waiver.

The Effects of Transfers Between Regional Centers on HCBS Waiver Eligibility

Under federal regulations, Medicaid (Medi-Cal) funding is "portable" within a state. Thus, an individual may move from one location within a state to another location within the same state and retain his or her eligibility for Medi-Cal and the HCBS Waiver as well as access to the services identified in his or her IPP. Since HCBS Waiver eligibility is valid throughout California, a person transferring between regional centers continues to be eligible for the HCBS Waiver funding. There are administrative actions that are required by both the receiving and sending regional centers. The consumer remains HCBS Waiver eligible through the sending regional center until the receiving regional center has accepted fiscal responsibility. There should be no gap or interruption in the individual's HCBS Waiver eligibility (assuming all eligibility conditions continue to be met) during the case transfer process. Likewise there is no requirement that the receiving regional center conduct a new level of care assessment upon case transfer. The transfer of Medi-Cal eligibility from county to county is handled by DHS. "Terminations" from the sending center and "adds" or "reactivations" at the receiving center are necessary to track the person and ensure appropriate billing for services. However, the anniversary date for recertification of eligibility does not change.

Steps in Terminating and Activating Case Transfers

1. The receiving center must activate the person when fiscal responsibility is accepted, which is typically the first day of the month.
2. The sending regional center should be notified that HCBS Waiver eligibility tracking at that center must end the day before the receiving center accepted fiscal responsibility.

3. The receiving center must ensure that HCBS Waiver eligibility is reviewed no more than 12 months from the time the sending center last reviewed the person's eligibility.

Example:

A person is recertified for the HCBS Waiver on 2/1/06 and subsequently transfers from Harbor Regional Center (HRC) to North Bay Regional Center (NBRC). NBRC activates the person's HCBS Waiver eligibility and begins its fiscal responsibility on 5/1/03 notifying HRC to terminate the person on 4/30/03 ending its fiscal responsibility, which allows for tracking. The next recertification must be completed no later than 2/1/07.

Retro-Termination

Retro-termination occurs when a person who did not meet the HCBS Waiver eligibility criteria was made eligible in error. Upon discovery of the error the person is terminated from the HCBS Waiver retroactively. The termination date is the same date as the person's initial eligibility date, indicating the person never had HCBS Waiver eligibility.

Example:

A person's initial eligibility date is 2/1/07, a determination is made the person was never eligible for HCBS Waiver funding; the retro-termination date would also be 2/1/07.

Reactivation

A person previously terminated from the HCBS Waiver can be made eligible again if he or she meets all of the HCBS Waiver eligibility criteria. The reactivation date will either be the first of the month for non-event specific reasons such as increased qualifying conditions or a specific date in the month when the eligibility is dependent upon an event, such as the day of discharge from a long-term health care facility.

**HOME AND COMMUNITY BASED SERVICES WAIVER CONSUMER
Standardized Annual Review Form**
(DDS Form, Revised 11-19-98)

Name:
UCI:
Date of Annual Review:

(File with annual reviews in consumer's record)

1. A review of the consumer's general health status was completed on _____.

Summary of Health Status Review

(Note any concerns and indicate if any referrals have been made to regional center clinicians, the consumer's physician, or other health resources)

2. The IPP Planning Team has reviewed the consumer's IPP, dated _____, and has determined that no new services or supports are required, and the IPP remains appropriate to meet the consumer's needs and wants.

Explain why no changes are necessary to the current IPP

3. The IPP Planning Team has reviewed the consumer's IPP, dated _____, and amended the IPP to include the following new service(s) or support(s):

4. The IPP Planning Team has reviewed the consumer's CDER, dated _____, and determined that no changes are necessary.

5. The IPP Planning Team has reviewed the consumer's CDER, dated _____, and a new updated CDER was completed on _____.

IPP Planning Team Signatures

1. Name: _____ Date: _____ (Consumer)
2. Name: _____ Date: _____ (Service Coordinator)
3. Name: _____ Date: _____ ()
4. Name: _____ Date: _____ ()



DEPARTMENT OF DEVELOPMENTAL SERVICES

COMMUNITY SERVICES DIVISION

PROGRAM ADVISORY



PSB-99-5

DATE: July 28, 1999

DEPARTMENT OF DEVELOPMENTAL SERVICES' POLICY ON REPRISALS

INTRODUCTION

The purpose of this advisory is to set forth the Department of Developmental Services' (DDS) policy on prohibition of reprisals against consumers, families, advocates or others who make a complaint against a service provider or the regional center.

BACKGROUND

The Health Care Financing Administration (HCFA) conducted a review of the Home and Community- Based Services (HCBS) Waiver in June through August of 1997. One of the issues raised was that consumers, families, advocates and others who made a complaint against a service provider or the regional center could be subject to reprisals by the provider or regional center. In response to this finding, DDS agreed to provide a policy statement to regional centers prohibiting such reprisals.

POLICY ON PROHIBITION OF REPRISALS

Regional centers shall ensure that none of their staff engage in any behavior that could be considered to be a "reprisal" against any consumer, family member, advocate or others, for making a complaint against the regional center or a service provider.

If you have any questions regarding the policy information in this Program Advisory, please contact Walter Kealy, Chief, Federal Programs Operations Section at (916) 654-2052.

"Building Partnerships, Supporting Choices"

State of California—Health and Human Services Agency

Department of Developmental Services

VENDOR APPLICATION

DS 1990 (Rev. 11/2004) (Electronic Version)

Print**Reset Form**

Applicant Name					Federal Tax ID or SSN *
Name of Governing Body or Management Organization					
Mailing Address	(Street)	(City)	(State)	(Zip)	(County)
Service Address	(Street)	(City)	(State)	(Zip)	(County)
<i>(if different than mailing address)</i>					
Applicant <i>(owner or executive director)</i>				Telephone number ()	
Type of Service to be Provided				Facility Capacity	

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature ▶	Date
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INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

- (A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;
- (B) Any academic degree required for performance or operation of the service;
- (C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;
- (D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;
- (E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;
- (F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;
- (G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;
- (H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.

* "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."

**HOME AND COMMUNITY BASED-SERVICES
PROVIDER AGREEMENT**

Name of Service Provider *(Please type or print)*

Address

Telephone

Vendor Number

Service Code

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. The Provider shall also certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE REGIONAL CENTER A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER OF CARE CLAIM FORM.

I certify that the undersigned will be A PARTICIPATING provider of Medi-Cal home and community-based services upon SUBMISSION OF THIS AGREEMENT TO THE REGIONAL CENTER and satisfaction of all vendorization requirements pursuant to Title 17, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and in California Code of Regulations, Title 22.

Department of Health Services

Signature of Service Provider

Date

SERVICES AVAILABLE THROUGH THE HCBS WAIVER

ADULT RESIDENTIAL

BEHAVIOR INTERVENTION SERVICES

CHORE SERVICE

COMMUNICATION AIDES

CRISIS INTERVENTION FACILITY

DAY HABILITATION

ENVIRONMENTAL MODIFICATIONS

FAMILY TRAINING

HOME HEALTH AIDE

HOMEMAKER

MOBILE CRISIS INTERVENTION

NON-MEDICAL TRANSPORTATION

NUTRITION

PERSONAL EMERGENCY RESPONSE SYSTEM

PREVOCATIONAL SERVICES

RESIDENTIAL HABILITATION FOR CHILDREN SERVICES

RESPIRE CARE

SKILLED NURSING

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

SPECIALIZED THERAPEUTIC SERVICES

SUPPORTED EMPLOYMENT SERVICES

TRANSITION/SET UP EXPENSES

VEHICLE ADAPTATIONS

Home and Community-Based Services Waiver

MONITORING PROTOCOL

VERSION 5.0

CALIFORNIA DEPARTMENTS OF
DEVELOPMENTAL SERVICES
AND
HEALTH SERVICES

HOME AND COMMUNITY-BASED SERVICES WAIVER MONITORING PROTOCOL

OVERVIEW OF THE CALIFORNIA HOME AND COMMUNITY-BASED SERVICES WAIVER

Medicaid, known as Medi-Cal in California, is a jointly-funded, federal-state health insurance program for certain low income and needy people that includes long-term care benefits. Before 1981, these long-term care benefits were limited to institutional facilities that included hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation. In 1981, President Reagan signed into law the Medicaid Home and Community-Based Services Waiver program, section 1915c of the Social Security Act. The legislation provided a vehicle for states, for the first time, to offer services not otherwise available through their Medicaid programs to serve people in their own homes and communities. The HCBS Waiver program is administered by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Division.

California was approved for its first Waiver for the developmental disabilities service system in 1982 with a total enrollment cap of 3,360. Today, the Waiver has an enrollment limit of 55,000 persons that will increase to 70,000 persons in the federal year ending September 30, 2006. A condition of Waiver approval is agreement to comply with six required federal assurances.

1. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under the HCBS Waiver;
2. Plans of care are responsive to Waiver participant needs;
3. Only qualified providers serve Waiver participants;
4. Level of care need determinations are consistent with the need for institutional care;
5. The state Medicaid Agency retains administrative authority over the Waiver program; and
6. The state provides financial accountability for the Waiver.

ADMINISTRATION OF THE CALIFORNIA WAIVER



QUALITY ASSURANCE AND MONITORING

CMS and the states are responsible for quality assurance in HCBS Waiver programs. The CMS monitoring protocol explains the respective scopes of responsibility as, "States have first-line responsibility for quality assurance in the

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Waiver programs, and that the RO reviewers' (CMS) responsibility is to evaluate whether and to what extent the States are meeting their responsibilities. The States should be conducting front-line monitoring activities; the RO (CMS) review should be more of a "look behind" review."

States spell out how they will address the six assurances in their approved HCBS waivers. CMS considers the state's compliance with the assurances as the core for a Waiver review. Thus, the current CMS monitoring protocol focuses on the design and implementation of the state's quality assurance system in each of the six assurance areas.

The administrative structure for California's HCBS Waiver places responsibility for quality assurance and monitoring at all three levels. DHS has principle responsibility for ensuring that the design and operation of the Waiver are consistent with the assurances in the approved Waiver and with Medicaid statute and regulation. DDS is responsible for overseeing the overall design and operation of the quality assurance program and for monitoring its implementation. The regional centers are responsible for implementing the Waiver through establishing Waiver eligibility, developing plans of care, providing or purchasing needed services and supports, and vendorizing and overseeing providers of services and supports.

One way that DHS and DDS monitors compliance with the HCBS Waiver requirements is through joint biennial on-site monitoring reviews of the regional centers. The biennial reviews are conducted in accordance with process set forth in this Protocol.

OVERVIEW OF THE HCBS WAIVER MONITORING PROCESS

Collaborative reviews of regional centers are conducted every two years. Each review has three phases: pre-review, on-site review, and post review. Pre-review activities include notification of the regional center, sending out the regional center self-assessment tool and selecting a sample of Waiver participants. The on-site review includes the review of consumer records at the regional center, residential facilities and day programs; interviews with regional center service coordinators, clinical services staff, and quality assurance staff; interviews with service providers and direct support staff; program/facility reviews; and a review of special incident reports. The post review includes developing the report of the review that delineates areas that regional centers need to address, and receiving and reviewing a plan of action from the regional center.

SAMPLING PROCEDURE

The sample for the two-year review cycle consists of a statewide sample of 350 Waiver participants selected at random from each of three major residence types: Own Home-Parent, Community Care Facility, and Independent Living or Supported Living. The combined sample for the three residence types is 1050 participants. The size of the sample for each regional center will vary. The size of the regional center sample matches the regional center's percentage of the statewide total Waiver participants within each residence type. For example, if Regional Center A serves 40 percent of all Waiver participants in the state who reside in CCFs, while Regional Center B serves 60 percent of all Waiver participants who reside in CCFs, the CCF portion of the sample would consist of 140 Waiver participants from Regional Center A (40% x 350) and 210 Waiver participants from Regional Center B (60% x 350). The procedure to produce a list of Waiver participants to be reviewed is shown below.

1. The review begins by calculating the actual percentage of all Waiver participants in each residence type for the regional center that is the subject of the Waiver review. This is done by calculating the regional center's percentage of the statewide total of Waiver participants in each residence type. The calculation is made using data for the quarter immediately preceding the start of the audit.
2. Multiplying the regional center's percentage for each residence type by 350 derives the number of Waiver participants to be reviewed in each residence type. For example, Regional Center X serves 10 percent of all Waiver participants in the state who reside in CCFs, 20 percent of all Waiver participants who reside in their own home, and 10% of all Waiver participants who reside in ILS or SLS settings. The regional center's sample would include 35 participants in CCFs (10% x 350), 70 participants who

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live at home (20% x 350), and 35 participants (10% x 350) who live in ILS or SLS settings for a total sample of 140 participants.

3. The next step is to create a list of Waiver participants for review. The list is created by randomly selecting the number of participants in each residence type. The actual number of selected consumers of each residence type should be 20 percent larger (or contain at least 10 more consumers) than the actual number required to allow for substitutions in the event a participant is not available for the review. The additional participants should be reviewed only if participants selected earlier cannot be reviewed.

SCOPE OF REVIEW

The regional center, CCF and day program consumer records will be reviewed for all participants in the sample. An attempt will be made to interview all participants in the sample. Participation in the interview is voluntary. All reviews will include interviews with regional center service coordinators, clinical staff and quality assurance staff. Interviews are also conducted with service providers and direct support staff. A physical inspection is conducted at CCFs and day programs. Special incident reports are reviewed for compliance with reporting and follow-up requirements.

REVIEW AND DATA COLLECTION INSTRUMENTS

Section I Regional Center Self-Assessment

The Centers for Medicare and Medicaid Services (CMS) requires all States to provide six assurances as a condition of Waiver approval. The assurances are for the health and welfare of Waiver participants, for plans of care responsive to Waiver participant needs, that only qualified providers serve Waiver participants, that the State conducts level of care need determinations consistent with need for institutionalization, that the State Medicaid Agency retains administrative authority over the Waiver program, and that the State provides financial accountability for the Waiver. DHS is the State Medicaid Agency. DDS has responsibility for the operational aspects of implementing the Waiver. All Waiver services are provided through the regional center system. As such, regional centers have a role in carrying out five of the Waiver assurances. The purpose of the regional center self-assessment is to gain assurance from the regional center that it has written policies, procedures and practices and a system to assure compliance in 24 areas associated with the HCBS Waiver assurances. The 24 regional center assurances are limited to areas where DDS does not routinely collect information from the regional centers. The report to the regional center on the results of the review will contain comments and recommendations for those regional center assurances where there is a need for improvement.

Section II Regional Center Consumer Record Review

The consumer record is the key document used to monitor regional center compliance with the HCBS Waiver requirements. It is a document that is reviewed by the DDS/DHS monitoring team as well as the Federal Centers for Medicare and Medicaid Services (CMS) during compliance audits. In the DDS/DHS review, the consumer record establishes the baseline for the consumer interview, the service coordinator interview, the service provider interview, and the direct care staff interview, the community care facility record review, the day program record review and the Special Incident Report (SIR) review. The record review consists of 34 criteria associated with waiver eligibility certification and recertification, choice, fair hearings, health status, Individual Program Plan (IPP) development and implementation, and monitoring of services. The report to the regional center will address those areas where there were negative findings.

Section III Community Care Facility Consumer Record Review

The HCBS Waiver review follows consumers into the community to assure that: they are living in safe environments; receiving the services on their IPPs; being treated with respect and dignity; and their health is safeguarded. The 18 review criteria for CCF consumer records cover documentation, IPP

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implementation, health and safety, medication safeguards, quarterly and semiannual reports, and special incident reporting. The report to the regional center will address those areas where there were negative findings.

Section IV Day Program Consumer Record Review

The HCBS Waiver review follows consumers into the community to assure that they are receiving day services in safe, productive environments that will assist in achieving the goals and objectives on their IPPs. The 17 criteria in Section IV address the day program requirements for maintaining consumer records and preparing written reports of consumer progress toward achievement of Individual Program Plan (IPP) services for which the program is responsible. The report to the regional center will address those areas where there were negative findings.

Section V Consumer Interview and Observations

Consumers are interviewed and observed by the monitoring team at the day programs or residential homes. The purpose of the consumer interviews and observations is twofold. The interviews are conducted with consumers who are willing to participate to capture the consumer's own feelings about his or her life. The interview format is designed to elicit information about consumer satisfaction with their living arrangements and the staff who assist them in their residences; their school or day program and staff who assist them; choice; time spent with friends; food; recreation; interactions with the regional center; safety; and health. The interview format is taken from the revised CDER. The results of the interviews for each question will be summarized in the report to the regional center.

The observations are conducted to verify that the consumers appear to be healthy and clean. A standardized checklist is used to document the observations. Any findings related to the observations will be included in the report to the regional center.

Section VI Interviews with Regional Center Staff

VI.A Service Coordinator Interview

The service coordinator has a critical role in the life of the consumer. Among other things he/she is responsible for assessing the needs of the consumer, facilitating the development a person-centered Individual Program Plan, linking the consumer to services and supports on the IPP, monitoring progress and service delivery, monitoring health and safety, and advocating for the consumer. The purpose of the interview is to determine how well the service coordinator knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how services are monitored, how health issues are addressed and monitored, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

VI.B Clinical Services Interview

Regional center clinical services staff and contractors provide support to consumers and service coordinators on matters affecting the health, safety and medical needs of consumers living in the community. An informational interview is conducted with the clinical staff to ascertain how the regional center has organized itself to provide the support. The interview questions ask what processes the regional center has in place for routine monitoring of consumers with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health, improvements in access to preventive health care resources, and the role of clinical services in special incident reporting and the Risk Management Committee. Since the interview is informational, no attempt will be made to assign a rating to

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each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

VI.C. Quality Assurance Staff Interview

Quality assurance (QA) is an important component in assuring the health and safety of consumers in the community and provider competence. An informational interview is conducted with QA staff to gain an understanding of how the regional center has organized itself to conduct: Title 17 monitoring of community care facilities (CCFs); two unannounced visits to CCFs; QA evaluations of CCFs, and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and to ascertain what is done to assure quality among programs and providers where there is no regulatory authority to conduct QA monitoring. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Section VII Interviews with Service Providers and Direct Support Staff

VII.A. Service Provider Interview

The service provider has a critical role in the life of the consumer. The service provider not only is responsible for assessing the needs of the consumer, participating in the development a person-centered Individual Program Plan, provision of services and supports on the IPP, fostering consumer progress, ensuring the health and safety of the consumer, and advocating for the consumer. The purpose of the interview is to determine how well the service provider knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how the accuracy of documentation is ensured, communication, how medications are safeguarded, how health issues are addressed and monitored, emergency preparedness, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

VII.B. Direct Support Staff Interview

Direct support staff are the individuals who work with and assist the consumers in day programs and residential settings. Direct support staff play an important role in the implementation of the IPP. The purpose of the interview is to determine the direct support staff's familiarity with the consumer, understanding of the IPP and service delivery requirements, communication, level of preparedness to address safety issues, understanding of emergency preparedness, and knowledge about safeguarding medications. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

Section VIII Vendor Monitoring Review

Residential programs and day programs are reviewed by the monitoring team utilizing a vendor monitoring review form consisting of 25 review criteria. The purpose of the vendor review is to ensure that the consumers are served in safe, healthy, positive environments where their rights are respected. The 25 criteria are divided into grouped under five categories: environment and safety; health and medications; services and staff; money (applies to residential programs); and rights. Each review criterion has interpretive guidelines to clarify the expectations and to provide a framework to promote effective and efficient provisions of services and supports to enable the consumers to reach their goals. The review is conducted through an inspection of the physical environment of the program and observations. The results of the reviews will be summarized in the report to the regional center.

Section IX Special Incident Reports

Title 17, California Code of Regulations (CCR), § 54327 defines special incidents as those incidents that have occurred during the time the consumer was receiving services and supports from any vendor or long term health care facility, including: the consumer is missing and the vendor or long-term care facility has filed a missing persons report with a law enforcement agency; reasonably suspected abuse/exploitation; reasonably suspected neglect; a serious injury/accident; any unplanned or unscheduled hospitalization; and, regardless of when or where the following incidents occurred, the death of any consumer regardless of cause and/or the consumer is the victim of a crime. The purpose of this section is to verify that special incidents have been reported within the timelines, that the documentation meets the requirements of Title 17, and that the follow-up was complete. The report to the regional center will include those areas where there were negative findings.

Section X Supplementary Issues

This section contains any supplementary issues identified by the monitoring team during the review that are not specifically addressed by the standard review protocol criteria. The following are examples of issues that may be included in this section: follow-ups on specific issues relating to consumers; additional regional center follow-up on special incidents; documentation of problems relating to regional center procedures or systems that are currently in place; referrals to the DDS Audit Section.

REVIEW PROCESS AND TIME LINES

1. DDS will contact the regional center to determine a mutually agreed upon review date and confirm the date in writing, with a copy provided to DHS.
2. DDS will generate a sample of consumers based on selection criteria (60 days prior to the review).
3. DDS will transmit the Regional Center Self-Assessment to the regional center and request the regional center to identify a staff person to serve as the contact and review coordinator (60 days prior to the review)
4. The Federal Programs Operations Section will request data base information such as fair hearings, special incident reports, consumer complaints, etc., for any consumer in the HCBS Waiver sample for pre-audit review and analysis.
5. Thirty days prior to the date of the on site review, DDS will mail the list of the consumers selected for review to the regional center. However, the consumer names will not be available to the facilities until the first week of the on site review.
6. The regional center's response to the self-assessment questions is returned to DDS 30 days prior to the review. DDS staff will review the self-assessment results and identify those areas where follow-up information and/or staff interviews are needed during the on site review. A copy of the self-assessment responses and any information regarding complaints, fair hearing requests and special incident reports (SIRs) will be provided to DHS. DDS staff will notify the regional center of the staff that need to be interviewed and the nature of the additional information needed. DHS will be provided with this information.
7. The monitoring team will coordinate logistics with the regional center to arrange times for provider site visits during the first week of the on site review.

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8. First week of the on site review:
 - a. The monitoring team conducts an entrance conference at the regional center to introduce the DDS/DHS staff and explain the purpose, scope and duration of the review
 - b. The monitoring team meets with selected regional center management staff to review and discuss the self-assessment. Any clarifications and revisions are discussed and confirmed.
 - c. The regional center consumer records for the selected sample are reviewed for compliance with the criteria in the monitoring protocol
 - d. The monitoring team interviews service coordinators and quality assurance staff assigned to.
 - e. The CCF and day program service provider records maintained by the regional center are reviewed.
 - f. The monitoring team coordinates the site visits to the selected CCFs and day programs with the regional center.
9. Second week of the on site review:
 - a. CCFs and day programs are visited by the monitoring team. An entrance conference is conducted to explain the purpose and scope of the review. A standardized interview is conducted with each service provider.
 - b. The monitoring team reviews the sample consumer records maintained by the service provider for compliance with the criteria in the review protocol.
 - c. The monitoring team conducts standardized interviews with the consumers in the review sample.
 - d. The monitoring team conducts a program site inspection at each CCF and day program visited.
 - e. The monitoring team conducts an informal exit conference with the service provider and the regional center representative, if present. The team members discuss any problems and concerns that have been identified, and may request that follow-up actions be taken, if necessary.
 - f. Within two weeks following the on site review, the monitoring team conducts an informal telephone exit conference with the regional center to present preliminary information on the general review findings and identify any urgent issues that require immediate attention. The monitoring team also explains that, because of the numerous components of the review and the amount of information gathered, it is not possible to discuss detailed findings at this point in time. The details of the specific findings and recommendations will be provided to the regional center in a written report prepared jointly by DDS and DHS within 60 to 90 days.

MONITORING REPORT

Findings and Recommendations

Within 60 to 90 days following the exit conference, DDS/DHS will submit a written report of the HCBS Waiver review findings and recommendations to the regional center. DDS will also submit the report findings and recommendations for the Targeted Case Management (TCM) and Nursing Home Reform (NHR) reviews that were conducted by DDS staff simultaneously with the HCBS Waiver review. The DDS transmittal letter will request the regional center to submit a written response and action plans for all of the recommendations within 30 days follow their receipt of the reports.

Regional Center Response and Action Plans

Upon receipt of the regional center's response and actions plans to the recommendations in the HCBS Wavier, TCM, and NHR reports, DDS will review the response and action plans to ensure that all report recommendations have been appropriately addressed. DDS will notify the regional center in writing that their response has been approved, or request additional information to document the regional center's actions regarding the report recommendations.

TIME LINES FOR MONITORING REPORT AND REGIONAL CENTER RESPONSE

TIME	ACTIVITY	TIME LINE
Month 1	Telephone exit conference with regional center	<u>Within two weeks</u> following the completion of the monitoring review.
	Rough drafts completed by DDS.	<u>Within two weeks</u> following the completion of the monitoring review.
	Rough drafts received from DHS.	<u>Within two weeks</u> following the completion of the monitoring review.
	HCBS Waiver draft report completed by DDS.	<u>Within two weeks</u> following receipt of the draft HCBS Waiver sections from the monitoring team.
	TCM/NHR draft reports completed by DDS.	<u>Within one month</u> following the completion of the monitoring review.
Month 2	HCBS Waiver, TCM and NHR reports reviewed and approved by DDS Management.	<u>Within two weeks</u> following receipt of the first draft.
	Draft HCBS Waiver report reviewed by DHS.	<u>Within three weeks</u> following receipt of the first draft.
	Draft Report revised by DDS Team Leader.	<u>Within one week</u> following receipt of the first draft from DHS.
	Final draft completed.	<u>Within two months</u> following the completion of the monitoring review.
Month 3	10. Final draft sent to the regional center.	Within 60 to 90 days following completion of the final draft.
Month 4	Regional center response received by DDS.	<u>Within three months</u> following the completion of the monitoring review.
	Regional center response reviewed and approved by DDS.	<u>Within two weeks</u> following receipt of the response from the regional center.
	Written notification to the regional center.	<u>Within four months</u> following the completion of the monitoring review.

SECTION I REGIONAL CENTER SELF-ASSESSMENT

Purpose

The Centers for Medicare and Medicaid Services (CMS) requires all States to provide six assurances as a condition of Waiver approval. The assurances are for the health and welfare of Waiver participants, for plans of care responsive to Waiver participant needs, that only qualified providers serve Waiver participants, that the State conducts level of care need determinations consistent with need for institutionalization, that the State Medicaid Agency retains administrative authority over the Waiver program, and that the State provides financial accountability for the Waiver. DHS is the State Medicaid Agency. DDS has responsibility for the operational aspects of implementing the Waiver. All Waiver services are provided through the regional center system. As such, regional centers have a role in carrying out five of the Waiver assurances.

The purpose of the regional center self-assessment is to gain assurance from the regional center that it has written policies, procedures and practices and a system to assure compliance in 24 areas associated with the HCBS Waiver assurances. The 24 regional center assurances are limited to areas where DDS does not routinely collect information from the regional centers. The report to the regional center on the results of the review will contain comments and recommendations for those regional center assurances where there is a need for improvement.

Self Assessment Tool

The Self Assessment tool is transmitted to the regional center electronically prior to the on-site monitoring review. The table shown below explains what is required for each of the fields on the tool.

Field or Question on Self-Assessment Tool	Explanation of Field or Question
Federal HCBS Requirement	The HCBS Waiver assurance that is associated with the regional center assurance stated in the next field.
Regional Center Assurance to Achieve Requirement	One of the 24 regional center assurances
Check box if there are written policies/ procedures or practices in place to implement the assurance.	This asks regional centers if they have developed a consistent set of guidelines to implement the assurance.
If no written policies/procedures are in place, please explain why.	This asks the regional center for an explanation of why there are no written guidelines.
If yes, where would one go to look at them?	Regional centers are not asked to produce the written documents, only to indicate where they are kept.
What system or process do you use to assure compliance and consistency in application?	This asks the regional center to explain how they monitor the implementation of the guidelines.
How do you verify that the system or process is operational and produces accurate/timely results?	This asks the regional center to explain how they oversee the system or process used to monitor implementation to assure that it is working.
To what extent are you meeting this assurance? (Always, Almost always, Usually, Sometimes, Rarely)	This asks for an assessment of the outcome of the efforts to implement the assurance.
Other questions with respect to the assurance	Special questions that apply only to the assurance that is the subject of the set of questions.
Optional: What other quality improvement actions/initiatives has your center taken related to this assurance.	Provides an opportunity for the regional center to tell DDS and DHS about other things they are doing related to the assurance.

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Regional Center Assurances

The regional center assurances are listed below under the HCBS Waiver shown in bold print.

State conducts level of care need determinations consistent with the need for institutionalization

- 1.1. The regional center ensures that consumers meet ICF-DD, ICF-DDH, or ICF/DD-N facility level of care requirements as a condition of initial and annual eligibility for the HCBS Waiver Program.
- 1.2. Regional center ensures that the regional center staff responsible for certifying and recertifying consumers' HCBS Waiver eligibility meet the federal definition of a Qualified Mental Retardation Professional (QMRP).
- 1.3. The regional ensures that consumers are eligible for full scope Medi-Cal benefits before enrolling them in the HCBS Waiver

Necessary safeguards have been taken to protect the health and welfare of persons receiving Waiver Services

- 1.4. The regional center takes action(s) to ensure consumers' rights are protected.
- 1.5. The regional center takes action(s) to ensure that the consumers' health needs are addressed.
- 1.6. The regional center ensures that behavior plans preserve the right of the consumer to be free from harm.
- 1.7. The regional center maintains a Risk Management, Risk Assessment and Planning Committee.
- 1.8. The regional center has developed and implemented a Risk Management/Mitigation Plan.
- 1.9. Regional centers and local Community Care Licensing offices coordinate and collaborate in addressing issues involving licensing requirements and monitoring of CCFs pursuant to the MOU between DDS and Department of Social Services
- 1.10. The regional center has developed and implemented a quality assurance plan for Service Level 2, 3 and 4 community care facilities.
- 1.11. The regional center reviews each community care facility annually to assure services are consistent with the program design and applicable laws, and development and implementation of corrective action plans as needed.
- 1.12. The regional center conducts not less than two unannounced monitoring visits to each CCF annually.
- 1.13. Service coordinators (SCs) perform and document periodic reviews (at least annually) to ascertain progress toward achieving IPP objectives, and the consumer's and the family's satisfaction with the IPP and its implementation
- 1.14. Service coordinators have quarterly face-to-face meetings with consumers in CCFs, Family Home Agencies, and Supported Living Services to review services and progress toward achieving the IPP objectives for which the service provider is responsible
- 1.15. The regional center ensures that needed services and supports are in place when a consumer moves from a developmental center (DC) to a community living arrangement.

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- 1.16. Service coordinators provide enhanced case management to consumers who move from a DC by meeting with them face-to-face every 30 days for the first 90 days they reside in the community

Only qualified providers serve Waiver participants

- 1.17. The regional center ensures that all HCBS Waiver service providers have signed the "HCBS Provider Agreement Form" and meet the required qualifications at the time services are provided.

Plans of care are responsive to Waiver participant needs

- 1.18. The regional center ensures that all HCBS Waiver consumers are offered a choice between receiving services and living arrangements in an institutional or community setting.
- 1.19. Regional centers ensure that planning for IPPs includes a comprehensive assessment and information gathering process which addresses the total needs of HCBS Waiver consumers and is completed at least every three years at the time of his/her triennial IPP
- 1.20. The IPPs of HCBS Waiver consumers are reviewed at least annually by the planning team and modified, as necessary, in response to the consumers' changing needs, wants and health status.
- 1.21. The regional center uses feedback from consumers, families and legal representatives to improve system performance.
- 1.22. The regional center documents the manner by which consumers indicate choice and consent.

The state provides financial accountability for the Waiver

- 1.23. The regional center conducts fiscal reviews of vendors.
- 1.24. The regional center retains the documentation required for the HCBS Waiver for a period of five (5) years.

SECTION II REGIONAL CENTER CONSUMER RECORD REVIEW

Purpose

The regional center maintains a record for each consumer that contains relevant information. The record is established at the time the consumer is made eligible for regional center services and is maintained throughout his or her life. All of the relevant information about the consumer and is documented in the record including the basis for initial eligibility for regional center services; Individual Program Plans that are developed by the planning team to define and address his or her service and support needs; running ID notes to document relevant contacts with and about the consumer; purchase of services authorizations to establish a payment mechanism for the services and supports that are the responsibility of the regional center; periodic progress and monitoring reports; and initial and ongoing eligibility for the Home and Community-Based Services (HCBS) Waiver.

The consumer record is the key document used to monitor regional center compliance with the HCBS Waiver requirements. It is a document that is reviewed by the DDS/DHS monitoring team as well as the Centers for Medicare and Medicaid Services (CMS) during compliance audits. In the DDS/DHS review, the consumer record establishes the baseline for the consumer interview, the service coordinator interview, the service provider interview, and the direct care staff interview, the community care facility record review, the day program record review and the Special Incident Report (SIR) review. The report to the regional center will address those areas where there were negative findings. The overall ratings will also be presented using the Regional Center Consumer Record Rating Sheet shown in this section.

The review criteria in Section II address the requirements for documentation contained in the regional center's consumer records in the following areas: HCBS Waiver eligibility, consumer choice, notification of proposed action and fair hearing rights, level of care, Individual Program Plans (IPPs), assessment of needs, and periodic reviews and reevaluations of services. The criteria are derived from federal/state statutes and regulations, and from CMS directives and guidelines relating to the provision of HCBS Waiver services. Each criterion is followed by verification instructions for determining compliance. In some cases there is an explanation for the criterion.

Criterion

2.0 The consumer is Medi-Cal eligible. (SMM 4442 1)

Explanation

Medi-Cal eligibility is a basic requirement for participation in the HCBS Waiver. The purpose of this criterion is to verify that consumers in the review sample meet the requirement.

Verification Instructions

Prior to the on site review, DDS verifies the consumer's Medi-Cal eligibility in the "Medicaid Waiver Eligibility Report," (MWS 770), for the period being reviewed.

2.1 Each record contains a "Medicaid Waiver Eligibility Record," (DS 3770 form), signed by a Qualified Mental Retardation Professional (QMRP), which documents the date of the consumer's initial HCBS Waiver eligibility certification and annual recertification, qualifying conditions, and short-term absences. (SMM 4442.1), (42 CFR 483.430(a))

Explanation

To be eligible for the HCBS Waiver a consumer must have substantial limitations in his or her present adaptive functioning that would qualify the consumer for the level of care provided in an intermediate care facility.

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There is a further requirement that initial level of care determination be certified and that there is an annual recertification.

The staff person that makes the level of care determination is required to meet the Federal qualifications of a QMRP that include 1 year of experience working directly with persons with mental retardation or other developmental disabilities and is either an MD, RN, or an individual who holds at least a bachelor's degree in a professional category specified in the CFR 483.430(b)(5) that includes social work and related fields.

Short-term absence is defined as an absence of no more than 120 days when the consumer was not eligible for Waiver participation due to loss of Medi-Cal or a temporary change of living arrangement to a hospital, intermediate care facility or other location that is not covered by the Waiver.

The current Waiver specifies that the DS 3770 form will be used to document the requirements. The criterion consists of four sub criteria that are reviewed and rated independently.

2.1.a The DS 3770 is signed by a Qualified Mental Retardation Professional and the title "QMRP" appears after the person's signature.

Verification Instructions

1. Score as (+) if signed and the QMRP title is included.
2. If the form is signed and the "QMRP" title is not included, inquire as to whether the person who signed the form meets the definition of a QMRP.
 - a. If the person meets the definition of a QMRP make a note on the comment section of the form and score as (+). Inform the regional center of the omission.
 - b. If the person does not meet the definition of a QMRP make a note on the comment section of the form and score as (-). Inform the regional center.
3. Score as (-) if the form is not signed.

2.1.b The DS 3770 form summarizes the consumer's qualifying conditions and any special health care requirements for meeting the Title 22 level of care requirements.

Verification Instructions

1. Review the Client Development Evaluation Report (CDER) and other information in the chart for qualifying conditions.
2. Score as (+) if the DS 3770 form summarizes the qualifying conditions indicated in the CDER and other information in the chart, and, if applicable, special health care requirements used to determine the consumer's HCBS Waiver eligibility.
3. Score as (-) if the DS 3770 form does not identify the qualifying conditions indicated in the CDER and other information in the chart. Comment on what is missing.

2.1.c The DS 3770 form documents annual recertifications.Verification Instructions

1. Score as (+) if the date of recertification is within 12-months of the last certification/recertification.
2. Score as (-) if the date of recertification is later than 12 months of the last certification/recertification. Comment on how late the recertification was done.

2.1.d The DS 3770 form documents short-term absences of 120 days or less, if applicable.Verification Instructions

1. Review the record for any short-term absences that occurred prior to the date of the last recertification. Short-term absences that occur after the date of the last recertification are excluded from the scope of the review.
2. Score as (NA) if there were no short-term absences that occurred prior to the date of the last recertification
3. Score as (+) if applicable short-term absences are documented on the DS 3770 form.
4. Score as (-) if there are short-term absences identified in the record that are not documented on the DS 3770 form

2.2 Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form, (DS 2200). (SMM 4442.7), (42 CFR 441.302(d))Explanation

The Waiver requires that participants be given a choice of living arrangements. The DS 2200 form is used to document that the consumer has been informed of any feasible alternative services under the HCBS Waiver and has been given a choice of receiving those services in a CCF, in-home living arrangement, or long-term health facility.

The form is also used to document a consumer's choice to voluntarily disenroll from the HCBS Waiver.

Verification Instructions

1. Review the DS 2200 form in the consumer's record and determine if it has been dated and signed by the consumer, parent of a minor, legal guardian/conservator, or appropriate consumer representative at the time of the consumer's initial HCBS Waiver eligibility, or the date of reenrollment in the HCBS Waiver after a period of ineligibility greater than 120 days.
2. Score as (+) if:
 - a. The date the choice was offered (use the date that the form was signed) is concurrent with the date of the consumer's initial enrollment in the HCBS Waiver, or concurrent with the date of reenrollment after a period of ineligibility greater than 120 days; **and**
 - b. *For minors* - the parent/legal guardian/legal representative has made the choice in Section III, marked the box in Section I indicating who has made the choice, and signed and dated the form; **or**

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- c. *For adults* - the consumer has made his/her choice in Section III, signed and dated Section II.a or made his/her mark that has been witnessed and dated (planning team member may be a witness); **or**
 - d. *For adults who have a legal representative* - the legal representative has made the choice in Section III, marked box (b) in Section II, and signed and dated the form; **or**
 - e. *For adults who are not able to indicate their choice and do not have a legal representative* - the parent, relative, or other person involved in the consumer's IPP who represents the planning team has made the choice in Section III, marked box (c) in Section II, and signed and dated the form; **and**
 - f. The person who has made the choice and signed the DS 2200 form is consistent with the person who has signed the consumer's other consent forms, release of information forms, etc., contained in the consumer's record.
3. Score as (-) if any of the elements in one of the applicable situations under #2 is not documented in the DS 2200 form and comment on what is missing.

- 2.3 There is written notification of a proposed action and documentation that the consumer has been sent written notice of the fair hearing rights whenever choice of living arrangements is not offered, services or choice of services are denied or reduced without the agreement of the consumer/authorized representative, or the consumer/authorized representative does not agree with all, or part of the components in the consumer's IPP, or the consumer's eligibility has been involuntarily terminated. (SMM 4442.7), (42 CFR Part 431, Subpart E), (WIC § 4646(g))**

Verification Instructions

1. Review the consumer's DS 2200 and DS 3770 forms, IPP, interdisciplinary notes, purchase of service (POS) approvals and terminations, written notification of proposed actions and fair hearing rights, fair hearing requests, and any relevant correspondence for documentation that choice of living arrangements has not been offered, or services or choice of services has been denied, or the consumer has voluntary disenrolled.
2. Score as (NA) if:
 - a. The consumer **has been offered** a choice of living arrangements as indicated in the DS 2200 form; **and**
 - b. The consumer **has not been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **and**
 - c. The consumer/parent/legal guardian or legal representative **has not disagreed** with any of the components in the consumer's IPP; **or**
 - d. The consumer **has voluntarily disenrolled** from the HCBS Waiver by signing the appropriate section of the DS 2200 form. Indicate that this is the reason for the (NA) by scoring "**Voluntary Disenrollment in lieu of NOA**" as (+).
3. Score as (+) if:
 - a. The consumer **has not been offered** a choice of living arrangements; **or**

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- b. The consumer **has been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **or**
 - c. The consumer's HCBS Waiver eligibility **has been terminated for no longer meeting Waiver level of care** and the consumer has not signed the voluntary disenrollment section of the DS 2200 form; **or**
 - d. The consumer/parent/legal guardian or legal representative **has disagreed** with any of the components in the consumer's IPP; **and**
 - e. There is documentation that the regional center has informed the consumer/parents/legal guardian, or representative in writing with a notification of the proposed action (even if the consumer does not request a fair hearing); **and**
 - f. There is documentation that the regional center has notified the consumer in writing of his/her fair hearing rights.
4. Score as (-) when any of the situations described in a. - d. under #3 have occurred and e. and f. are not documented

2.4 The consumer record contains a current Client Development Evaluation Report (CDER) that has been reviewed within the last 12-months. (SMM 4442.5), (42 CFR 441.302(c))

Explanation

The CDER is designated in the Waiver as the source of information for level of care determinations. The HCBS Waiver requires that eligibility be reviewed annually.

Verification Instructions

- 1. Review the consumer's most recent CDER and annual review documentation.
- 2. Score as (+) if:
 - a. A new CDER with updated information has been completed within the past 12-months; **or**
 - b. The "HCBS Waiver Standardized Annual Review Form" or other documentation indicates that the CDER has been reviewed within the past 12-months, and no changes were necessary.
- 3. Score as (-) if either a. or b. under #2 is not documented.

2.5.a The consumer's qualifying conditions and any special health care requirements used to meet the level of care requirements for care provided in an ICF-DD, ICF-DDH, ICF/DD-N facility are documented in the consumer's CDER and/or assessments. (SMM 4442.5), (42 CFR 441.302(c)), (Title 22, CCR, § 51343)

Explanation

To be eligible for the HCBS Waiver a consumer has to meet the level of care requirements for care provided in intermediate care facilities. California's definition of conditions that satisfy the level of care determination for intermediate care facilities is described in Appendix A of the March 2002 program advisory.

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Verification Instructions

1. Review the CDER and/or other evaluations to ensure that at least two qualifying conditions and/or special health care requirements of sufficient severity to qualify for the level of care provided in an intermediate care facility are identified.
2. Score as (+) if the CDER and/or other evaluations identify at least two qualifying conditions and/or special health care requirements of sufficient severity to qualify for the level of care provided in an intermediate care facility.
3. Score as (-) if the CDER or other evaluations contain less than two sufficient qualifying conditions. Comment on any work.

2.5.b The consumer's qualifying conditions documented in the CDER or other evaluations are consistent with information contained in the consumer's record.

Verification Instructions

1. Score as (+) if the qualifying conditions or special health care requirements documented in the CDER are consistent with information in the record.
2. Score as (-) if the qualifying conditions or special health care requirements are not consistent with information in the record. Provide specific comments and request a reevaluation of the consumer's level of care.

2.6.a The IPP is reviewed (at least annually) by the planning team and modified, as necessary, in response to the consumer's changing needs, wants, or health status. (42 CFR 441.301(b)(1)(I))

Explanation

The IPP is the consumer's most important document. It is the plan that is used to translate the person's needs, wants and preferences into measurable objectives that are met through specified services and supports. The IPP is a product of a planning team that includes at a minimum the consumer and a regional center representative. The IPP establishes the authority for regional centers to arrange and fund needed services and supports when there is no other source of funding. The system recognizes that the IPP is not a static document and therefore it is necessary for the regional centers to review the document periodically and make necessary changes. For Waiver participants, the review must occur at least annually.

Verification Instructions

1. Score as (+) if the IPP has been reviewed within the past 12-months **and**
 - a. A new IPP document has been completed, **or**
 - b. The "HCBS Waiver Standardized Annual Review Form" documents why no changes are necessary to the existing IPP, **or**
 - c. An addendum to the existing IPP has been completed in response to changes in the consumer's needs, preferences, or health status.
2. Score as (-) if the IPP has not been reviewed within the past 12-months.

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- 2.6.b The HCBS Waiver Standardized Annual Review Form is completed and signed annually by the planning team to document whether or not a change to the existing IPP is necessary, and that the consumer's health status and CDER have been reviewed. (HCBS Waiver Requirement)**

Explanation:

The HCBS Waiver Standardized Annual Review Form is required only when a new or revised IPP was not developed as a part of the annual review.

Verification Instructions

1. Score as (NA) if a new or revised IPP was developed as a part of the annual review.
2. Score as (+) The HCBS Waiver Standardized Annual Review Form was completed at the time of the consumer's IPP annual review when there was not a new or revised IPP. Comment on any missing information, if the form has not been filled out completely or appropriately.
3. Score as (-) if:
 - a. There is not a new or revised IPP and the form was not completed: **or**
 - b. The form is lacking any of the required planning team signatures.

- 2.7.a The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the consumer or, where appropriate, his/her parents, legal guardian, or conservator. (WIC § 4646(g))**

Explanation

Signatures denote agreement with the plan.

Verification Instructions

1. Review the consumer's current IPP and determine if the regional center representative and the consumer or, where appropriate, his/her parents, legal guardian, or conservator has signed and dated the IPP.
2. If the consumer or, where appropriate, his or her parents, legal guardian, or conservator, does not agree with all components of the plan, they **may** indicate that disagreement on the plan. Disagreement with specific plan components does not prohibit the implementation of services and supports agreed to by the consumer, parents, legal guardian, or conservator. If the consumer or, where appropriate, his or her parents, legal guardian, or conservator, does not agree with the plan in whole or in part, he or she shall be sent written notice of the fair hearing rights (see criterion 2.3).
3. Score as (+) if the regional center representative, and the consumer or, where appropriate, his/her parents, legal guardian, or conservator, has signed the IPP prior to its implementation.
4. Score as (-) if the regional center representative, and the consumer or, where appropriate, his/her parents, legal guardian, or conservator, has not signed the IPP prior to its implementation.

- 2.7.b IPP addenda are signed by an authorized representative of the regional center and the consumer or, where appropriate, his/her parents, legal guardian, or conservator.**

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Explanation

An IPP addendum is required whenever it is determined that a consumer needs a new service or support or when there are changes in the level of an existing service. The planning team makes the determination about changes or additions. The addendum becomes a part of the IPP. Signatures of the planning team denote agreement with the change.

Verification Instructions

See verification instructions under 2.7.a above.

2.7.c The IPP is prepared jointly with the planning team. (WIC §4646(d))

Verification Instructions

1. Review the consumer's current IPP and determine if the regional center representative and the consumer or, where appropriate, his/her parents, legal guardian, or conservator has signed and dated the IPP.
2. Review the list of participants in the development of the IPP to determine if the planning consisted of the regional center representative, consumer, and, where appropriate, his/her parents, legal guardian, or conservator.
3. Score as (+) if the IPP is signed by the regional center representative and the consumer or, where appropriate, his/her parents, legal guardian, or conservator and there is documentation of the planning team participants.
4. Score as (-) if the IPP is not signed by the regional center representative and/or the consumer or, where appropriate, his/her parents, legal guardian, or conservator nor is there any documentation as to the planning team participants.

2.8 The IPP includes a statement of goals based on the needs, preferences, and life choices of the consumer. (WIC § 4646.5(a)(2))

Verification Instructions

1. Score as (+) if the IPP contains goals that address the consumer's needs, preferences and life choices which are consistent with relevant information found in the consumer's record.
2. Score as (-) if #1 is not documented in the IPP.

2.9 The IPP addresses the consumer's goals and needs. (WIC § 4646.5(a)(2))

Explanation

See explanation under Criterion 2.6a

Criterion 2.9 consists of seven sub criteria that are reviewed and rated independently as follows:

2.9.a The IPP addresses the qualifying conditions identified in the CDER and "Medicaid Waiver Eligibility Record," (DS 3770).

Verification Instructions

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1. Review the consumer's identified qualifying conditions in the CDER and DS 3770. Assess and determine whether or not the IPP contains objectives addresses the qualifying conditions and/or if there is documentation indicating that any of the conditions are not a current priority for the planning team.
2. Score as (+) if the IPP contains objectives that addresses the consumer's qualifying conditions identified in the CDER and DS 3770.
3. Score as (-) if the IPP does not contain objectives to address any or all of the consumer's qualifying conditions. Comment on what is missing.

2.9.b The IPP addresses the special health care requirements, health status and needs as appropriate.

Verification Instructions

1. Review the DS 3770 for any special health care requirements identified as qualifying conditions. Review the CDER and/or other information in the record for health status and major health needs. For the purposes of this criteria health status and needs may include current major health conditions that require ongoing treatment, monitoring or medication.
2. Score as (NA) if the consumer does not have any identified special health care requirements or current major health conditions.
3. Score as (+) if the consumer has any identified special health care requirements and/or current major health conditions and the IPP contains objectives for the providers and/or regional center to address and/or follow up with them.
4. Score as (-) if the consumer has any identified special health care requirements and/or current major health conditions and the IPP does not contain objectives to address them.
5. Comment on which health requirements and/or health conditions are not addressed.

2.9.c The IPP addresses the services for which the CCF provider is responsible for implementing.

Verification Instructions

1. Score as (NA) if the consumer does not live in a CCF.
2. Score as (+) if the IPP contains objectives that meet the consumer's service needs for which the CCF provider is responsible
3. Score as (-) if the IPP does not contain specific objectives for the CCF provider.
4. Comment on which of the needs are not addressed.

2.9.d The IPP addresses the services for which the day program provider is responsible for implementing.

Verification Instructions

1. Score as (NA) if the consumer does not receive day program services.
2. Score as (+) if the IPP contains objectives that meet the consumer's service needs for which the day program provider is responsible.

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3. Score as (-) if the IPP does not contain specific objectives for the day program provider or, if applicable; the IPP does not identify areas for the ISP to address.
4. Comment on which of the needs are not addressed.

2.9.e The IPP addresses the services for which the supported living services agency or independent living provider is responsible for implementing.

Verification Instructions

1. Score as (NA) if the consumer does not receive supported living services or independent living services.
2. Score as (+) if the IPP contains objectives that meet the consumer's service needs for which the supported living or independent living agency is responsible
3. Score as (-) if the IPP does not contain specific objectives for the supported living agency or independent living agency.
4. Comment on which of the needs are not addressed.

2.9.f The IPP addresses the consumer's goals, preferences, and life choices.

Verification Instructions

1. Review the goals statements in the consumer's IPP and Life Quality Assessment, if applicable.
2. Score as (+) if the IPP contains objectives that address the consumer's identified goals, preferences and life choices.
3. Score as (-) if the IPP does not contain objectives addressing all of the consumer's goals, preferences and life choices.
4. Comment on which of the goals, preferences and life choices are not addressed.

2.9.g The IPP includes a family plan component if the consumer is a minor. (WIC § 4685 (c)(2))

Explanation

The family plan component describes those services and supports necessary to successfully maintain the child at home.

Verification Instructions

1. Score as (NA) if the consumer is 18 or older.
2. Score as (+) if the consumer is under 18, lives with his or her family and the IPP includes a family plan component.
3. Score as (-) if the consumer is a minor and the IPP does not include a family plan component.

2.10.a The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. (WIC § 4646.5(a)(4))

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Explanation:

The IPP establishes the authority for regional centers to arrange and fund needed services and supports when there is no other source of funding

Verification Instructions

1. Review the MWS 706 and 707 reports for billed and unbilled services reported to DDS. Review the current POS authorizations in the consumer's record.
2. Score as (+) if the IPP identifies the type and amount of all services and supports being purchased by the regional center.
3. Score as (-) if the IPP does not identify the type and amount of all services and supports purchased by the regional center.
4. Comment on which services are not identified in the IPP.

2.10.b The IPP includes a schedule of the type and amount of all services and supports obtained from generic agencies or other resources. (WIC § 4646.5(a)(4))

Verification Instructions

1. Review the record for documentation of services or supports that are obtained from generic agencies or other non-regional center sources such as the Department of Rehabilitation, Medi-Cal, school, etc.
2. Score as (+) if the IPP identifies the type and amount of services and supports being obtained from generic agencies or other resources as documented in the record.
3. Score as (-) if the IPP does not identify the type and amount of services and supports obtained from generic agencies or other resources that are documented in the record.
4. Comment on which services are not identified in the IPP that are documented in the record.

2.10c The IPP specifies the approximate scheduled start date for new services and supports. (WIC § 4646.5(a)(4))

Verification Instructions

1. Score as (+) if the IPP or addenda specify an approximate scheduled start date for new services and supports.
2. Score as (-) if the IPP or addenda do not specify a scheduled start date for new services and supports.
3. Score as (N/A) if the IPP or addenda do not contain objectives for new services and supports.

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- 2.11 The IPP identifies the provider or providers of service responsible for implementing services, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. (WIC § 4646.5(a)(4))**

Verification Instructions

1. Score as (+) if the IPP identifies the provider or providers of service responsible for implementing services
2. Score as (-) if IPP does not identify the provider or providers of service responsible for implementing services
3. Comment on which objectives do not identify the provider or providers of service responsible for implementing the services.

- 2.12 Periodic reviews and reevaluations are completed (at least annually) to ascertain that planned services have been provided, that consumer progress has been achieved within the time specified, and the consumer and his/her family are satisfied with the IPP and its implementation. (WIC § 4646.5 (a)(6))**

Explanation

The purpose of this criterion is to assure that services are monitored on a periodic basis. There are three components to the monitoring: 1) assurance that services that were authorized have been delivered; 2) assurance that there has been consumer progress toward IPP objectives; and 3) indications of consumer/family satisfaction with the IPP and its implementation.

Verification Instructions

1. Review the IPP, annual review summary or fourth quarter progress report and other relevant documents (i.e., POS authorizations). Indications of consumer/family satisfaction include signatures on IPPs and/or Standardized Annual Review Form.
2. Score as (+) if the IPP/ annual review summary or fourth quarter progress report documents progress toward IPP objectives and services, and satisfaction of the consumer/family, at least annually.
3. Score as (-) if progress reporting toward IPP objectives and services, and consumer/family satisfaction, is not documented at least annually.

- 2.13.a Quarterly face-to-face meetings with the consumer are completed for consumers living in community out-of-home settings, i.e., Service Level 2, 3, or 4 community care facilities, family home agencies, or supported living and independent living settings. (Title 17, CCR, § 56047), (Title 17, CCR, § 56095), (Title 17, CCR, § 58680) (Contract requirement)**

Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 2, 3, or 4 community care facility (CCF), family home agency (FHA), or supported living services (SLS) or independent living setting.
2. Score as (+) if the consumer lives in a Service Level 2, 3, or 4 CCF, FHA, or SLS or ILS setting, and all four quarterly face-to-face meetings with the consumer and the regional center service coordinator are documented. At least two of the meetings must take place at the CCF or FHA, for consumers living in these settings.

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3. Score as (-) if the consumer lives in a Service Level 2, 3, or 4 CCF, FHA, r SLS or ILS setting and fewer than all four quarterly face-to-face meetings are documented. Comment on which of the quarters are not documented.

2.13.b Quarterly reports of progress toward achieving IPP objectives are completed for consumers living in community out-of-home settings, i.e., service Level 2, 3, or 4 community care facilities, family home agencies, or supported living and independent living settings. (Title 17, CCR, § 56047), (Title 17, CCR, § 56095), (Title 17, CCR, § 58680) (Contract requirement)

Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 2, 3, or 4 CCF, FHA, SLS or independent living setting.
2. Score as (+) if the consumer lives in a Service Level 2, 3, or 4 CCF, FHA, SLS or independent living setting and there are quarterly reports documenting progress toward achieving the IPP objectives for which the facility is responsible.
3. Score as (-) if the consumer lives in a Service Level 2, 3, or 4 CCF, FHA, SLS or independent living setting and less than four quarterly reports of progress were completed. In the comment section, note the quarterly reports and the total number of expected reports. For example, if there were three quarterly reports in the record for a period in which there should have been a total of four quarterly reports the comment would be $\frac{3}{4}$. (Or "In the comment section write 1, 2, 3, 4 and circle the quarters where there was a report.)

2.14 Face-to-face reviews are completed, no less than once every 30 days for the first 90 days, following the consumer's move from a developmental center to a community living arrangement. (WIC § 4418.3)

Verification Instructions

1. Score as (NA) if the consumer has not moved from a developmental center during the review period.
2. Score as (+) if the Title 19 notes, or other documentation, indicates that the consumer has been seen in the first 90 days, after moving from a developmental center to a community living arrangement. In the comment section note the actual number of visits and the total number of expected visits (3).
3. Score as (-) if there is no documentation indicating that the consumer has been seen within the 90 day period.

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Home and Community-Based Services Waiver		Department of Developmental Services			
		Department of Health Services			
REGIONAL CENTER CONSUMER RECORD RATING SHEET					
Consumer	UCI #	R.C.	Residence	Program	Date
Reviewers	1.	2.	3.		
Criteria			+	-	NA
2.0	Medi-Cal Eligible				
2.1	Medicaid Waiver Eligibility Record (DS3770)				
2.1.a	Signed with QMRP Title				
2.1.b	Qualifying conditions and special health care requirements summarized				
2.1.c	Timely annual recertification				
2.1.d	Short-term absence identified				
2.2	Choice of Services/Living Arrangements (DS 2200)				
2.3	Notification of proposed action and fair hearing rights				
2.4	CDER reviewed annually				
2.5.a	Level of care qualifying conditions (QC)				
2.5.b	QC consistent with information in record				
2.6.a	IPP reviewed annually by planning team				
2.6.b	Standard Annual Review form completed				
2.7.a	IPP signed by consumer and regional center				
2.7.b	IPP addendums signed by consumer and regional center				
2.7.c	IPP prepared jointly by planning team				
2.8	IPP contains goals based on needs, preferences and choices				
2.9	Specific IPP objectives implement goals and address needs				
2.9.a	IPP addresses qualifying conditions				
2.9.b	IPP addresses special health care requirements and current health conditions				
2.9.c	IPP addresses CCF services				
2.9.d	IPP addresses day program services				
2.9.e	IPP addresses SLS agency or ILS services				
2.9.f	IPP addresses goals, preferences and choices				
2.9.g	IPP includes family plan component				
2.10.a	IPP includes type and amount of all RC POS				
2.10.b	IPP includes types and amounts of all generic and other services				
2.10.c	IPP includes approximate start date for new services				
2.11	IPP identifies provider(s) responsible for implementing services				
2.12	Consumer progress documented at least annually				
2.13.a	Quarterly face-to-face contact (CCF, FHA, SLS, ILS)				
2.13.B	Quarterly progress reports (CCF, FHA, SLS, ILS)				
2.14	Monthly face-to-face contact first 90 days after moving from DC to community				

SECTION III COMMUNITY CARE FACILITY CONSUMER RECORD REVIEW

Purpose

The HCBS Waiver review follows consumers into the community to assure that: they are living in safe environments; receiving the services on their IPPs; being treated with respect and dignity; and that their health is safeguarded. The information from the review of regional center consumer records is used as a baseline for the community care facility (CCF) record review. The report to the regional center will address those areas where there were negative findings. The overall ratings will also be presented using the Community Care Facility Consumer Record Rating Sheet.

The review criteria in Section III address the CCF requirements for maintaining consumer records and preparing written reports of consumer progress toward achievement of Individual Program Plan (IPP) services for which the facility is responsible. The criteria are derived from Titles 17 and 22, California Code of Regulations, and from the HCBS Waiver. Each criterion is followed by verification instructions for determining compliance.

Criterion

- 3.1 An individual consumer record is maintained by the CCF that includes the documents and information specified in Title 17 and Title 22.** *(Title 17, CCR, § 56017(b)), (Title 17, CCR, § 56059(b)), (Title 22, CCR, § 80069)*

Explanation

CCFs are required to maintain a record for each consumer. The focus of the review is to assure that the consumer is in a setting that can meet his or her ambulatory, health, safety and behavioral needs; is equipped with basic information to identify the consumer to others in the event of an emergency; and current emergency notification information (i.e., family, physician, etc).

Verification Instructions

1. Score as (+) if the CCF maintains an individual consumer record.
2. Score as (-) if the facility does not maintain an individual consumer record and notify the regional center immediately.

- 3.1.a The consumer record contains a statement of ambulatory or non-ambulatory status.**

Verification Instructions

1. Score as (+) if the record contains a statement of ambulatory status.
2. Score as (-) if the record does not contain a statement of ambulatory status.

- 3.1.b The consumer record contains known information related to any history of aggressive or dangerous behavior toward self or others.**

Verification Instructions

1. Score as (NA) if the consumer does not have a history of aggressive or dangerous behavior.
2. Score as (+) if the consumer has a history of aggressive/dangerous behavior and information is contained in the record.

3. Score as (-) if the consumer has a history of aggressive/dangerous behavior and information is not contained in the record.

3.1.c The consumer record contains current health information that accurately describes and addresses the consumer's medical, dental and other health conditions that require ongoing treatment, monitoring and/or medication.

Verification instructions

1. Score as (+) if the record contains current health information that accurately describes and addresses the consumer's medical, dental and other health conditions that includes annual visit dates, physician orders, medications, allergies and other relevant information.
2. Score as (-) if the record does not contain information that accurately describes and addresses the consumer's medical, dental and other health conditions or the information is not current (within the last year).
3. Comment on what is missing.

3.1.d The consumer record contains current emergency information including the names and phone numbers for medical and dental providers, pharmacies, family members, conservators, legal representatives, etc.

Verification Instructions

1. Score as (+) if the record contains a current emergency information.
2. Score as (-) if the record does not contain emergency information
3. Comment on what information is missing.

3.1.e The consumer record contains a recent photograph and a physical description of the consumer.

Verification Instructions

1. Score as (+) if the record contains a recent photograph and a complete physical description of the consumer that includes height, weight, eye and hair color, eyeglasses, prominent marks, etc.
2. Score as (-) if the record is missing a recent photograph and/or physical description.
3. Comment if the photograph is not recent and/or if the physical description does not include specific information regarding all of the consumer's physical and distinguishing characteristics.

3.1.f Criterion deleted 11/03. Health information is contained in Criterion 3.1c.

3.1.g Criterion deleted 11/03. Health information is contained in Criterion 3.1c.

3.1.h Criterion deleted 11/03. Health information is contained in Criterion 3.1c.

3.1.i The consumer record identifies and addresses the special safety and behavior needs of the consumer.Explanation

Some consumers have behaviors or health conditions that create a need for enhanced safety measures in the residence. The behaviors or health conditions should be identified in the regional center record and in the CCF record. Some examples are: AWOL behaviors, tendencies to choke on food, lack of awareness about street crossing, etc.

Verification Instructions

1. Review the functional capabilities description, IPP and other information in the CCF record and ongoing notes to identify special safety and behavior needs.
2. Score as (NA) if the consumer does not have special safety and/or behavior needs.
3. Score as (+) if the consumer has special safety and/or behavior needs that are identified and addressed in the record.
4. Score as (-) if the consumer has identified safety and/or behavior needs that are not addressed in the record.

3.2 A written admission agreement is completed for the consumer that is signed by the consumer or his/her authorized representative, the regional center, and the facility administrator that includes the certifying statements specified in Title 17. (Title 17, CCR, § 56019(c)(1))Explanation

The admission agreement is reviewed to verify that the consumer chose to live in the facility and retains the right to change his or her living arrangement.

Verification Instructions

1. Score as (+) if there is an admission agreement that is signed by the facility administrator, the regional center and the consumer or the consumer's authorized representative, and includes statements certifying that:
 - a. No objection has been made to the admission of the consumer;
 - b. The consumer or authorized representative has been informed of the consumer's rights defined in Title 17, CCR, § 56002(a)(8); and
 - c. The consumer has a continuing right, which will be honored by all facility staff, to choose where he/she will live.
2. Score as (-) if there is no admission agreement, the agreement is not signed by all parties, or one or more of the statements a. - c. under #1 is not included in the agreement.
3. Comment on what is missing.

3.3 The facility has a copy of the consumer's current IPP. *(Title 17, CCR, § 56022(c))*Verification Instructions

1. Compare the date of the facility's most recent copy of the consumer's IPP and any addendums, if applicable, with the date of the most recent IPP and addendums that were found in the consumer's regional center record. Review the date and signatures for the IPP planning team meeting that developed, reviewed, or revised the IPP.
2. Score as (+) if the facility has a copy of the consumer's current IPP and any addendums.
3. Score as (-) if the facility does not have a copy of the consumer's most recent IPP or addendums.
4. Comment if the regional center takes more than 30 days after the planning team meeting to provide the facility with a copy of the consumer's IPP. Indicate the date of the planning team meeting and the date the facility received a copy of the IPP. Also, Indicate if the facility received a copy of the IPP, but it is not in the record and the facility cannot locate the IPP.

3.4.a Service Level 2 and 3 facilities prepare and maintain written semiannual reports of the consumer's progress. *(Title 17, CCR, § 56026(b))*Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 2 or 3 facility.
2. Score as (+) if the consumer lives in a Service Level 2 or 3 facility and the provider prepares and maintains written semiannual reports of the consumer's progress.
3. Score as (-) if the reports have not been completed semiannually and comment on which report periods are missing.

3.4.b Semiannual reports address and confirm the consumer's progress toward achieving each of the IPP objectives for which the facility is responsible.Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 2 or 3 facility.
2. Score as (+) if the consumer's semiannual reports address the specific IPP objectives for which the provider is responsible and comment on the consumer's progress.
3. Score as (-) if the semiannual reports do not address specific IPP objectives. Comment on the missing objectives. Also comment if the IPP does not contain provider specific objectives.

3.5.a Service Level 4 facilities prepare and maintain written quarterly reports of the consumer's progress that are completed within 30 days of the end of the quarter. *(Title 17, CCR, § 56026(c))*Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 4 facility.
2. Score as (+) if the consumer lives in a Service Level 4 facility and the provider prepares and maintains quarterly reports of the consumer's progress.

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3. Score as (-) if the reports have not been completed quarterly and comment on which quarters are missing.

3.5.b Quarterly reports address and confirm the consumer's progress toward achieving each of IPP objectives for which the facility is responsible.

Verification Instructions

1. Score as (NA) if the consumer does not live in a Service Level 4 facility.
2. Score as (+) if the consumer's quarterly reports address and document the following:
 - a. The consumer's progress toward achievement of the specific IPP/behavior plan objectives for which the facility is responsible; **and**
 - b. Identification of barriers to consumer progress and actions taken in response to these barriers; **and**
 - c. The date of completion of the report and signature of the person completing the report.
3. Comment on which of the objectives are not addressed.

3.5.c Quarterly reports include a summary of data collection for target behaviors.

Verification Instructions

1. Score as (NA) if there are no IPP/behavior plan target behaviors.
2. Score as (+) if a data collection system is maintained and the quarterly report summarizes the data for the target behaviors.
3. Score as (-) if there is no data being collected and summarized for the target behaviors. Comment if the original or previous quarter's base lines cannot be determined.

3.6.a The facility prepares and maintains ongoing, written consumer notes, as required by Title 17. (Title 17, CCR, § 56026(a))

Verification Instructions

1. Score as (+) if there are ongoing, up-to-date written consumer notes that document the following applicable activities and situations:
 - a. Community and leisure activities;
 - b. Overnight visits away from the facility;
 - c. Illness;
 - e. SIRs, as defined in Title 17, CCR, § 56002(a)(46);
 - f. Medical and dental visits; and
 - g. The date and signature of the staff person making the entry.

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2. Score as (-) if ongoing notes are not being maintained. Comment if the notes are not up-to-date, or if any of the applicable activities or situations under #1 a. - f. are not being documented.

3.6.b The ongoing written notes and/or other information in the facility consumer record verifies that identified behavior needs are being addressed.

Verification Instructions

1. Score as (NA) if the consumer does not have identified behavior needs.
2. Score as (+) if there are ongoing, up-to-date written consumer notes or other information in the consumer record that demonstrate that behavior needs are being addressed.
3. Score as (-) if ongoing notes are not being maintained or if there is no other information in the consumer record that demonstrate that behavior needs are being addressed.
4. Comment about what is missing from the documentation.

3.7a Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. (Title 17, CCR, § 54327)

Verification Instructions

1. Review the special incident reports (SIRs) that meet the Title 17 definition of reportable incidents completed by the CCF during the past 12 months. Interview the service provider and review available documentation determine when the facility reported the incident to the regional center. If possible, verbally verify the information with the regional center.
2. Score as (NA) if there were not SIRs that met the Title 17 definitions for reportable incidents during the past 12 months.
3. Score as (+) if the CCF reported the incident to the regional center within 24 hours after learning of the occurrence of the special incident. Comment on how this was determined, e.g., date in the SIR, consumer notes, or service provider's statement. Identify the type of incident on the rating sheet.
4. Score as (-) if not reported within 24 hours. Comment on how this was determined, and if reported late or not reported. Identify the type of incident on the rating sheet.

3.7.b A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. (Title 17, CCR, § 54327)

Verification Instructions

1. Score as (NA) if there were no SIRs that met the Title 17 definitions for reportable incidents during the past 12 months.
2. Score as (+) if the CCF submitted a written SIR to the regional center within 48 hours after the occurrence of the special incident. The CCF may submit to the regional center a copy of the report submitted to Community Care Licensing (CCL) if the report contains all of the information specified in Title 17, CCR, § 54327(b) (1) through (10).
3. Verbally verify with the service coordinator and/or with documentation from the regional center that a SIR was submitted.

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4. Score as (-) if a written report was not submitted within 48 hours. Comment on whether the report was late, never submitted, or never received by the regional center.

3.7c Follow-up activities were undertaken by the facility to prevent, reduce or mitigate future danger to the consumer.

Verification Instructions

1. Review the follow-up activities noted in the consumer record to determine if actions were taken to prevent, reduce or mitigate future danger to the consumer.
2. Score as (+) if the CCF follow-up was complete and resulted in a reduction or mitigation of the danger.
3. Score as (-) if there was no follow-up or the follow-up activities were not sufficient to mitigate or reduce future danger.
4. Comment on why the follow-up was insufficient.

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COMMUNITY CARE FACILITY CONSUMER RECORD RATING SHEET						
Consumer	UCI #	R.C.	Residence	Program		Date
Reviewers:	1.		2.	3.		
Criteria				+	-	NA
						Comments
3.1	Consumer file maintained by CCF					
3.1.a	Statement of ambulatory or non-ambulatory status					
3.1.b	Known information on history of aggressive/dangerous behavior toward self or others.					
3.1.c	Consumer record contains current health information .					
3.1.d	Current emergency information: family, physician, pharmacy, etc.					
3.1.e	Recent photograph and physical description.					
3.1.i	Special safety and behavior needs are addressed					
3.2	Admission agreement completed and signed					
3.3	Facility has copy of current IPP					
3.4.a	Semiannual reports of progress completed by Level 2 and 3 CCFs					
3.4.b	Semiannual reports address and confirm progress on the specific IPP objectives for which the facility is responsible.					
3.5.a	Quarterly reports of progress completed by Level 4 CCFs					
3.5.b	Quarterly reports address and confirm progress on the specific IPP objectives for which the facility is responsible.					
3.5.c	Quarterly reports include a summary of data collected for target behaviors.					
3.6	Ongoing consumer notes document required activities, SIRs, illness, medical and dental visits.					
3.6.a	Ongoing consumer notes/ information verifies that behavior needs are being addressed.					
3.7.a	Special incidents reported to regional center within 24 hours					
3.7.b	Written incident reports sent to regional center within 48 hours.					
3.7.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the consumer.					

SECTION IV DAY PROGRAM CONSUMER RECORD REVIEW

Purpose

The HCBS Waiver review follows consumers into the community to assure that they are receiving the services on their IPPs; being treated with respect and dignity; and that their health is safeguarded. The information from the review of regional center consumer records is used as a baseline for the day program record review. The report to the regional center will address those areas where there were negative findings. The overall ratings will also be presented using the Day Program Consumer Record Rating Sheet shown in this section.

The review criteria in Section IV address the day program requirements for maintaining consumer records and preparing written reports of consumer progress toward achievement of Individual Program Plan (IPP) services for which the program is responsible. The criteria are derived from Titles 17 and 22, California Code of Regulations, and from the HCBS Waiver. Each criterion is followed by verification instructions for determining compliance.

Criterion

- 4.1. A consumer file is maintained by the day program for each consumer that includes the documents and information specified in Title 17. (Title 17, CCR § 56730)**

Explanation

Day programs are required to maintain a record for each consumer. The focus of the review is to assure that the consumer is in a setting that can meet his or her health, safety and behavioral needs; is equipped with basic information to identify the consumer to others in the event of an emergency; current emergency notification information (i.e., family, physician, etc); and progress toward the IPP objectives.

Verification Instructions

1. Score as (+) if the day program maintains an individual consumer file for the consumer(s).
2. Score as (-) if the day program does not maintain an individual consumer record and notify the regional center immediately.

- 4.1.a The consumer record contains current emergency and personal identification information including the consumer's address and telephone number; the names and telephone numbers of the residential care provider, relatives, and/or guardian or conservator; physician's name(s) and telephone number(s); pharmacy name, address and telephone number; and health plan, if appropriate.**

Verification Instructions

1. Score as (+) if the record contains current emergency and personal identification information
2. Score as (-) if the record does not contain complete information or if the information is not current (within the last year).
3. Comment on what is missing.

- 4.1.b. The consumer record contains current health information that includes medical, dental and other health or safety needs of the consumer including current medications, known allergies, medical disabilities, infectious, contagious, or communicable conditions, special nutritional needs, and immunization records.**

Verification Instructions

1. Score as (+) if the record contains current health information
2. Score as (-) if the record does not contain complete information or if the information is not current (within the last year).
3. Comment on what is missing

- 4.1.c. The consumer record contains psychological, social, or medical evaluations provided by the regional center that identify the consumer's ability and functioning level.**

Verification Instructions

1. Score as (+) if the record contains one or more of the evaluations.
2. Score as (-) if the record does not contain any evaluations.
3. Comment on any of the types of evaluations that are missing, but present in the regional center consumer record.

- 4.1.d. The consumer record contains authorization for emergency medical treatment signed by the consumer and/or the authorized consumer representative.**

Verification Instructions

1. Score as (+) if the record contains a signed authorization for emergency medical treatment.
2. Score as (-) if the record does not contain a signed authorization.

- 4.1.e. The consumer record contains documentation that the consumer and/or the authorized consumer representative has been informed of his/her personal rights.**

Verification Instructions

1. Score as (+) if the record contains documentation that the consumer has been informed of his/her rights.
2. Score as (-) if the record does not contain documentation that the consumer has been informed of his/her rights.

- 4.1.f. The consumer record includes up-to-date data collection for IPP objectives.**

Verification Instructions

1. Score as (+) if the day program maintains copies of data collected that measures consumer progress toward achieving IPP objectives, e.g., narrative notes, skills and task analysis charting, behavior frequency counts, etc.

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2. Score as (-) if the day program does not maintain copies of data collected or the data is not up-to-date.
3. Comment on what is missing or not up-to-date.

4.1.g The consumer record contains up-to-date case notes reflecting important events or information.

Verification Instructions

1. Score as (+) if the day program up-to-date case notes.
2. Score as (-) if the day program does not maintain case notes collected or the notes are not up-to-date.
3. Comment on what is missing or not up-to-date and inform the regional center.

4.1.h The consumer record identifies and addresses the special safety and behavior needs of the consumer.

Explanation

Some consumers have behaviors or health conditions that create a need for enhanced safety measures in the residence. The behaviors or health conditions should be identified in the regional center record and in the day program record in the psychological, social and/or medical evaluations. Some examples are: AWOL behaviors, tendencies to choke on food, lack of awareness about street crossing, etc.

Verification Instructions

1. Review the psychological, social and medical evaluations; IPP, and other information in the day program record and ongoing notes to identify special safety and behavior needs.
2. Score as (NA) if the consumer does not have special safety and/or behavior needs.
3. Score as (+) if the consumer has special safety and/or behavior needs that are identified and addressed in the record.
4. Score as (-) if the consumer has identified safety and/or behavior needs that are not addressed in the record.

4.2 The day program has a copy of the consumer's current IPP. (Title 17, CCR, § 56720)(b))

Verification Instructions

1. Compare the date of the day program's most recent copy of the consumer's IPP and any addendums, if applicable, with the date of the most recent IPP and addendums found in the consumer's regional center record. Review the date and signatures for the IPP planning team meeting that developed or revised the IPP.
2. Score as (+) if the day program has a copy of the consumer's most recent IPP and any addendums.
3. Score as (-) if the day program does not have a copy of the consumer's most recent IPP.

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4. Comment if the regional center takes more than 30 days after the planning team meeting to provide the day program with a copy of the consumer's IPP. Indicate the date of the planning team meeting and the date the day program received a copy of the IPP. Also, indicate if the day program received a copy of the IPP, but it is not in the file and the day program cannot locate the IPP.

4.3.a The day program develops, maintains, and modifies, as necessary, documentation regarding the manner in which it will assist the consumer in achieving the IPP/ISP objectives for which the day program is responsible. (Title 17, CCR, § 56720)(a))

Verification Instructions

1. Score as (+) if the day program maintains documentation regarding the manner in which it will assist the consumer in achieving the IPP/ISP objectives for which the day program is responsible. This documentation includes, but is not limited to, ISPs, task analysis, skills-training curriculum, classroom lesson plans, and behavior plans.
2. Score as (-) if there is no specific program plan(s) or other documentation describing how the day program will assist the consumer in achieving the IPP/ISP objectives.

4.3.b The day program's ISP or other program documentation is consistent with the consumer's IPP objectives for which the day program is responsible.

Verification Instructions

1. Score as (+) if the day program's ISP or other program documentation is consistent with the consumer's IPP objectives for which the day program is responsible. To score as (+), the IPP must contain specific day program objectives that can be compared to the day program's ISP.
2. Score as (-) if the IPP does not identify what areas, activities, skills, interests, etc., that are contained in the day program's ISP to assist the consumer, or the IPP identifies day program objectives that are different from the ones contained in the ISP.

4.4.a The day program prepares and maintains written semiannual reports of the consumer's performance and progress. (Title 17, CCR, § 56720)(c))

Verification Instructions

1. Score as (+) if the day program prepares and maintains written semiannual reports of the consumer's performance and progress.
2. Score as (-) if the reports have not been completed semiannually. Comment on which of the report periods are missing.

4.4.b Semiannual reports address the consumer's performance and progress toward achieving each of the IPP objectives for which the day program is responsible.

Verification Instructions

1. Score as (+) if the semiannual reports address specific IPP objectives for which the day program is responsible.
2. Score as (-) if the semiannual reports do not address specific IPP objectives. Comment on what is not being addressed.

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4.5.a Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. (Title 17, CCR, § 54327)

Verification Instructions

1. Review the special incident reports (SIRs) that meet the Title 17 definition of reportable incidents completed by the day program during the past 12-months. Interview the service provider and review available documentation to determine when the day program reported the incident to the regional center. If possible, corroborate with information from the regional center.
2. Score as (NA) if there were no SIRs that meet the Title 17 definitions for reportable incidents during the past 12-months.
3. Score as (+) if the day program reported the incident to the regional center within 24 hours after learning of the occurrence of the special incident. Comment on how this was determined, e.g., date in the SIR, consumer notes, or service provider's statement. Identify the type of incident in the rating sheet table.
4. Score as (-) if not reported within 24 hours. Comment on how you determined this and if reported late, or not reported. Identify the type of incident in the rating sheet table.

4.5.b A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. (Title 17, CCR, § 54327)

Verification Instructions

1. Score as (+) if the day program submitted a written SIR to the regional center within 48 hours after the occurrence of the special incident. The day program may submit to the regional center a copy of the report submitted to Community Care Licensing (CCL) if the report contains all of the information specified in Title 17, CCR, and § 54327(b) (1) through (10).
2. Corroborate with the service coordinator and/or with documentation from the regional center that a SIR was submitted.
3. Score as (-) if a written report was not submitted within 48 hours. Comment on whether the report was late, never submitted, or never received by the regional center.

4.5.c Follow-up activities were undertaken by the facility to prevent reduce or mitigate future danger to the consumer.

Verification Instructions

1. Review the follow-up activities noted in the consumer record to determine if actions were taken to prevent, reduce or mitigate future danger to the consumer.
2. Score as (+) if the day program follow-up was complete and resulted in a reduction or mitigation of the danger.
3. Score as (-) there was no follow up or the follow-up activities were not sufficient to mitigate or reduce future danger.
4. Comment on why the follow-up was not sufficient to mitigate or reduce future danger.

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Home and Community-Based Services Waiver		Department of Developmental Services Department of Health Services			
DAY PROGRAM CONSUMER RECORD RATING SHEET					
Consumer	UCI #	R.C.	Residence	Program	Date
Reviewers:	1.	2.	3.		
Criteria		+	-	NA	Comments
4.1	Consumer file maintained by day program				
4.1.a	Current emergency and personal identification information				
4.1.b	Consumer record contains current health information.				
4.1.c	Consumer record contains psychological, medical, and /or social evaluations provided by regional center				
4.1.d	Authorization for emergency medical treatment				
4.1.e	Documentation that consumer informed of personal rights				
4.1.f	Consumer record contains data collection for IPP objectives.				
4.1gf	Consumer record contains case notes of important events and information.				
4.1.h	Special safety and behavior needs are addressed.				
4.2	Day program has a copy of the current IPP.				
4.3.a	Documentation on how the program will implement services.				
4.3.b	ISP and program documentation is consistent with IPP				
4.4.a	Reports of progress completed semiannually				
4.4.b	Semiannual reports address specific IPP objectives for which the program is responsible				
4.5.a	Special incidents reported to regional center within 24 hours				
4.5.b	Written incident reports sent to regional center within 48 hours.				
4.5.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the consumer.				

SECTION V CONSUMER OBSERVATIONS AND INTERVIEWS

Purpose

Consumers are interviewed and observed by the monitoring team at the day programs or residential homes. The purpose of the consumer Interviews and observations is twofold. The interviews are conducted with consumers who are willing to participate to capture the consumer's own feelings about his or her life. The interview format is designed to elicit information about consumer satisfaction with their living arrangements and the staff who assist them in their residences; their school or day program and staff who assist them; choice; time spent with friends; food; recreation; interactions with the regional center; safety; and health. The interview format is taken from the revised CDER. The results of the interviews for each question will be summarized in the report to the regional center

The observations are conducted to verify that the consumers appear to be healthy and clean. A standardized checklist is used to document the observations. Any findings related to the observations will be included in the report to the regional center.

Interview Form

CONSUMER INTERVIEW FORM

These questions capture the consumer's own feelings about his or her life. The consumer must provide the information in this section without someone else interpreting the response. If the consumer is not able or willing to provide any of this information, indicate why below.

If the consumer did not answer any of the questions in this section, indicate why by circling one of the numbers below. You should also put the appropriate symbol next to all questions in this section.

- X = The consumer is not able to respond without interpretation and/or cannot understand the questions.
- ? = The consumer is not available to respond at this time.
- R = The consumer chooses not to respond to a particular question.
- N = The question does not apply to the particular consumer.

Begin by explaining that the purpose of the questionnaire is to find out how the consumer feels about his or her life. Make sure the consumer understands that he or she should describe feelings and impressions that are current (within the previous month or two), not those that may have occurred at an earlier time.

These questions should be read aloud. Fill in the name of the pertinent person, place, or agency as needed, using terms the consumer would recognize (e.g., "Do you like going to the Lauren Training Center?"). You may paraphrase the question if the consumer asks for clarification or repeat the question as needed.

Do not read the response options to the consumer. Instead, allow the consumer to respond naturally. Listen carefully to the consumer's response, requesting clarification as needed.

- ⇒ If a particular question is not appropriate for this consumer, do not read it. Record *Question Does Not Apply (N)* and move on to the next question.
- ⇒ Record *Not Sure (X)* if the consumer is unsure or does not understand the question.
- ⇒ Record *Consumer Chooses Not To Respond (R)* if the consumer prefers not to answer a particular question.

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Insert the name of the place the consumer lives in each question below. If the consumer lives in a residence within a facility, use the name of the residence.

Questions 5.1 and 5.2 apply only to consumers who do not live at home. Question 5.3 applies only to adult consumers who do not live at home.

5.1 *Some people like where they live and others don't. When you think about how you feel most of the time...*

Do you like living at ____?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand.
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

5.2 *Some people like the people who help them at home and others don't. When you think about how you feel most of the time...*

Do you like the people who help you at ____?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand.
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

5.3 *Some people wish they could live some place else. Others want to stay where they are. When you think about how you feel most of the time...*

Do you want to keep living at ____?

Follow up if no: Did you tell your regional center worker about it?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand.
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

Insert the name of the school, job, or day program the consumer attends most often in each question below. Volunteer jobs are included.

Questions 5.4, 5.5, 5.6, and 5.7 apply only to consumers who attend a school, day program, and or work-site.

5.4 *Some people like their school (or day program or job) and others don't. When you think about how you feel most of the time...*

Do you like going to ____?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

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5.5 *Some people like the people who help them at their school (or day program or job) and others don't. When you think about how you feel most of the time...*

Do you like the people who help you at _____?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time

5.6 *Some people wish they could go to another school (or day program or job). Others want to stay where they are. When you think about how you feel most of the time...*

Do you want to keep going to _____?

- 0 = Negative Response
- 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
- 2 = Positive Response

- N = Question does not apply
- X = Consumer is not sure or does not understand
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

Question 5.7 applies only to consumers who answer NO to questions 5.5 and 5.6, indicating that do not like the school, day program, or job.

5.7 *I'm sorry you don't like _____. Sometimes people get to go someplace else...*

If you could go someplace else most of the time, where would you like to go?

Follow-up: Did you tell somebody at the regional center about it?

- 0 = Consumer indicates a preference that was communicated to the service coordinator, but follow-up did not occur.
- 1 = Consumer indicates a preference that was not communicated to the service coordinator,
- 2 = Consumer indicates a preference that was communicated to the service coordinator, and appropriate follow-up occurred.

- N = Question does not apply
- X = Consumer is not sure or does not understand
- R = Consumer chooses not to answer
- ? = Consumer is not available to respond at this time.

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5.8 *Some people get to choose how they spend their money, and others do not. When you think about what happens most of the time...*

Do you get to choose how you spend your money?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.9 *Some people are happy with how much time they get to spend with their friends, and others are not. When you think about how you feel most of the time...*

Are you happy with how much time you get to spend with your friends?

0 = Negative Response
 1 = Ambivalent or Mixed Response
 2 = Positive Response (e.g., maybe; it depends, sometimes)

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.10 *Some people get to choose what they eat at home, and others do not. When you think about how you feel most of the time...*

Are you happy with how much say you have in what you eat at home?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

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5.11 *Some people are able to have a snack when they want it, and others are not. When you think about how you feel most of the time...*

Are you able to get a snack when you want one at home?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.12 *Some people get to choose what they do on the weekend, and others do not. When you think about how you feel most of the time...*

Are you happy with how much say you have in what you do on the weekend?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.13 *Some people get to choose what time they go to bed, and others do not. When you think about how you feel most of the time...*

Are you happy with how much say you have in when you go to bed?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.14 *Some people get to talk to someone at the regional center whenever they want to, and others do not. When you think about what happens most of the time...*

Do you get to talk to your regional center worker when you want to?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

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5.15 *Some people like the help they get from people at the regional center, and others do not. When you think about how you feel most of the time...*

Are you happy with the help you get from the regional center?

0 = Negative Response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive Response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

5.16 *Some people feel safe in their neighborhood and some people don't feel safe. When you think how you feel most of the time*

Do you feel safe in your neighborhood most of the time?

0 = Negative response
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Positive response

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer

5.17 *We all feel sick sometimes. Some people feel like that a lot of the time. Others feel good most of the time.*

Do you feel sick or good most of the time?

0 = Sick
 1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
 2 = Good

N = Question does not apply
 X = Consumer is not sure or does not understand
 R = Consumer chooses not to answer
 ? = Consumer is not available to respond at this time.

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5.18 *Some people get the help they need when they feel sick, and others do not. When you think about what happens most of the time...*

Who do you tell when you feel sick

Follow up question: Do they help you?

0 = Negative Response
1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
2 = Positive Response

N = Question does not apply
X = Consumer is not sure or does not understand
R = Consumer chooses not to answer
? = Consumer is not available to respond at this time.

5.19 *We all have times when we need something or want to do something different. Sometimes we speak up and sometimes we keep quiet about it.*

Do you tell people what you want most of the time?

0 = Negative Response
1 = Ambivalent or Mixed Response (e.g., maybe; it depends, sometimes)
2 = Positive Response

N = Question does not apply
X = Consumer is not sure or does not understand
R = Consumer chooses not to answer
? = Consumer is not available to respond at this time.

Interviewer Comments:

Visual Observation Form

V. Visual Observation of the Consumer		
<p>The purpose of the visual observation of the consumer is to verify that the consumer appears to be healthy, has good hygiene with regard to skin, nails, teeth and clothing; and is dressed and groomed in a manner that will not set him or her apart from others in the community. The observer should take care to treat the consumer under observation with dignity and respect. The observation must be done in a discrete manner that will not embarrass the consumer or expect him or her to undergo any physical examination or other mandatory request. It is important to remember that the consumer has the right to make choices with respect to his or her style of clothing and appearance. When in doubt about the appropriateness of the clothing or other aspects of his or her appearance, the interviewer should inquire discretely from the consumer about his or her role in choosing the clothing, hair style, etc..</p>		
Consumer #	Consumer Name:	Regional Center:
Facility/Program	Interviewer	Date:
<input type="checkbox"/> Hair: Neat, trimmed, clean <input type="checkbox"/> Glasses: Proper fit and in good repair <input type="checkbox"/> Skin: Appears clean and without significant problem to casual observer <input type="checkbox"/> Face and hands: Appear clean and well kept	<input type="checkbox"/> Teeth or dentures: Appear clean and without significant problem. <input type="checkbox"/> Clothing: Clean, in good repair, properly sized, and appropriate to the season. <input type="checkbox"/> Shoes: Clean, properly fitted and in good repair. <input type="checkbox"/> Accessories: Clean and in good repair	
<input type="checkbox"/> Overall appearance: Reflects personal choice and individual style.		
Comments:		

SECTION VI INTERVIEWS WITH REGIONAL CENTER STAFF

VI.A. SERVICE COORDINATOR INTERVIEW

Purpose

The service coordinator has a critical role in the life of the consumer. Among other things he/she is responsible for assessing the needs of the consumer, facilitating the development a person-centered Individual Program Plan, linking the consumer to services and supports on the IPP, monitoring progress and service delivery, monitoring health and safety, and advocating for the consumer. The purpose of the interview is to determine how well the service coordinator knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how services are monitored, how health issues are addressed and monitored, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

Interview Form

Regional Center:

Interviewer(s)

Service Coordinator:

Date:

Instructions: The interview is divided into two major categories: I. questions that apply to a particular consumer and II general questions. There are areas of interest under each of the categories with a series of questions to test the knowledge of the staff person. The series of questions are related and are offered as a guide to the topics that should be covered. At time it will not be necessary to ask each individual question. The focus should be on listening carefully to the response given and making an assessment as to whether the topic has been fully explained. The interviewer is free to ask follow-up questions if there is a need for further clarification or to skip questions that have been answered as a part of a previous response. Each area of interest is to be rated by the interviewer based upon the answers to the series of questions. There are four ratings to each group of questions. The rating matrix defines the criteria for the responses. After you interview the person please check the appropriate rating for each question.

6.A.1 Questions in the context of Consumer # ____

6.A.1.a Questions to determine how well the SC knows the consumer

1. Can you tell me about _____? [Strengths, needs, preferences, etc?]
2. How do you communicate with him/her?
3. How does he/she indicate his/her needs, wants and preferences?
5. How does he/she indicate agreement?

<input type="checkbox"/> Very familiar	<input type="checkbox"/> Familiar	<input type="checkbox"/> Somewhat familiar	<input type="checkbox"/> Not at all
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6.A.1.b Questions to determine the extent of the assessment process for the annual plan development/review

1. Describe how you gathered information on consumer #___ preferences and personal goals, needs and abilities, health status and other available supports for the annual review

Discussion	Yes	Review of Records/Reports	Yes
Consumer		Previous IPP goals and objectives	
Family/legal representative		ID notes	
Circle of support members		Provider service plans	
Service providers		Provider reports	
Other regional center staff		Quarterly monitoring reports	
Other		SIRs	
		CDER	
		Other	

2. What questions do you ask when you contact people for information?
3. What do you look for in reports/records?
4. How do you organize and use the information that you gather? Do you use a particular form?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

6.A.1.c Questions to determine extent of plan participation

1. Who did you invite to participate in the annual plan development/review meeting?
2. Who participated in the plan development meeting?

	Invite	Participate		Invite	Participate
Consumer			Residential provider		
Family member			Level 4 Facility consultant		
Legal representative			Day program provider		
Advocate			Regional center clinical staff		
Friend			Other		

3. What determines when the meeting will be scheduled?
4. What happens when there are people who would like to attend but are unavailable at the scheduled time?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

6.A.1.d Questions to determine how the plan was developed

1. Discuss how and why the individual goals and specific objectives were selected.
2. How did the consumer participate?
3. What support did you provide the consumer to assist him or her to participate as a decision maker?

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4. How did the consumer choose particular services and providers?
5. How did he/she indicate understanding of the IPP goals and objectives?
6. Does the consumer have access to all needed services?
7. Was there general agreement on the final plan? If not how was the matter resolved?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

6.A.2 General Questions [some questions ask for information on a specific consumer]

6.A.2.a Questions to determine how services are monitored

1. What means do you use to monitor services and supports? How often do you see consumers?
2. How do you assess the effectiveness of services being provided?
3. How do you determine whether there has been progress in meeting the consumer's goals and objectives?
4. How do you evaluate whether the person is receiving the appropriate mix of services?
5. How do you use the information gained in the monitoring?
6. How do you assess the consumer/family satisfaction with services?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

6.A.2.b Questions to determine how health issues are addressed and monitored

1. What are the current medical needs of consumer #___ [including health, mental health and dental] and how are they addressed?
2. What criteria do you use to determine when a consumer needs a clinical team referral?
3. What training have you received regarding medications and side effects?
4. How often is the health status of a consumer reviewed? What is done with the information?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

6.A.2.c Questions to determine how safety is monitored

1. What kind of assessments do you do to determine whether the consumer is in a safe environment?
2. What actions do you take if you feel that the consumer's environment is becoming less safe? How often in the past year have you had experience with this?
3. How do you monitor the effectiveness of behavior plans and reports?

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4. Has the consumer ___ had any reportable SIRs within the last year? If so what were they?
5. What is the regional center's process for follow-up actions and documentation after the SIR incident has been resolved?
6. Do you get SIR information from the Risk Management/Mitigation system? How frequently? If so what do you do with it?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets expectations	<input type="checkbox"/> Below expectations
---	---	--	---

SUPPLEMENTARY SERVICE COORDINATOR INTERVIEW QUESTIONS

Do you have any specific concerns regarding the health and welfare of the consumers being visited by the monitoring team? Is there anything the monitoring team should be aware of when observing and/or interviewing any of the consumer[s], i.e., individual preferences, communication challenges, behavior challenges, etc.?

Notes Regarding Consumer _____ SC _____ CCF/DP _____

VI.A. SERVICE COORDINATOR INTERVIEW RATING MATRIX

The scale below describes the rating criteria for each of the sections of the service coordinator interview.

Part I Questions in Context of a Consumer

	VERY FAMILIAR	FAMILIAR	SOMEWHAT FAMILIAR	NOT AT ALL
6.A.1.a. Familiarity with the consumer	Knows the person as a human being and gave comprehensive responses	Knows the person well and gave acceptable responses to all questions	Has some knowledge about the person but could not respond to all of the questions	Has little or no knowledge about the person
	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS EXPECTATIONS	BELOW EXPECTATIONS
6.A.1.b. Performing an assessment of consumer needs, preferences and desires.	Information was gathered from a wide range of sources; the inquiries were in depth and consumer focused; and the information was well organized and used as a part of the plan development discussion.	Information was gathered from the critical sources,, questions were consumer focused and the information was organized and used to develop the plan.	Information gathering was limited.	Little or no information gathering beyond the review of documents in the consumer record.
6.A.1.c. Gaining participation in plan development	Efforts were made to include a wide range of individuals and to schedule the meeting at a time to maximize participation; and gave comprehensive responses.	Efforts were made to include the critical individuals and to schedule the meeting at a time convenient for most of the individuals; and gave acceptable responses.	Efforts were made to include some, but not all of the critical individuals, but not all responses were clear.	Only minimal effort was made to gain participation.
6.A.1.d. Developing a person centered plan	Consumer focused and driven goals and objectives; consumer was supported to participate fully; there was consensus on the plan and all issues were resolved satisfactorily; and gave comprehensive responses.	Goals and objectives reflect the needs and preferences of the consumer; consumer was supported to participate; there was consensus on the plan and all issues were resolved; and gave acceptable responses	Goals and objectives reflect at least some of the needs and preferences of the consumer. Not all of the responses were clear as to how the plan was developed.	Responses indicate a lack of understanding of plan development.

Part II General Questions

	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS EXPECTATIONS	BELOW EXPECTATIONS
6.A.2.a. Service monitoring	Thorough understanding of how to monitor services and use the information. Meets or exceeds required frequency of face-to-face contact. Answers were comprehensive.	Understands how to monitor services and use information. Meets required frequency of face-to-face contact. Responses to all questions were acceptable.	Monitors services and meets the frequency of face-to-face contact. Not all of the responses were clear.	Does not fully understand monitoring and/or failed to meet frequency of face-to-face contact.
6.A.2.b. Health monitoring	Thorough understanding of the medical needs of consumer and has a well-developed understanding of the how to monitor the health of consumers. Answers to all questions were comprehensive.	Understands medical needs of consumer and has an understanding of how to monitor the health of consumers. Answers to all questions were acceptable.	Some understanding of the medical needs of consumer and how to monitor the health of consumers. Not all responses were clear.	Responses indicate a lack of understanding of health monitoring.
6.A.2.c. Safety monitoring	Thorough understanding of safety monitoring and SIRs. Answers to all questions were comprehensive.	Understands safety monitoring and SIRs. Answers to all questions were acceptable.	Some understanding of the safety monitoring and SIRs. Some responses were not clear.	Responses indicate a lack of understanding about safety monitoring and/or SIRs.

VI.B. CLINICAL SERVICES STAFF INTERVIEW**Purpose**

Regional center clinical services staff and contractors provide support to consumers and service coordinators on matters affecting the health, safety and medical needs of consumers living in the community. An informational interview is conducted with the clinical staff to ascertain how the regional center has organized itself to provide the support. The interview questions ask what processes the regional center has in place for routine monitoring of consumers with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health, improvements in access to preventive health care resources, and the role of clinical services in special incident reporting and the Risk Management Committee. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Interview Form

Instructions: The clinical services interview is an informational interview. The purpose of the interview is to gain an understanding of how the regional center has organized itself to provide clinical support to consumers and service coordinators on matters affecting the health, safety and medical needs of consumers living in the community. Since the interview is informational, no attempt is made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the final report to the regional center.

Regional Center:

Interviewer(s):

Clinical Staff Interviewed:

Date:

- 6.B.1. How does the clinical staff monitor consumers with medical issues? If so, what criteria are used to determine which medical issues should be monitored and the frequency of monitoring?
- 6.B.2. How and when does the clinical staff monitor medications? If so, what criteria are used to determine the medications to be monitored?
- 6.B.3. How and when does the clinical staff review and monitor behavior plans?
- 6.B.4. What role does clinical services play in ensuring coordination of medical and mental health care for individual consumers?
- 6.B.5. Under what circumstances does clinical services initiate action with respect to a medical or behavior issues?
- 6.B.6. What clinical supports does the regional center have in place to assist service coordinators to carry out their responsibilities?
- 6.B.7. How has the regional center improved access to preventive health care resources?
- 6.B.8. Do you have any role in the regional center Risk Management Committee? If so will you please describe what you do?
- 6.B.9. What role do you have in special incidents?
- 6.B.10. What issues/problems, if any, is the regional center experiencing regarding Medi-Cal providers in your catchment area? Are there any gaps in specialty provider groups?
- 6.B.11. Is the regional staff aware of any provider concerns/issues with billing Medi-Cal services?

VI.C. QUALITY ASSURANCE STAFF INTERVIEW

Purpose

Quality assurance (QA) is an important component in assuring the health and safety of consumers in the community and provider competence. An informational interview is conducted with QA staff to gain an understanding of how the regional center has organized itself to conduct: Title 17 monitoring of community care facilities (CCFs); two unannounced visits to CCFs; QA evaluations of CCFs, and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and to ascertain what is done to assure quality among programs and providers where there is no regulatory authority to conduct QA monitoring. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Interview Form

Instructions: The quality assurance (QA) interview is an informational interview. The purpose of the interview is to gain an understanding of how the regional center has organized itself to conduct Title 17 and QA monitoring of community care facilities, service provider training, unannounced visits, resource development activities, verification of provider qualifications, and QA among programs and providers where there is no regulatory authority to conduct QA monitoring. Since the interview is informational, no attempt is made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the final report to the regional center.

Regional Center: _____ Interviewer(s): _____
 QA Staff Interviewed: _____ Date: _____

6.C.1. Who participates in the Title 17 reviews?

<input type="checkbox"/> QA staff	<input type="checkbox"/> Other regional center staff
<input type="checkbox"/> Service coordinators	<input type="checkbox"/> Other (specify)

6.C.2. What information do you review or gather prior to conducting the Title 17 review?

<input type="checkbox"/> Vendor file	<input type="checkbox"/> Residents' behavior plans	<input type="checkbox"/> SIR trend data
<input type="checkbox"/> Residents' IPPs	<input type="checkbox"/> SIRs	<input type="checkbox"/> CAPs
<input type="checkbox"/> Contact CCL	<input type="checkbox"/> Program design	<input type="checkbox"/> Talk to service coordinators
<input type="checkbox"/> QA review reports	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Other (specify)

- 6.C.3. Are Title 17 reviews generally scheduled at times when consumers are at home?
- 6.C.4. What kinds of consultation or technical assistance do you provide during reviews?
- 6.C.5. Describe the regional center's process for issuing sanctions for CCFs.
- 6.C.6. How do you follow-up and verify that the issues related the sanctions have been resolved?
- 6.C.7. Does regional center staff receive training in identifying substantial inadequacies and immediate dangers?
- 6.C.8. Who is responsible for conducting the two unannounced visits to CCFs?
- 6.C.9. What is done with the information from the unannounced visits and Title 17 reviews?

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6.C.10. Who participates as evaluation team members in the QA reviews of CCFs?

<input type="checkbox"/> QA staff	<input type="checkbox"/> Facility liaison	<input type="checkbox"/> Other regional center staff
<input type="checkbox"/> Service coordinators	<input type="checkbox"/> Consumer	<input type="checkbox"/> Family member
<input type="checkbox"/> Board member	<input type="checkbox"/> Providers	<input type="checkbox"/> Other (specify)

6.C.11. What kind of training do team members receive?

6.C.12. What information do you review prior to the QA review?

<input type="checkbox"/> Vendor file	<input type="checkbox"/> Residents' behavior plans	<input type="checkbox"/> SIR trend data
<input type="checkbox"/> Residents' IPPs	<input type="checkbox"/> SIRs	<input type="checkbox"/> CAPs
<input type="checkbox"/> Contact CCL	<input type="checkbox"/> Program design	<input type="checkbox"/> Talk to service coordinators
<input type="checkbox"/> Title 17 reports	<input type="checkbox"/> Prior QA evaluations	<input type="checkbox"/> Talk to family members
<input type="checkbox"/> Staff schedule)	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Other (specify)

6.C.13. What roles are assigned to the various team members?

6.C.14. Are reviews generally scheduled at times when consumers are at home?

6.C.15. What kinds of consultation or technical assistance do you routinely provide during reviews?

6.C.16. What actions have you taken as a result of the QA reviews?

6.C.17. What follow-up actions have you taken?

6.C.18. Are CAPs written and given to the provider at the conclusion of the review?

6.C.19. What, if anything, do you do to assure quality among programs and providers where there is no regulatory authority to monitor?

6.C.20. How do you verify the qualifications of providers?

6.C.21. What kind of training do you give to providers?

6.C.22. How do you assure quality in resource development?

6.C.23. What role does QA staff play in investigating and following-up on SIRs?

6.C.24. Do QA staff participate as a member of the Risk Management Committee?

6.C.25. What SIRs data do you routinely use?

6.C.26. Do you have a role in distributing SIRS information or analyses?

SECTION VII INTERVIEWS WITH SERVICE PROVIDERS AND DIRECT SUPPORT STAFF

VII.A SERVICE PROVIDER INTERVIEW

Purpose

The service provider has a critical role in the life of the consumer. The service provider not only is responsible for assessing the needs of the consumer, participating in the development a person-centered Individual Program Plan, provision of services and supports on the IPP, fostering consumer progress, ensuring the health and safety of the consumer, and advocating for the consumer. The purpose of the interview is to determine how well the service provider knows the consumer, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how the accuracy of documentation is ensured, communication, how medications are safeguarded, how health issues are addressed and monitored, emergency preparedness, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

Interview Form

Regional Center:

Interviewer(s)

Service Provider:

Program type and #: CCF ____ Day ____ SLS/ILS ____

Name and Title of Person Interviewed

Date

Instructions: The interview is divided into two major categories: I. questions that apply to a particular consumer and II general questions. There are areas of interest under each of the categories with a series of questions to test the knowledge of the staff person. The series of questions are related and are offered as a guide to the topics that should be covered. At time it will not be necessary to ask each individual question. The focus should be on listening carefully to the response given and making an assessment as to whether the topic has been fully explained. The interviewer is free to ask follow-up questions if there is a need for further clarification or to skip questions that have been answered as a part of a previous response. Each area of interest is to be rated by the interviewer based upon the answers to the series of questions. There are four ratings to each group of questions. The rating matrix defines the criteria for the responses. After you interview the person please check the appropriate rating for each question.

7.A.1 Questions in the context of Consumer #____

7.A.1.a Questions to determine how well the service provider knows the consumer

1. Can you tell me about _____? [Strengths, needs, preferences, etc?]
2. How do you communicate with him/her?
3. How does he/she indicate his/her needs, wants and preferences?
4. How does he/she indicate agreement?

<input type="checkbox"/> Very familiar	<input type="checkbox"/> Familiar	<input type="checkbox"/> Somewhat familiar	<input type="checkbox"/> Not at all
--	-----------------------------------	--	-------------------------------------

7A.1.b Questions to determine the extent of the assessment preparation for the annual plan development/review

1. Describe how you gathered information on consumer #____ to prepare for the annual review. [Preferences and personal goals, needs and abilities, health status and other available supports.

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Discussion	Yes	Review of Records/Reports	Yes
Consumer		Previous IPP goals and objectives	
Family/legal representative		Consumer file	
Circle of support members		Your service plan	
Direct support staff		Your reports	
Consultants		Consultant reports	
Service coordinator		SIRs	
Other service provider		Other	
Other			

2. What questions do you ask when you contact people for information?
3. What do you look for in reports/records?
4. How do you organize and use the information that you gather? Do you use a particular form?
5. What actions do you take if you determine a consumer's needs or preferences have changed between annual reviews?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
---	---	---	---

7.A.1.c Questions to determine the development of person centered plan

1. How do you participate in the consumer's IPP meetings? Do you always attend?
2. Discuss how and why the individual goals and specific objectives were selected for your program/facility.
3. What support did you provide the consumer to assist him/her to participate as a decision maker?
4. What role did the consumer play in directing the goals and objectives related to your program?
5. Does the consumer have access to all needed services?
6. Was there general agreement on the final plan? If not how was the matter resolved?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
---	---	---	---

7.A.1.d Questions to determine how consumer progress is fostered

1. Does your program/facility develop ISPs? If so, how is the ISP developed for consumer #___? If so how do the ISP objectives correlate with IPP objectives?
2. If not, what method do you use to assure that the IPP objectives that are your responsibility are carried out?
3. Describe the data collection system in place for consumer #___IPP objectives. What type of data is collected? How frequently is it compiled?

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4. What are the barriers that have been identified for consumer#___ in achieving his/her IPP objectives and how has the program addressed these issues?
5. How does the program/facility support the consumer#___ strengths?
6. How do you assess consumer#___ satisfaction with your services?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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General Questions [some questions ask for information on a specific consumer]

7.A.2.a Questions to determine how health issues are addressed and monitored

1. What are the current medical needs of consumer #___ [including health, mental health and dental] and how are they addressed?
2. What criteria do you use to determine when you need regional center assistance in addressing health issues?
3. Who is responsible for review and oversight of the health status of consumers you serve?
4. As a program/facility what is your system for knowing that the overall health needs are being taken care of? What is your system for training staff to know?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.A.2.b Questions to determine safeguarding medications

1. What medications does consumer#___ take? Any observed side effects?
2. Does the prescribing physician/psychiatrist clearly state the reason for the prescription? Where is this documented? How is this communicated to staff?
3. What system do you have in place to ensure that medications are stored and administered appropriately? How do you verify that the system is working?
4. What training have you received regarding medications and side effects? When? By whom?
5. How does direct support staff get trained on medications and side effects?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.A.2.c Questions to determine systems in place to assure accuracy of progress documentation

1. What system do you have in place to ensure that there is accurate, timely, complete and consistent documentation for each consumer? How do you verify that the system is producing the desired result?

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2. Level 4 only: How often does the consultant review and make any necessary revisions to the behavior plan?
3. Who is responsible for the day-to-day documentation of progress and events?
4. How do you train staff in documentation?
5. What data does your program collect and use to assess consumer satisfaction?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.A.2.d Questions to determine providers understanding of importance of communication

1. Do you communicate with the regional center? When and about what?
2. Do you communicate with other service providers who serve the same consumers that you do? When and about what??
3. How do you ensure that relevant information about consumers is passed on when there are shift changes?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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4. How do you ensure that the staff communicates appropriately with the consumers?

7.A.2.e Questions to determine emergency preparedness

1. Describe your procedures in the event of natural disasters and public emergencies.
2. How often do you review and practice the emergency procedures?
3. What would you do for example if there were an electrical problem that forced evacuation of the facility/program site for 24 hours or more?
4. What would you do if there were a heavy rainstorm that closed the roads and consumers could not get home/leave their day program?
5. What is your contingency plan for times when staff doesn't show up for work without telling you?
6. What is your contingency plan for scheduled time off by staff?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.A.2.f Questions to determine how safety is monitored

1. As a program/facility, what is your system for knowing that the overall and individual safety needs of the consumers you serve are being addressed? What is your system for training staff to know?
2. Describe the conditions under which you would report a special incident to the regional center.
3. Has the consumer # ___ had any reportable SIRs within the last year? If so what were they and what did you do? [If the consumer has not required a SIR in the last year please describe another consumer.]

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- 4. What is your process for follow-up actions and documentation after the SIR incident has been resolved?
- 5. How do you train staff to respond to incidents that require a SIR?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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SUPPLEMENTARY SERVICE PROVIDER INTERVIEW QUESTIONS

Do you have any specific concerns regarding the health and welfare of the consumers being visited by the monitoring team? Is there anything the monitoring team should be aware of when observing and/or interviewing any of the consumer[s], i.e., individual preferences, communication challenges, behavior challenges, etc.?

SERVICE PROVIDER INTERVIEW RATING MATRIX

The scale below describes the rating criteria for each of the sections of the service provider interview.

7.A.1 QUESTIONS IN THE CONTEXT OF A CONSUMER

	Very Familiar	FAMILIAR	SOMEWHAT FAMILIAR	NOT AT ALL
7.A.1.a. Familiarity with the consumer	Knows the person as a human being and gave comprehensive responses	Knows the person well and gave acceptable responses to all questions	Has some knowledge about the person but could not respond to all of the questions	Has little or no knowledge about the person
	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS EXPECTATIONS	BELOW EXPECTATIONS
7.A.1.b Performing an assessment of consumer needs, preferences and desires.	Information was gathered from a wide range of sources; the inquiries were in depth and consumer focused; and the information was well organized and used as a part of the plan development discussion.	Information was gathered from the critical sources, questions were consumer focused and the information was organized and used to develop the plan.	Information gathering was limited and was used as a part of the plan development.	Little or no information gathering beyond the review of documents in the consumer record.
7.A.1.c. Developing a person centered plan	Provider participated fully, consumer was supported to participate fully, IPP is consumer focused and directed; and gave comprehensive responses.	Provider participated, goals and objectives reflect the needs and preferences of the consumer; consumer was supported to participate; and gave acceptable responses to the questions	Goals and objectives reflect at least some of the needs and preferences of the consumer, but not all of the responses were clear as to how the plan was developed.	Responses indicate a lack of understanding of plan development.
7.A.1.d Fostering consumer progress	Thorough understanding of how to develop and monitor ISP and use the information to maximize consumer progress and gave comprehensive responses.	Understands how to develop and monitor ISP and use information to foster consumer progress; and gave acceptable responses..	Some understanding of development of and monitoring ISB but not all of the responses were clear.	Does not understand monitoring..

7.2 GENERAL QUESTIONS

	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS EXPECTATIONS	BELOW EXPECTATIONS
7.A.2.a. Understanding health issues and monitoring	Thorough understanding of the medical needs of consumer, and systems are in place to monitor health of consumers. Comprehensive answers to all questions .	Understands medical needs of consumer and has an understanding of how to monitor the health of consumers. Acceptable answers to all questions.	Some understanding of the medical needs of consumer and how to monitor the health of consumers. Some responses were not clear.	Has little or no understanding of medical needs and health monitoring.
	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS EXPECTATIONS	BELOW EXPECTATIONS
7.A.2.b. Process to safeguard medications	Thorough understanding of the need and comprehensive process in place to store and administer medications. Comprehensive answers to all questions	Has an acceptable understanding of the need and process in place to store and administer medications. Answers to all questions were acceptable.	Some understanding of the need and/or all or part of a process in place but not all responses were clear.	His little understanding of the need to safeguard medications and/or an incomplete process in place.
7.A.2.c. Determining accuracy of progress documentation	Comprehensive system in place to collect and verify the accuracy of progress documentation. Comprehensive answers to all questions	Has an acceptable system in place to collect and verify accuracy of progress documentation. Answers to all questions were acceptable	Has some components of system in place to collect and verify accuracy of progress documentation, but not all answers were clear.	No system in place to collect and/or verify the accuracy of progress documentation.
7.A.2.d Understanding of the communication process in service delivery and care	Comprehensive understanding of what to communicate, how often communication should occur and the importance of communication to continuity of service delivery and care.	Has an acceptable understanding of what to communicate, how often communication should occur, and the importance of communication to continuity of service delivery and care.	Has some understanding of the communication process, but did not give clear answers to all of the questions.	Has little or no understanding
7.A.2.e. Understanding of emergency procedures	Thorough understanding of emergency procedures and responded comprehensively to all questions	Has an acceptable understanding of emergency procedures and gave acceptable responses to the questions.	Has some understanding of emergency procedures but did not give clear answers to all of the questions.	Has little or no understanding of emergency procedures.
7.A.2.g Understanding of safety monitoring	Thorough understanding of safety monitoring and SIRs and responded comprehensively to all questions.	Has an acceptable understanding of safety monitoring and SIRs and gave acceptable responses to the questions.	Has some understanding of the safety monitoring and SIRs but did not give clear answers to all questions.	Responses indicate a lack of understanding about safety monitoring and/or SIRs.

VII.B. DIRECT SUPPORT STAFF INTERVIEW

Purpose

Direct support staff are the individuals who work with and assist the consumers in day programs and residential settings. Direct support staff play an important role in the implementation of the IPP. The purpose of the interview is to determine the direct support staff's familiarity with the consumer, understanding of the IPP and service delivery requirements, communication, level of preparedness to address safety issues, understanding of emergency preparedness, and knowledge about safeguarding medications. The interview form is divided into two major categories. The questions in the first category are related to specific consumers. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

Interview Form

Regional Center: _____ Interviewer(s) _____

Direct Support Staff: _____ Facility/Program _____ Date: _____

Instructions: The interview is divided into two major categories: I. questions that apply to a particular consumer and II general questions. There are areas of interest under each of the categories with a series of questions to test the knowledge of the staff person. The series of questions are related and are offered as a guide to the topics that should be covered. At times it will not be necessary to ask each individual question. The focus should be on listening carefully to the response given and making an assessment as to whether the topic has been fully explained. The interviewer is free to ask follow-up questions if there is a need for further clarification or to skip questions that have been answered as a part of a previous response. Each area of interest is to be rated by the interviewer based upon the answers to the series of questions. There are four ratings to each group of questions. The rating matrix defines the criteria for the responses. After you interview the person please check the appropriate rating for each question.

7.B.1 Questions in the context of Consumer # _____

7.B.1.a. Questions to determine how well the direct support staff knows the consumer:

1. Can you tell me about _____? [Strengths, needs, preferences, etc.]
2. How do you communicate with him/her?
3. Does he/she have any health issues? What are they? Are there any special things that you do for the individual in relation to these health issues?
4. Is he/she at increased risk for injury or illness for any reason, for example, has difficulty swallowing or doesn't transfer independently? If so, what has been done to reduce or mitigate the risk?
5. What does he/she like to do in his/her leisure time?
6. Does _____ have any favorite foods? What are they?

<input type="checkbox"/> Very familiar	<input type="checkbox"/> Familiar	<input type="checkbox"/> Somewhat familiar	<input type="checkbox"/> Not at all
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7.B.1.b. Questions to determine how familiar the direct support staff are with the IPP and service delivery.

1. Where is the individual's IPP located? Would you please show me?
2. What does that IPP require you and other staff in the home to do for the individual?
3. How do you know, or learn about, his/her likes and dislikes?
4. Name some of his/her likes and dislikes.
5. Describe choices that the person has made or has the opportunity to make in his/her daily life.
6. How do you make sure that the services you provide meet his/her needs and preferences?
7. How do you know when the needs or preferences of the consumer change?
8. What do you do when you observe such a change?
9. What kinds of input are you asked to give when it is time to develop or amend the person's IPP?

<input type="checkbox"/> Very familiar	<input type="checkbox"/> Familiar	<input type="checkbox"/> Somewhat familiar	<input type="checkbox"/> Not at all
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7.B.1.c. Questions to determine the direct support staff's level of understanding about the importance of communication.

1. How often do you communicate with other staff that also deals with this individual?
2. What kinds of things do you pass on when there is a change in direct support staff [i.e. reassignment, shift rotation]?
3. Do you communicate with other programs the person attends? When and about what?
4. Do you communicate with family or conservators? When and about what?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.B.2 General questions

7.B.2.a. Questions to determine the direct support staff's level of preparedness to address safety issues.

1. What would you do if one of the consumers arrived at the facility or program with bruises on his/her arms and face?
2. Who would you call?
3. How would you follow-up?
4. What do you do to keep it from happening again?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.B.2.b. Questions to determine the direct support staff's level of understanding about emergency preparedness.

1. What would you do if there were a fire?
2. What would you do if there were a storm that closed the roads so that the consumers could not get home?
3. What would you do if there were an earthquake?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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7.B.2.c. Questions to determine the direct support staff's knowledge regarding safeguarding and assisting with self-administration of medications.

1. Do you help the individual to take his/her medications?
2. What are the medications? Do you know about any possible side effects?
3. Are there any special precautions that you take with any of the medications, for example, taken only with food?
4. Describe what assistance you provide. What do you do to assist the individual to take his/her medications? What are the steps that you take?
5. How do you make sure that the person gets the right medication at the right time?
6. What would you do if a mistake was made and the person got the wrong medicine?

<input type="checkbox"/> Exceeds expectations	<input type="checkbox"/> Meets expectations	<input type="checkbox"/> Somewhat meets	<input type="checkbox"/> Below expectations
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DIRECT SUPPORT STAFF RATING MATRIX

The scale below describes the rating criteria for each of the sections of the direct support staff interview.

7.B.1 QUESTIONS IN THE CONTEXT OF A CONSUMER

	VERY FAMILIAR	FAMILIAR	SOMEWHAT FAMILIAR	NOT AT ALL
7.B.1.a. Familiarity with the consumer	Knows the person as a human being and gave comprehensive responses	Knows the person well and gave acceptable responses to all questions	Has some knowledge about the person but could not respond to all of the questions	Has little or no knowledge about the person
7.B.1.b. Familiarity with the consumer's IPP, need or preferences, and services	Has complete understanding of the IPP and service delivery and gave comprehensive responses	Understands the IPP and service delivery and gave acceptable responses to the questions	Has some understanding but did not give clear answers to all of the questions	Has little or no understanding of the IPP and/or service delivery
	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS	BELOW EXPECTATIONS
7.B.1.d. Understanding of communication process in service delivery and care	Has a comprehensive understanding of what to communicate, how often communication should occur and the importance of communication to continuity of service delivery and care.	Has an acceptable understanding of what to communicate, how often communication should occur, and importance of communication to continuity of service delivery and care.	Has some understanding of the communication process but did not give clear answers to all of the questions.	Has little or no understanding of the communication process.

7.B.2 GENERAL QUESTIONS

	EXCEEDS EXPECTATIONS	MEETS EXPECTATIONS	SOMEWHAT MEETS	BELOW EXPECTATIONS
7.B.2.a. Understanding of safety issues and precautions.	Has a thorough understanding of safety issues and procedures and responded comprehensively to all questions	Has an acceptable understanding of safety issues and procedures and gave acceptable responses to the questions.	Has some understanding of safety issues and procedures but did not give clear answers to all of the questions.	Has little or no understanding of safety issues and procedures.
7.B.2.b. Understanding of emergency procedures	Has a thorough understanding of emergency procedures and responded comprehensively to all questions	Has an acceptable understanding of emergency procedures and gave acceptable responses to the questions.	Has some understanding of emergency procedures but did not give clear answers to all of the questions.	Has little or no understanding of emergency procedures.
7.B.2.c.. Safeguarding and assisting with	Has a complete	Understands safeguarding	Has some understanding	Has little or no

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self-administration of medications	understanding of safeguarding and assisting with self-administration medications and gave comprehensive responses	and assisting with self-administration medications and gave acceptable responses to the questions	of safeguarding and assisting with self-administration medications but did not give clear answers to all of the questions	understanding of safeguarding and assisting with self-administration medications.
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SECTION VIII VENDOR MONITORING REVIEW FORM

Purpose

Residential programs and day programs are reviewed by the monitoring team utilizing a vendor monitoring review form consisting of 25 review criteria. The purpose of the program review is to ensure that the consumers are served in safe, healthy, positive environments where their rights are respected. The 25 criteria are divided into grouped under five categories: environment and safety; health and medications; services and staff; money (applies to residential programs); and rights. Each review criteria has interpretive guidelines to clarify the expectations and to provide a framework to promote effective and efficient provisions of services and supports to enable the consumers to reach their goals. The review is conducted through an inspection of the physical environment of the program and observations. The results of the reviews will be summarized in the report to the regional center.

The vendor monitoring review form is shown on the next page.

Vendor Monitoring Review Form

Instructions: The vendor monitoring review is conducted through an inspection of the physical environment of the program, observation of staff interactions with consumers, observations of consumers, and inspection of personal and incidental fund records to determine whether there is a process in place to protect the resources of the consumer. The interpretive guidelines provide a framework to promote effective and efficient provisions of services and supports.

	Interpretive Guidelines	Yes	No	N/A	Comments
8.1. Environment and Safety					
8.1.a. Cleanliness of home or vendor site	Is home/facility clean? Look for dirt, insects, rodents, pests, trash. Are food preparation and storage sites clean? *Unclean is defined as anything that may represent a health or safety threat for the people living or spending time there.				
8.1.b. Odors	Are there any unusual odors present [urine, feces, spoiled food, natural gas]?				
8.1.c. Maintenance of home / vendor site	Is the home/vendor site in good repair? No broken windows, doors, walls, plumbing, electrical, etc. All appliances are in working order, all steps and railings are in good condition, all furniture is clean and in good repair. There are no safety hazards.				
8.1.d. Adaptations	Is the home/vendor site adapted for the consumers? Can they get in and out in case of an emergency?				
8.1.e. Soap and towels or paper towels	Are these items present in the bathrooms and kitchen? Are people and staff using them?				

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	Interpretive Guidelines	Yes	No	N/A	Comments
8.1.f. Precautions to prevent the spread of infectious disease	Does the staff use gloves when engaging in activities where there is a chance that they could come into contact with or spread infection? Do they wash their hands when they remove the gloves? Do they wipe down surfaces with disinfectant after changing diapers? Do they appropriately dispose of diapers, cleaning materials and other potentially contaminated articles?				
8.1.g. Appropriate storage	Are there pesticides or other toxic substances stored in the kitchen and food areas? Are soaps, detergents, and cleaning compounds stored separately from food supplies? Is perishable food/beverages stored in the refrigerator/freezer?				
8.2. Health and Medications					
8.2.a. First aid supplies	Are first aid supplies accessible to all staff? Ask staff where the first aid supplies are kept. Is there a manual? Ask staff to explain how to treat a bleeding cut.				
8.2.b. Medication storage	Is medication stored centrally in a safe locked location? Is the medication stored in the original container with the label intact and unaltered? Who has access to the medication? Is there a designated staff person for each shift?				
8.2.c. Medication records [non PRN]	How are the medication records maintained? Are records maintained of all medications [non PRN] taken by the consumer?				

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	Interpretive Guidelines	Yes	No	N/A	Comments
8.2.d. Medication records PRN	A record [date, time, dosage and consumer's response] is kept in the consumer record for each PRN dose.				
8.2.e. Medication disposal	Are there expired or discontinued medications? What is the procedure to dispose of such medications? Are records kept on medication disposal?				
8.2.f. Special dietary needs	Do any of the residents/participants have special dietary needs? Is staff aware of the needs? Ask about grocery shopping and have the staff person show the contents of refrigerator or pantry where the food is stored.				
8.2.g. Adaptive equipment	Is the equipment clean, in good repair and is it being used as prescribed? Do the consumer and staff know how to use the equipment?				
8.3. Services and Staff					
8.3.a. Staff interactions	Observe! Are staff interactions respectful, attentive and positive? Are staff teaching and mentoring people?				
8.3.b. Contingency plan	What is the contingency plan for times when staff does not report for work?				
8.3.c. Staff requirements	Are there first aid certificates on file? If there is a pool, do staff who supervise residents have a valid water safety certificate?				

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	Interpretive Guidelines	Yes	No	N/A	Comments
8.4. Money (Applies to residential programs)					
8.4.a. Spending money	Where is the money kept? What records are kept? What is the cash disbursement procedure?				
8.4.b. P&I accounts	Have there been any purchases? Are there receipts? For large items, does the person have the item?				
8.4.c. Appropriate expenditures	Expenditures are not used for basic services to be provided by the facility or Medi-Cal				
8.5. Rights					
8.5.a. Control	Observe: Do people appear to ask staff for permission frequently? Do people choose who visits in their home? Is staff taking care of personal business while at work [errands, children at work, phone calls, etc.]?				
8.5.b. Privacy	Can people talk privately? Do people have privacy for daily activities that are typically private [dressing, bathroom, etc.]? Do people, other than roommates, knock and ask permission to enter bedrooms?				

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	Interpretive Guidelines	Yes	No	N/A	Comments
8.5.c. Rights	Is the statement of rights posted? Ask staff how they explain the list to the consumers.				
8.5.d. Rules	Ask if there are any rules other than those that are posted? If so, ask who made up the rules.				
8.5.e Restrictions	Are there any restrictions? Are the places in the home that are off limits (other than bedrooms)? Is the refrigerator off limits or restricted? Are there alarms on the doors in the house?				

SECTION IX SPECIAL INCIDENT REPORTS

Purpose

Title 17, California Code of Regulations (CCR), § 54327 defines special incidents as those incidents that have occurred during the time the consumer was receiving services and supports from any vendor or long term health care facility, including: the consumer is missing and the vendor or long-term care facility has filed a missing persons report with a law enforcement agency; reasonably suspected abuse/exploitation; reasonably suspected neglect; a serious injury/accident; any unplanned or unscheduled hospitalization; and, regardless of when or where the following incidents occurred, the death of any consumer regardless of cause and/or the consumer is the victim of a crime. Title 17 requires all vendors to report special incidents be reported to the regional center in not more than 24 hours after learning of the occurrence to be followed with a written report to the regional center within 48 hours after the occurrence, unless the initial report contained all of the required information. The regional centers are required to report these special incidents to Department of Developmental Services (DDS) electronically. Reporting of follow-up of special incidents is an important safeguard for consumers living in the community. The purpose of this section is to verify that special incidents have reported within the timelines, that the documentation meets the requirements of Title 17, and that the follow-up was complete. The report to the regional center will include those areas where there were negative findings.

Criterion

- 9.0 A special incident is completed for all consumer deaths and reported to DDS.** (Title 17, CCR § 54327.1) Note: This is completed prior to the on-site review.

Sample

1. All HCBS Waiver status "code 7", (closed/deceased) consumers in the Client Master File (CMF) or CADDIS for the 12-month review period.
2. SIRs of HCBS Waiver consumer deaths submitted by the regional center during the 12-month review period.

Verification Instructions

1. Compare the SIRs deaths reported to DDS for the 12-month review period with the list of status "code 7" Waiver consumers in the CMS or CADDIS.
2. Score as (NA) if there were no HCBS Waiver status "code 7", closed/deceased, consumers in the CMF or CADDIS for the 12-month review period.
3. Score as (+) if the Waiver consumer has a status "code 7" in the CMF or CADDIS, and a SIR of the consumer's death was submitted to DDS.
3. Score as (-) if a SIR was not submitted and the Waiver consumer has a status "code 7" in the CMF or CADDIS. Comment on the number of unreported deaths.

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9.1 The regional center reports special incidents to DDS. *(Title 17, CCR, § 54327.1)*

Sample

1. The sample of HCBS Waiver consumer records selected for the regional center HCBS Waiver review.
2. A list of SIRS submitted to DDS pursuant to Title 17 requirements during the 12-month review period for the sample of HCBS Waiver consumer records selected for the regional center HCBS Waiver review.

Verification Instructions

1. Compare SIRS in the sample of HCBS Waiver consumer records selected for the regional center HCBS Waiver review with the list of SIRS reported to DDS.
2. Score as (NA) if there were no SIRS in the record or on the DDS list of reported SIRS for the consumer.
3. Score as (+) if the SIRS in the consumer records match the DDS list.
4. Score as (-) if the consumer records contain SIRS that do not match the DDS list.
5. Comment on unreported SIRS. Obtain photocopies of unreported SIRS and documentation of any follow-up activities or reports.

9.2.a The vendors report special incidents to the regional center within the timeframe specified in Title 17. *(Title 17, CCR, § 54327)*

Explanation

The vendor shall submit a written report of the special incident to the regional center within 48 hours after the occurrence of the special incident.

Sample

Ten (10) HCBS Waiver consumers who had special incidents pursuant to Title 17 reported to DDS within the 12-month review period.

Verification Instructions

1. Compare the date of the incident with the date the incident was reported to the regional center.
2. Score each special incident as (+) if the incident was reported to the regional center within the specified timeframe.
3. Score each special incident as (-) if the incident was not reported to the regional center within the specified timeframe. Place the date of the incident of the report and the date of the report to the regional center in the comment section.

9.2.b The regional center reports special incidents to DDS within the timeframe specified in Title 17. *(Title 17, CCR, § 54327.1)*

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Explanation

Regional centers are required to submit an initial report to DDS of any special incident defined in Title 17 within two working days following receipt of the report, or where a report has not been submitted to the regional center, within two working days of learning of the occurrence.

Sample

Ten (10) HCBS Waiver consumers who had special incidents pursuant to Title 17 reported to DDS within the 12-month review period.

Verification Instructions

1. Compare the date of the incident with the date the incident was reported to DDS.
2. Score each special incident as (+) if the incident was reported to DDS within the specified timeframe.
3. Score each special incident as (-) if the incident was not reported to DDS within the specified timeframe. Place the date of the receipt of the report and the date of the report to DDS in the comment section.

9.3 The regional center documents follow-up activity. (Title 17, CCR, § 54327.1)

Explanation

Regional centers are required to document follow-up activities taken in response to the special incident. The purpose of the follow-up activity is to assure that special preventative actions are taken to mitigate or reduce future risk including delineation of outcomes and actions taken in response to the incident.

Sample

Ten (10) HCBS Waiver consumers who had special incidents pursuant to Title 17 reported to DDS within the 12-month review period.

Verification Instructions

1. Review all documentation related to each of the special incidents in the sample for timeliness, appropriate to the situation and resulting in an outcome that ensures that consumers are protected from adverse consequences, potential risk factors are explored, and risks are either minimized or eliminated.
2. Score as (+) if the subsequent activities have been documented and are timely, appropriate to the situation and result in an outcome that ensures that consumers are protected from adverse consequences, , potential risk factors are explored, and risks are either minimized or eliminated.
3. Score as (-) if the subsequent activities were not documented or were not timely. Comment on why the activities were not timely.
4. Score as (-) if the subsequent activities were not documented or were not appropriate to the situation. Comment on why the activities were not appropriate to the situation.

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SECTION X SUPPLEMENTARY ISSUES

Purpose

This section contains any supplementary issues identified by the monitoring team during the review that are not specifically addressed by the standard review protocol criteria. The following are examples of issues that may be included in this section: follow-ups on specific issues relating to consumers; additional regional center follow-up on special incidents; documentation of problems relating to regional center procedures or systems that are currently in place; referrals to the DDS Audit Section.