

# **SUPPORTS for COMMUNITY LIVING POLICY MANUAL**

## **2012**

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# Supports for Community Living Policy Manual

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## DDID MISSION

It is the Mission of DDID to empower each person to realize his or her place in the community as a citizen of the Commonwealth of Kentucky. To accomplish this mission, DDID will partner with and support persons with intellectual or developmental disabilities, families, advocates, stakeholders, and government agencies.

## DDID VISION

People, throughout their lifespan, are active, contributing and respected members of their community. People have the ability to choose from a full array of effective and meaningful natural and paid supports to access what is important **for** them and to access and maintain what is important **to** them.

## DDID VALUES

The following principles guide the work of DDID staff as we strive to make a positive difference in the lives of all participants with whom we come in contact.

### **Person Centered Thinking and Communities**

Person centered thinking drives our actions by emphasizing the importance of each person. Communities are the first places to seek, identify, and nurture supports and opportunities.

### **Participation in the Community**

We affirm all people can direct their own supports and thereby encourage and promote true and meaningful participation in the community as essential to person centered practices.

### **Employment**

Participants of working age are employable: employment is life-enriching.

### **Direct Support Professionals**

We recognize and embrace Direct Support Professionals as essential team members whose input is valued and respected at all levels of planning and implementation of services pertinent to participants they support.

### **Natural Supports**

We promote and respect the involvement of family members and natural supports to empower participants in the pursuit of active meaningful participation within their community.

### **Best Practice**

Initiatives and supports are driven by research and data to include the array of promising, evidence-based, and identified best practices.

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## SECTION 1

### INTRODUCTION

The Kentucky Supports for Community Living (SCL) Medicaid Waiver program offers statewide individualized community based services to participants who meet ICF/IID criteria. Citizens with intellectual or developmental disabilities are active contributing members of their communities who expect to utilize integrated person centered services in order to enjoy living and working in their communities. Thus, SCL services are: a) offered with respect, b) designed to ensure participants are afforded choices, and c) provided in a manner whereby participants feel and are safe in the community.

Participants utilizing SCL services may choose one of the following methods of access to services:

- 1) Participant directed non-medical, non-residential services;
- 2) Blended traditional and participant directed services; or
- 3) Traditional services.

Information regarding each of these methods will be covered throughout the Policy Manual.

## SECTION 2

### PERSON CENTERED SYSTEM

#### 2.0 INTRODUCTION

A person centered system involves person-centered thinking, planning, and organizations devoted to implementation. The person centered system acknowledges the role of families and guardians in planning for people who need assistance in making informed choices. The SCL person centered services provides the participant the opportunity to pursue individual interests and dreams. Through the acknowledgement of the person's life history and unique individuality, systems and organizations promote dignity and respect by incorporating these elements in the design of services.

#### 2.1 PERSON CENTERED GUIDING PRINCIPLES

It is the goal of the Division of Developmental and Intellectual Disabilities (DDID) to partner with and support persons with intellectual/developmental disabilities (I/DD), families, advocates, stakeholders, and governmental agencies to accomplish the mission of empowerment and realization of community life.

Throughout their lifespan, people are active, contributing, and respected members of their community. Participants utilizing the SCL Waiver Program have the ability to choose from a full array of effective and meaningful natural and paid supports to access what is important **for** them and to access and maintain what is important **to** them.

Throughout the SCL Waiver Program, it is expected that providers will use the following person centered guiding principles in the provision of evidence-based best practice services for the participants utilizing SCL services:

##### ***A. Person Centered Thinking and Communities***

- Person centered thinking drives the actions of the person centered team (Team) by emphasizing the importance of the participant.
- Participants, family members, and guardians are treated with dignity and respect.
- The Team promises to listen to and act upon what the participant communicates and will seek to understand the participant in the context of their age, gender, culture, ethnicity, belief system, social and income status, education, familial tradition, and any other factor that makes them unique.
- Acknowledges that communities are the first places to seek, identify, and nurture supports and opportunities.

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- Fosters community connections in which participants can develop relationships, learn, work, earn, income, and actively participate in community life.

## ***B. Participation in the Community***

- All participants can direct their own services and are encouraged and empowered to set and reach their personal goals and seek true and meaningful participation in the community.
- The Team recognizes and supports mutually respectful partnerships among participants, their families and friends, communities, providers, and professionals.

## ***C. Employment***

- Acknowledges participants of working age are employable and should not be denied the opportunity to explore meaningful employment which is life-enriching.
- The Team recognizes the rights of participants to make informed choices, and the participant's right to take responsibility for those choices and related risks.

## ***D. Direct Support Professionals***

- Recognized and embraced as essential Team members whose input is valued and respected at all levels of planning and implementation of services pertinent to participants they support.

## ***E. Natural Supports***

- The Team promotes and respects the involvement of family members and natural supports as one way to empower participants in the on-going pursuit of active meaningful participation in the community.
- The Team builds on the strengths, gifts, talents, skills, and contributions of the participant and those who know and care about the participant.
- The Team acknowledges and values families and supports their efforts to assist their family members.

## ***F. Best Practice***

- When developing the participant's person centered plan of care, the Team pledges to be honest when trying to balance what is important to and important for the participant.
- The services include-an array of promising, evidence-based, and identified best practices that meet the needs of the participant.
- The Team advocates for laws, rules, and procedures for providing services, treatment, and support that meets a participant's needs and honors personal goals.
- The Team endorses the use of public resources to assure that qualified participants are served fairly and according to need.

## **2.2 PERSON CENTERED TEAM**

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The Team is comprised of individuals who possess the knowledge, skills, and expertise necessary to accurately identify the comprehensive array of the participant's needs and design a program that is responsive to those needs. The Team shall include the following:

- Conflict-Free Case Manager who serves as the coordinator and facilitator;
- Participant;
- Participant guardian as applicable;
- Participant circle of support which may include paid and unpaid providers and caregiver(s) such as:
  - Family members;
  - Friends;
  - Direct Support Professionals (DSPs);
  - Therapists;
  - Spiritual leaders; and
  - Consultants.

The Team participates in the relevant aspects of the active support process and each member provides input through whatever means necessary to ensure the person centered Plan of Care (POC) is responsive to the participant's needs and identified goals. The purpose of the Team process is to provide all members, including the participant to the greatest extent possible, the opportunity to review and discuss information and recommendations relevant to the participant's needs and identified goals. These discussions assist the Team in providing the participant choices on how best to address identified needs and goals.

## **2.3 PERSON CENTERED PLAN OF CARE (POC) MEETINGS**

The POC meetings are scheduled and facilitated by the Case Manager. It is the role of the Case Manager to engage the participation of all members, especially the participant unless the participant is clearly unable or unwilling.

The Case Manager is expected to pursue aggressively the attendance of all relevant Team members at the meeting. Conference calls shall meet this requirement if on-site attendance is not an available option for participation on a case-by-case basis. All Team members are expected to participate unless extenuating circumstances prohibit their face-to-face involvement.

The Case Manager shall question "unscheduled" absences by Team members and shall determine the impact on effectiveness and responsiveness of the POC to meet the participant's needs. The Case Manager shall document the absence of those individuals and the perceived impact on the POC in the case management monthly summary. The Case Manager may determine it necessary to schedule additional meetings with all members present if the participant's POC will be adversely impacted by the absence of the Team member(s).

## **2.4 PERSON CENTERED PLAN OF CARE (POC)**

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The focus is maintained on each participant as the key decision maker in their own life. This life planning process is rooted in what is most important to the participant and involves the participant directly with their community, network of connections, and close personal relationships in order to look at innovative ways to attain life goals and dreams.

The system used for person centered planning and the plan of care that results is flexible. As a participant's interests and priorities change, the planning process is revisited as often as necessary to ensure that both major and day-to-day decisions also change in response.

Person centered planning leads to transformation of a participant's life when creative new directions and approaches are taken. A participant moves towards the realization of specific life dreams and into a world of greater possibility for new goals to emerge.

Person centered planning systems are flexible and can change the array of services to reflect the participant's changing priorities and goals. Opportunities for new partnerships are encouraged and support for ongoing training for all individuals involved in the process is provided. Person centered models focus on personal interests and outcomes and not specific services, supports, or programs. There are alternative pathways to the achievement of participant priorities. Participants have the opportunity to experiment and re-visit decisions about priorities and services. Flexibility is demonstrated by the availability of intermittent services and by the Team coming together when necessary to ensure that necessary changes in the POC are made to reflect a participant's decision to live differently or make changes or new choices in daily routines. Feedback and input aimed at improving successful outcomes are sought and incorporated in the POC as warranted.

The POC identifies the integration of natural supports and paid services to assist each participant in securing valued outcomes, while also assuring basic health, safety, and welfare. The planning process enables each participant to identify their preferences in terms of service providers. Participants have options about receiving services from formal systems and organizations; from informal systems and volunteers; from family, friends and neighbors. Options are explored to connect participants to community organizations and opportunities which might include:

- Faith based communities
- Educational facilities (community and technical colleges, other post-secondary institutions, adult learning centers)
- Businesses
- Libraries
- Neighborhood associations, clubs, and recreational councils
- Other civic/volunteer organizations

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A POC is developed that addresses the unique needs, preferences, and choices of the participant. The planning process enables the participant to choose who, if anyone at all, should be involved in helping to plan or provide services. With the appropriate array of supports, which includes the conflict free Case Manager, participants can, if they choose, lead their planning meeting.

The POC is more than a service or support plan. The process enables each participant to express what they want in life and make decisions about the services needed to achieve the identified priorities. It enables the participant to have the quality of life they want and desire. Formal services are identified to address the specific needs of each participant based on an individualized assessment and identified quality of life priorities.

The Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST) assessment tools will assist in the development of the POC. The POC shall include:

- Identified needs from the assessment tools;
- Participant's identified outcomes;
- Objectives and interventions;
- Crisis prevention and interventions as warranted; and
- Positive behavioral supports as warranted.

The POC is developed with the involvement of the participant and their Team. All individuals participating in the development of the POC shall sign the document to indicate their involvement.

## **2.5 PARTICIPANT RIGHTS AND RESPONSIBILITIES**

### *A. SCL WAIVER PROGRAM PARTICIPANT RIGHTS AND RESPONSIBILITIES*

Case managers and service providers shall assist participants to exercise their rights and responsibilities within the SCL Waiver Program. Every effort must be made to assure applicants and participants understand available choices and the consequences of those choices. At the time of the person centered planning team meeting, and no less than annually, the Case Manager shall review the SCL Program Participant Rights and Responsibilities with the participant and guardian as applicable. After the participant or guardian reads and signs the SCL Program Participant Rights and Responsibilities, the Case Manager shall give a copy of the form to the participant and their guardian. The Case Manager shall place a copy of the signed form in the participant's record. The SCL Program Participant Rights and Responsibilities is referred to in Appendix A of this manual and can be found on the DMS SCL website.

### *B. SCL PROVIDER RESPONSIBILITIES*

SCL providers shall adhere to the following policies regarding participant rights:

#### **a. Voluntary Participation**

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Providers must assure that the participant's health, safety, and welfare needs are met. Participants have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a participant shall not be required to receive services that they may be eligible for but does not wish to receive.

## **b. Freedom of Choice**

Participants who qualify for SCL services have the freedom to select service providers.

## **c. Respect for the Participant**

Access to appropriate services, natural supports, care, and treatment is available regardless of:

- Age;
- Ethnicity;
- Gender;
- Religion;
- Cultural differences;
- Social status;
- Physical disability;
- Intellectual disability; or
- Payer source.

There are no barriers in accessing the services, care, and treatment offered by the provider agency, including but not limited to:

- Geographic;
- Architectural;
- Communication;
- Language access and interpreter services provided to participants with Limited English Proficiency (LEP) or who are sensory impaired; and
- Bias;
- Procedural; and
- Organizational scheduling and availability.

## **d. Human and Civil Rights**

The provider agency shall have policies and procedures that:

1. Do not discriminate.
2. Promote equitable and best-practice service delivery from the agency and its employees and volunteers.
3. Provide services in the least restrictive and integrated environment.

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4. Emphasize the use of positive communication and least restrictive interventions.
5. Identifies the rights and responsibilities of participants served.
6. Ensures humane treatment that affords protection from harm, exploitation, or coercion.
7. Ensure that unless adjudicated incompetent by a court of law, a participant shall be considered legally competent and maintain their civil, political, personal, or property rights.
8. Prohibit any abuse, neglect, and exploitation.
9. Explain grievance, complaint, and appeals processes clearly written in language accessible to participants and their guardian as applicable. Providers shall maintain records of all complaints and grievances and the resolutions of the same with the participant's file.
10. Comply with requirements of the Health Insurance Portability and Accountability Act (HIPPA) of 1996, 42 U.S.C. 1320d to 1320d-8.

Notice of availability for inspection of all agency policies and procedures are provided to participants, guardian, staff, and other interested parties.

### **e. Integration into the Larger Natural Community**

The intent of a person centered system is to assist the participant to become integrated into their community. To facilitate this integration, the provider shall ensure the following:

1. Inclusion and community integration is supported and evident.
2. Participants have opportunities for and access to employment, volunteer activities, church and civic membership, clubs, groups, educational opportunities, and associations.
3. The provider agency has partnerships that elicit input and involvement through joint planning efforts with:
  - a. Advocates;
  - b. Participants;
  - c. Families;
  - d. Business and community representatives; and
  - e. The Department

### **f. Participation in Care**

Person centered planning shall be utilized in the development of all services and natural supports to meet the participant's needs.

In order for providers to offer the level of service necessary to ensure the participant's health, safety, welfare, and support, the Team has a responsibility to monitor for any significant changes in the participant's needs. Service providers may not initiate requests for change of services or modify the POC without participation and consent of the participant or guardian(s).

### **g. Quality of Care**

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Provider agencies shall ensure that employees and volunteers are competent, trained, and qualified to deliver services to participants utilizing the SCL program as outlined in the person centered POC.

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## SECTION 3

### GENERAL INFORMATION

#### 3.1 ASSESSMENTS AND SCREENING TOOLS

The following assessments and screening tools shall be used to gather information about the participant and utilized to determine: 1) appropriate level of care; 2) their individual needs, desires, and personal goals during the person centered planning process; and 3) prior authorization of services. Information shall be updated in accordance with applicable regulatory requirements.

- a. The Supports Intensity Scale (SIS).
- b. The Health Risk Screening Tool (HRST).
- c. A participant's self-assessment to identify:
  1. Personal life goals;
  2. Perception of any issue(s) of concern;
  3. Strengths;
  4. Needs;
  5. Abilities; and
  6. Preferences.
- d. Medical history or relevant assessments.
- e. Appropriate diagnostic tools such as impairment indices, psychological or adaptive behavior testing.
- f. Life history which shall be updated annually noting events, activities, and other pertinent information that have positively or negatively impacted the participant's needs for services.
- g. School records as appropriate.
- h. Collateral history from persons significant to the participant if available.
- i. Additional assessments identified by the Team as relevant.

#### 3.2 ACCESS TO SERVICES BY PARTICIPANTS WITH LIMITED COMMUNICATION SKILLS

All providers are required to provide effective language access services to participants with limited communication skills or limited English proficiency (LEP). Specific procedures for assuring communication access may vary by provider, but are required to address assessment of the language or communication needs of participants, securing the provision of interpreter or translator services at no cost to the participant, and ensuring appropriate staff training for ongoing communication with the participant. The provider shall meet the requirements of the Americans with Disabilities Act (ADA) as deemed necessary by participant needs, including the provision of interpreter services for participants who are identified as deaf or hard of hearing.

#### 3.3 SMOKE FREE ENVIRONMENT

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SCL provider employees and volunteers shall maintain a smoke-free environment.

SCL provider employees and volunteers are expected to abide by local laws and ordinances governing smoke-free environments in those locations where said laws and ordinances exist. Additionally, SCL provider employees and volunteers are expected to provide a smoke-free environment for any participant who chooses such. This would include settings in which the participant is expected to spend any amount of time such as a home, Day Training site, a meeting site, or any other location.

The intention of this policy is not to deny choice for participants who choose to smoke. Rather, it is a safeguard and a means of protecting the rights of those who do not.

Therefore, it is expected that SCL participants will be carefully assessed to determine health needs and provided sufficient information to make fully informed choices about smoking and smoke-free environments and those choices will be documented and supported by SCL provider employees and, volunteers.

## 3.4 RESTRICTIVE MEASURES

It is recognized by DBHDID that person centered thinking and planning is a key to minimizing the risk of harm for all participants and support staff. It is the responsibility of all SCL providers to utilize person centered thinking, principles, and actions as a means of crisis prevention and intervention.

The DBHDID is dedicated to fostering a restraint-free environment in all waiver programs. Restraints shall not be used as punishment, for staff convenience, or through a positive behavioral support for purposes of controlling a participant's movement. The use of mechanical restraints, chemical restraints, seclusion, and physical restraints, including any manner of Prone (breast-bone down) or Supine (spine-down) restraint is expressly prohibited.

### A. MECHANICAL RESTRAINTS

Mechanical restraints involve the use of a device attached or adjacent to the participant's body that one cannot easily remove. These types of restraints restrict freedom and movement of normal access to a participant's body or body parts.

Those devices which restrain movements, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not solely for the control of hitting one's head against a hard surface or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered mechanical restraints. The following requirements apply to such devices:

- Shall be defined by a physician's order and specified in the POC;

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- All staff working with the participant shall be trained in the purpose of the device, criteria for use, and criteria for removal;
- Monitoring of utilization of a device shall ensure the participant's basic needs and health is intact (such as ensuring strap of helmet is not restricting air flow or ability to move mouth);
- Documentation shall specify when the device was used and why; the duration of use; when the device was removed and why; the response to application and removal of the device; and other notable information.

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## ***B. PHYSICAL RESTRAINT***

Physical restraint is also known as a manual hold or manual restraint. Circumstances of use must represent an emergency where health, safety, or welfare is judged to be at imminent risk and physical intervention is judged to be the last resort.

Brief handholding or support for the purpose of completing a task, providing safe crossing, safety or stabilization does not constitute a physical restraint.

## ***C. CHEMICAL RESTRAINT***

A chemical restraint is defined as the use of either over the counter or prescription medication to control a participant and their behavior for staff convenience or as a punishment.

Examples of chemical restraint include the following:

- The use of over-the-counter (OTC) medications such as Benadryl for the purpose of decreasing a participant's activity level;
- The use of an antipsychotic medication to manage someone who paces or appears agitated in the absence of being diagnosed with a form of psychosis.

A psychotropic PRN used as a pharmacological intervention is not considered a chemical restraint when defined as the administration of medication for an acute, episodic symptom of a participant's diagnosed behavioral health condition. It shall be documented by a physician's order which shall include drug name, dosage, directions, and reason for use. All diagnoses and the protocol for use of psychotropic PRN related to a specific diagnosis shall be documented in the participant's person centered POC.

## ***D. OTHER RESTRICTIVE MEASURES***

Other restrictive measures which shall be prohibited include:

- Withholding of food or hydration;
- Access to a legal advocate or ombudsman;
- Access to toilet, bath, or shower;
- Deprivation of medical attention or prescribed medications;
- Deprivation of sleep;
- Access to personal belongings; and
- Access to natural supports.

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## SECTION 4

### PROVIDER PARTICIPATION

#### 4.1 PROVIDER ENROLLMENT REQUIREMENTS

As noted in Kentucky's DBHDID and specifically the DDID Mission, Vision, and Values, we believe that it is essential the services provided through Kentucky's SCL Waiver Program are person-centered. Thus, each agency or organization enrolled in the SCL Waiver Program as a provider agency shall incorporate this belief into their service delivery to support participants utilizing the SCL program in living a meaningful life in the community. Specifically, the provider shall ensure:

1. Person centered planning and service delivery addresses what is important to participants in context with what is important for participants.
2. Capacity and capabilities, including qualified and competent employees and volunteers.
3. Participant safeguards.
4. Satisfactory participant outcomes which lead to relationships, dignity, choice, real contribution, and inclusion in community life.
5. Participant rights and responsibilities.
6. Participant access.

A provider seeking to participate in the Kentucky SCL Waiver Program shall comply with all requirements and materials incorporated by reference in 907 KAR 12:010.

#### 4.2 PROVIDER ENROLLMENT PROCESS

Providers choosing to enroll in the SCL Program may be a local public or private agency or an individual provider who meets the Kentucky Department for Medicaid Services (DMS) and the DBHDID enrollment criteria.

To become certified as an SCL Provider, a three-step process shall be completed:

##### A. *ORIENTATION PROCESS*

To initiate the orientation process, a potential provider shall review the DBHDID website: <http://dbhdid.ky.gov/kdbhdid/default.asp> and provider information found at: <http://dbhdid.ky.gov/ddid/newproviders.asp> and shall then contact the Division of Developmental and Intellectual Disabilities (DDID) within the DBHDID.

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The interested party shall complete the DBHDID New Provider Orientation (NPO) session. The NPO session is a required course for the Executive Director of an agency and is designed to give interested parties some basic information about the program and how to navigate the certification process.

A portion of the NPO session is available through on-line modules and a portion of the session is conducted via face-to-face training. The on-line modules shall be successfully completed prior to the face-to-face training. Registration shall be completed for the face-to-face sessions as outlined in material received from the DBHDID. Certificates of Attendance will be available to those who arrive on time and participate for the entire day. If the Executive Director (ED) is unable to arrive on time or must leave early, the ED shall be required to attend the face-to-face orientation session again.

### *B. CERTIFICATION PROCESS*

An SCL Provider Development Specialist will assist the Executive Director (ED) through the certification process.

The ED shall review the most recent regulation and policy manual related to the SCL Waiver Program. If the interested party or potential provider chooses to pursue enrollment in the SCL Program, the potential provider shall be required to submit an enrollment packet and the ED shall be required to demonstrate sufficient knowledge of the regulations and policy manual as part of the certification process. The ED shall demonstrate the organization has a thorough understanding of how to safely and effectively support participants with disabilities, as well as how to successfully operate a business. Enrollment as an SCL Medicaid waiver provider is something that should be given serious consideration and the potential provider should only proceed when they are sufficiently prepared.

### *C. APPLICATION PROCESS*

The application process is the third step and is handled through the Department for Medicaid Services (DMS). The application is referred to as the MAP-811 for non-credentialed providers. A copy of the MAP-811 and other forms and updates may be downloaded at the following link:  
[www.chfs.ky.gov/dms](http://www.chfs.ky.gov/dms).

Please note, the application should **not** be submitted to the Kentucky Department for Medicaid Services Provider Enrollment until the certification process and Pre-Service Review described below has been completed.

Beginning this three-step process does not guarantee potential providers will successfully complete enrollment and enter into a Medicaid Provider Agreement to become an SCL provider. Nor does it guarantee participants utilizing SCL services will choose to receive services from the provider agency.

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## 4.3 CERTIFICATION / PRE-SERVICE REVIEW

Upon successful completion of NPO – Level I, the interested party shall undergo a process known as Certification. Included in this process is the submission of an electronic Enrollment Packet via a CD, flash drive, or email attachment and a required Pre-Service Review. To begin the process, the ED shall submit the following items to the Division of Developmental and Intellectual Disabilities (DDID) address listed on the DDID website – New Provider page:

1. Credential of the Executive Director (ED).
  - a. This shall include a copy of a transcript and a resume or vitae which demonstrates the educational and experience requirements stipulated in 907 KAR 12:010 Section 1 are met.
  - b. The resume shall include the dates of employment, name of each employer, title of position(s), and a detailed list of the responsibilities in each position. Contact information shall also be submitted for verification of work experience that shall include the employer's work number and supervisor's name.
2. Criminal record check obtained from the Kentucky Administrative Office of the Courts (AOC) for the ED. If the ED has lived or worked out of the state of Kentucky during the past twelve (12) months, a criminal record check from the appropriate state(s) shall be submitted. This record check shall be obtained from the state's equivalent of the AOC in Kentucky.
3. Child Abuse Central Registry (CAN) check for the ED.
4. Kentucky Nurse Aid Registry check for the ED.
5. If the ED or the organization or subsidiary has been a provider of Medicaid services in other states, documentation from each state's program indicating the ED is a provider in good standing in that program shall be submitted. To fulfill this item, the following information is requested:
  - a. Has the organization or any subsidiary ever operated a Health Care business or enterprise (including SCL providers) in Kentucky or another state?
  - b. Has any owner, shareholder, partner, member of the board of directors, or executive staff member of this organization ever operated or been employed by a Health Care business or enterprise (including SCL providers) in Kentucky or any other state?
6. A copy of the agency's business plan. The business plan should include the following:
  - a. Description of the organization;
  - b. Services to be provided;
  - c. A market analysis and strategy section which shall include:
    - i. Identification of who are the intended customers;
    - ii. Comparison of the competition in the area of proposed operation;
    - iii. Trends;
    - iv. Plans for growth which includes the number of participants planned to be supported in the first six (6) months to a year;
    - v. Risks involved;

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- vi. Strategic alliances (if applicable); and
  - vii. How the organization plans to market services and recruit participants utilizing SCL services. (NOTE: The DBHDID specifically does not refer participants to provider agencies).
7. A copy of the agency's projected operating budget for the initial six (6) months past certification. This budget shall take into consideration all expenses which might be incurred for each service intended to be provided and under review for certification as well as the anticipated revenue for these services. The budget shall compare revenue to expenses on a month-by-month basis and demonstrate the agency's standing at the end of six (6) months. Projected budgets shall include details (e.g., number of people to be employed and their positions, anticipated subcontracts for services to be delivered, etc.) as to how the budget was determined. Most agencies do not receive revenue for the first one (1) to two (2) months and are typically operating in the red.
  8. A financial statement demonstrating that six (6) months of expenses are covered based upon the projected operating budget and which shall also demonstrate access to funding to pay operating costs. Please remove identifying information such as account numbers, Social Security numbers, etc.
  9. A completed Initial Questionnaire. The appropriate link may be obtained from the DDID website on the New Provider's page.
  10. A copy of the agency's Policy and Procedures Manual which shall include the following:
    - a. Table of Contents;
    - b. Policy Checklist (which may be obtained from the DDID website on the New Provider page);
    - c. Each policy shall have its own distinct number;
    - d. If the agency plans to also provide Michelle P. Waiver (MPW) services, each policy shall clearly identify whether it applies to SCL, MPW, or both;
    - e. Specify any differences in the agency's policies which accommodate the differences in Kentucky's SCL and MPW regulations.
  11. Organizational Chart which identifies the names of employees occupying each position when known.
  12. An assurance statement that the agency shall abide by the laws which govern the chosen business/tax structure of the agency.
  13. A copy of the agency's Articles of Incorporation and Bylaws or a copy of the agency's Articles of Organization and operating agreement. **(Please note: if the company only has one owner, these two documents will not be necessary).**
  14. A copy of the letter from the Internal Revenue Service (IRS) issuing the agency a tax identification number.
  15. If the agency is a non-profit agency, verification of the non-profit 501(c) 3 status shall be submitted.
  16. A Statement of Assurance that the provider agency is a legally constituted entity, which maintains a registered agent and a registered office in Kentucky as filed with the Office of the Secretary of State

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and is an agency in good standing with the Office of the Secretary of state of the Commonwealth of Kentucky.

### A. *ENROLLMENT PACKET*

Upon completion of the enrollment documentation, the packet shall be submitted via CD, flash drive, or email attachment to the DDID address listed on the DDID website – New Provider page. The ED information shall be reviewed first. If the ED does not meet the requirements no additional documents will be reviewed. If a new ED must be located, the enrollment packet may require resubmission. Information shall be provided by DDID regarding required documentation to be provided.

If the policies are not accepted, revisions shall be required. As noted in the paragraph above, the complete enrollment packet may require resubmission. Information shall be provided by DDID regarding required documentation to be provided.

Once all documents have been accepted, the on-site portion of the Pre-Service Review shall be scheduled.

### B. *ON-SITE PRE-SERVICE REVIEW*

The SCL Provider Development Specialist working with your agency shall coordinate with the Executive Director this portion of the review process. The ED shall be available during the On-Site Review process.

The following information shall be readily available for review during the on-site portion of the Pre-Service Review:

1. A complete set of Policies and Procedures, including Personnel Policies.
2. A complete set of training and personnel records for all current employees, which shall include a completed Personnel Checklist. (The Personnel Checklist form may be obtained from the DDID website – New Provider page).
3. Credentials for all employees whose job description or SCL regulations include specific education requirements or related experience. This shall include transcripts, resumes, copies of current licenses or certifications, etc.
4. Documentation of all training completed by current employees including orientation to the agency.
5. Training curricula and test(s) for all trainings not obtained through the Kentucky College of Direct Supports (CDS).
6. Criminal record and background checks for all current employees ~~[and subcontractors]~~ as specified in 907 KAR 12:010. The records shall be stamped with the date received.
7. Documentation of negative TB testing or TB risk assessment for each current employee dated within the past twelve (12) months which shall be obtained within seven (7) days of date of hire.
8. A plan demonstrating how the agency will participate in and work with the area Human Rights Committee (HRC) and the area Behavior Intervention Committee (BIC) as described in this manual.
9. Board of Directors (as applicable) meeting minutes or, if a Board of Directors is not required for the entity due to the tax structure, other appropriate documentation of appointment of the ED.

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10. A plan of how orientation shall be provided to the Board of Directors (BOD), including roles and responsibilities of a BOD.
11. A list of the owners of the company.
12. A statement of mission and values which shall:
  - a. Support participant empowerment and informed decision making;
  - b. Support and assist participants to remain connected to natural support networks;
  - c. Promote participant dignity and self-worth;
  - d. Support Team meetings to help ensure and promote the participant's right to choice, inclusion, employment, growth, and privacy;
  - e. Foster a restraint-free environment; and
  - f. Support the SCL program goals that participants:
    - i. Are safe, healthy, and respected in their community;
    - ii. Living in the community with effective, individualized assistance; and
    - iii. Enjoying living and working in their community.
13. An emergency and disaster plan.
14. A brochure or description of services offered to the public.
15. A plan for orientation of new employees.
16. A mock or sample participant's record and sample forms the agency plans to utilize.
17. A plan for ensuring ADA compliance.
18. A copy of the MAP-811 that will be submitted to the Department for Medicaid Services upon successful completion of the certification process.
19. Demonstrated knowledge of Incident Reporting as outlined in 907 KAR 12:010.
20. A plan for recruitment, training, and retention of qualified staff, including:
  - a. Training curricula;
  - b. Credentials of trainers; and
  - c. Methods for documenting training.
21. A plan for obtaining new admissions to the agency and plan for growth which adheres to ethical standards.
22. A plan for appropriate transition from one provider to another, or from the participant's current situation to another. **(NOTE: 907 KAR 12:010 requires the SCL Provider shall: "Not enroll a participant for whom they cannot meet the support needs.")**
23. A certificate issued by an insurance company authorized to do business in Kentucky certifying that the agency has a business and a professional liability insurance policy in force;
  - a. The policy includes a clause requiring that the insurer notify DBHDID whenever substantive changes are made in the policy, including any termination or failure to renew; and
  - b. In the event the insurer becomes unable to fulfill its obligation under the policy, notice shall be given immediately to DBHDID.

### C. PRE-SERVICE OUTCOME

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The agency shall receive written notification of the outcome of the Pre-Service Certification Review. This written notice will either be:

1. A letter of the agency's successful completion of the Pre-Service Review; or
2. A "Findings and Corrective Action Plan Report" indicating the deficiencies found and the necessary steps and procedure to follow to continue the Certification Process.

Upon successful completion of the Pre-Service Review, the DBHDID will send the agency and DMS written notification the agency has completed the DBHDID SCL Certification Process pending the issuance of the agency's provider number from DMS. Upon receipt of this notification, the agency shall submit the MAP-811 (application) to DMS. If application is approved, a provider number will be issued by DMS. The agency shall **not** provide or bill for services until the provider number is received.

Once the provider number is issued and received, the agency shall email the provider number to the provider development specialist working with your agency. The agency will be certified for six (6) months and may begin providing services. If the agency does not begin providing services to a participant within six (6) months, another Pre-Service Review shall be scheduled with the provider development specialist.

The agency **shall** notify the provider development specialist immediately when the first participant begins to receive any service(s).

Within a 30-45 day timeframe of service provided to the first participant, the provider development specialist will make an unannounced visit and conduct the agency's 45-day review. The agency shall receive notification of the outcome of the 45-day review which shall be:

1. A written notification of the agency's successful completion of the 45-Day Review; or
2. A "Findings and Corrective Action Plan Report" indicating deficiencies found and the process to be completed to correct the deficiencies.

Once a provider agency successfully completes the 45-Day Review, the agency may be certified for up to six (6) months.

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## 4.4 HUMAN RIGHTS COMMITTEE

The Area Human Rights Committee (HRC) is a group of individuals comprised of representatives from agencies and the community in a geographic area. The HRC shall meet on a routine, scheduled basis, and no less than quarterly, to ensure the rights of participants utilizing SCL services are respected and protected through due process. Each provider shall actively participate in the Area HRC process and shall provide the necessary documentation to the area HRC for review and approval prior to implementation of any rights restrictions or positive behavior support plans involving rights restrictions. The DBHDID, and specifically DDID, shall provide technical assistance in the establishment, orientation, and ongoing operation of the Area HRCs.

### A. *PURPOSE*

The purpose of the Area Human Rights Committee (HRC) is to:

- Ensure participants utilizing the Supports for Community Living (SCL) Waiver services exercise or are assisted in exercising all rights under the Constitution of the United States and Kentucky statute.
- Ensure that all Area Human Rights Committees operate as objective review committees in protecting the human and civil rights for participants.
- Ensure participants have information on the rights and responsibilities of citizenship.
- Ensure that each proposed limitation is given due process and that the participant is actively involved in the process and can make informed decisions.

Each service area shall convene an HRC to review, approve, and monitor Person Centered Plans of Care which contain restrictive means of support to include such items as a Positive Behavior Support Plan or a Rights Restriction.

### B. *MEMBERSHIP*

The members of the Committee shall include:

- Human Rights Committee Facilitator (which may be rotated among the Committee members);
- At least two (2) self-advocates;
- At least three (3) members from the community at large who have experience with human rights issues or experience within the field of intellectual and developmental disabilities;
- At least two (2) appointed guardians or family members of a participant;
- At least one (1) professional in the medical field, such as a nurse, pharmacist or doctor of osteopathy or medicine; and
- At least two (2) professionals with advanced degrees in a field of study related to intellectual and developmental disabilities.

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One (1) of the members shall be designated to complete a summary of the entire meeting and to submit the summary to designated DDID staff. This member shall send separate summaries of each Plan of Care reviewed to the participant or their guardian and the participant's case manager.

Each member shall complete an orientation provided by DDID staff and review and sign a Confidentiality Agreement provided by the DDID staff at the time of orientation. If a breach of confidentiality is suspected, the HRC Facilitator shall be informed. The Facilitator, in turn, shall notify the participant's case manager, who shall follow their agency's HIPPA policy.

### *C. FUNCTIONS*

The functions of the HRC are to:

1. Review and approve prior to implementation, and at least annually, all Plans of Care which are designated to:
  - a. Utilize restrictive techniques to manage challenging, maladaptive behaviors;
  - b. Restrict the participant's freedoms of choice or rights that have not been limited through legal proceedings; and
  - c. Have been recommended for review by the Area Behavior Intervention Committee (BIC);
2. Upon DDID request, review participant's grievance concerning rights restrictions approved by another Area HRC;
3. Ensure due process occurs for any rights that have been restricted which includes approval with the appropriate signatures, documentation of notifications regarding the restrictions, and documentation that participants are aware of the grievance process and they are assisted in accessing external advocacy supports if they so choose.
4. Provide recommendations and resources regarding participant rights;
5. Ensure the basic assumptions that a restriction is:
  - a. Temporary in nature;
  - b. Defined with specific criteria outlining how the restriction is to be imposed;
  - c. Paired with learning or training components to assist the participant in eventual reduction or elimination of the restriction;
  - d. Removed upon reaching clearly-defined objectives; and
  - e. Reviewed by the Area HRC at least annually.

### *D. ACCESS TO THE AREA HRC*

Each Area HRC shall establish meeting dates, which shall be made public through the DDID website. Meetings shall take place at least quarterly. The HRC may also distribute the dates to providers within the area or region. The schedule of the meetings shall be developed with the Area Behavior Intervention Committee (BIC) so that no more than two (2) months are between Area BIC and HRC meetings to avoid delay in review and implementation of all approved components of Plans of Care.

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Each Area HRC shall specify the manner in which the Facilitator is made aware of plans in need of review and how far in advance of the meeting submission of material is required. This information shall be published on the DDID website with the schedule of meetings.

### *E. SUBMISSION OF PROPOSED RIGHTS RESTRICTIONS TO THE AREA HRC*

Submission of documentation about the rights restrictions to the Area HRC shall come from the:

- Case Manager;
- Behavior Intervention Committee; or
- Participants or guardians.

The participant's Case Manager shall be available to the area HRC, either in person or by videoconference or telephonic conference, to present the information and answer questions. To assist in the presentation of information, the Committee may also request the presence of the guardian and any others as appropriate.

### *F. RIGHTS RESTRICTIONS*

To ensure the participant is treated with dignity and respect and to ensure proposed restrictive measures do not unduly violate the participant's rights, the Area HRC shall consider the following as restriction of rights:

1. A level of supervision which excludes private time and privacy for activities of daily living due to issues of safety or restriction of access rather than support.
2. Restricting access to personal property.
3. Restricting participation in activities or community involvement.
4. Restricting visitors.
5. Restricting receiving and sending mail or electronic mail.
6. Restricting receiving and making telephone or cell phone calls or text messages.
7. Restricting incidental money.
8. Altered diets.

### *G. REVIEW OF RIGHTS RESTRICTIONS IN EMERGENCY SITUATIONS (IMMINENT DANGER)*

In an emergency where there is imminent danger or potential harm to the participant or other persons, the direct service provider in consultation with the case manager and guardian, as appropriate, may limit or restrict rights for a maximum of one (1) week. If the participant is under the care of a psychologist, counselor, or psychiatrist, this plan shall be developed with their input and may be implemented for up to two (2) weeks. Any proposed continuation of the restriction must be immediately reviewed and approved by three (3) members of the Area HRC, including the Facilitator, while alternative strategies are being developed.

If it is decided that a rights restriction needs to be continued and addressed in the Person Centered Plan of Care, then the restriction shall be submitted to the Area BIC, as appropriate, and the area HRC at the next regularly scheduled meeting.

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The Area HRC shall submit procedures for initiating an Emergency approval to DDID for posting to the website and provide the information to providers within the Area.

## 4.5 BEHAVIOR INTERVENTION COMMITTEE

An Area Behavior Intervention Committee (BIC) is a group of individuals from agencies and the community in a geographic area established to evaluate the technical adequacy of a proposed behavior intervention for a participant utilizing SCL services. The Area BIC shall be established as a subset of the Human Rights Committee (HRC) and shall meet on a routinely scheduled basis. Each provider, at a minimum, shall actively participate in the BIC process as necessary should a participant's Team determine during the person centered POC process a Functional Assessment and Positive Behavior Support services are needed. Providers are expected to participate and actively contribute to the BIC process outlined below. The DBHDID, and specifically DDID, shall provide technical assistance in the establishment and ongoing operation of the Area BICs.

### A. PURPOSE

The purpose of the Area Behavior Intervention Committee (BIC) is to ensure participants receiving a Functional Assessment or Positive Behavior support services are:

1. Provided services which address environmental factors;
2. Provided services which are based on person centered values, particularly in consideration of what is important for the participant within the context of what is important to the participant;
3. Provided assessments and interventions which utilize evidenced based and best practices for treatment of a behavioral health condition as the primary support services when supplemental behavioral interventions are needed. The use of both behavioral health treatment and positive behavioral supports shall be utilized in a collaborative manner; and
4. Afforded due process and presented all information necessary.

An Area BIC shall be convened to review, approve, and as necessary, make written technical recommendations for each Positive Behavior Support plan including the plan to train and monitor implementation and effectiveness of the plan. The Area BIC shall ensure these components of a participant's Plan of Care meet each DDID requirement for a Functional Assessment and Positive Behavior Support Plan and that they are clinically sound and based on person centered principles. Each participant's Team shall not implement the Positive Behavior Support Plan until it is approved by the BIC, and if rights restrictions are recommended, until approval of the HRC.

Therefore, the primary role of the BIC is to meet and review plans:

- Upon each revision to the Positive Behavior Support Plan; or
- Prior to implementation and referral to the area HRC for review due to Rights Restrictions.

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## B. MEMBERSHIP

The members of the Area Behavior Intervention Committee shall include:

- Behavior Intervention Committee Facilitator (which may be rotated among the Committee members);
- At least one (1) self-advocate;
- At least one (1) representative or family member of a participant;
- One (1) representative of an SCL provider agency, other than a Positive Behavior Support Specialist or Psychologist;
- At least two (2) members from the community at large who have experience with human rights issues or within the field of developmental disabilities;
- At least one (1) professionals with advanced degrees in the medical field, such as a doctor of medicine or osteopathy, nurse, or a pharmacist; and
- At least three (3) professionals who meet requirements and qualifications for positive behavior support specialist; licensed or certified psychologist; licensed social worker; or a certified special education teacher whose certification and background is specific to Learning/Behavior Disorder with experience in behavioral supports and programming.

One of the members shall be designated to complete a detailed summary of the entire meeting and to submit the summary to the designated DDID staff and to the Area Human Rights Committee Facilitator. This member shall send separate summaries of each Plan reviewed to the participant or guardian and the participant's Case Manager.

Each member shall complete an orientation provided by DDID staff and review and sign a Confidentiality Agreement provided by the DDID staff at the time of orientation. All members of the BIC are bound by confidentiality. If a breach of confidentiality is suspected, the BIC Facilitator shall be informed. The Facilitator, in turn, shall notify the participant's Case Manager, who shall follow their agency's HIPPA policy.

## C. FUNCTIONS

The functions of the BIC shall be to:

1. Review and approve at least annually, all Positive Behavior Support Plans, including plans to train and monitor effectiveness to ensure the plans are clinically sound and based upon evidence-based best practices;
2. Review and approve prior to presentation to the Area HRC, each modification or restriction of a participant's rights to include the pairing with learning or training components to assist the participant in eventual reduction or elimination of the restriction;
3. Conduct at least a quarterly review of data and documentation related to utilization of emergency interventions, particularly physical restraints, for each participant and make written technical

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recommendation(s) to the Positive Behavior Support Specialist or psychologist, the participant's Case Manager, and DDID based upon the review; and

4. For a participant with a dual diagnosis, ensure evidence-based and best practices regarding treatment of the behavioral health condition which shall be the primary support service with supplemental behavioral interventions as needed are in place.

### *D. ACCESS TO THE AREA BIC*

Each Area BIC shall establish meeting dates, at least quarterly, which shall be made public through the DDID website. The Area BIC may also distribute the dates to providers within the area they serve. The schedule of the meetings shall be developed with the Area Human Rights Committee (HRC) so that no more than two (2) months are between BIC and HRC meetings to avoid delay and implementation of all approved components of Plans of Care.

### *E. SUBMISSION OF MATERIAL TO THE AREA BIC*

Submission of documentation to the Area BIC should come from the Positive Behavior Support Specialist and the participant's Case Manager.

The following shall be provided to the Area BIC for review:

- Plan of Care;
- Written objectives;
- Functional assessment;
- Life history;
- Most recent medical assessment; and
- Documentation provided by a medical specialist, including psychiatrist.

The BIC may request other information as needed.

The participant's Case Manager and the Positive Behavior Support Specialist shall be available to the Area BIC, either in person or by videoconference or conference call to present the information and answer questions. To assist in the presentation of information, the Committee may also request the presence of the guardian or others as appropriate.

Referrals to the Area BIC or to another Area BIC may be requested by:

- Participants or guardian if they disagree with the determination of the BIC in their area.

Upon review of all the documentation, the Area BIC shall make one or more of the following determinations:

1. Approve the Positive Behavior Support Plan;
2. Approve the Positive Behavior Support Plan and refer to the Area HRC;

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3. Defer the review for one (1) meeting and request additional information; or
4. Disapprove, with justification and written technical recommendation.

If the participant or guardian disagrees with the determination of the Area BIC, they may present additional information to the Committee, either in person or in writing, or they may file a formal complaint with designated DDID staff.

The Area BIC shall submit meeting summaries to designated DDID staff for review and identification of trends.

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## SECTION 5

### COVERED SERVICES

#### 5.0 INTRODUCTION

This section does not include all covered services in SCL. Refer to 907 KAR 12:010 for all SCL services available.

#### 5.1 CASE MANAGEMENT

Case Management involves working with the participant and others that are identified by the participant such as family member(s), friends, and direct support professionals in the development of a Person Centered Plan of Care (POC). Case management is responsible for the assessment, reassessment, appropriate evaluations, intake, referral, and eligibility processes as well as the ongoing monitoring of service delivery. The case manager who works with the participant shall utilize the person centered planning process in the identification and implementation of support strategies, and shall ensure the strategies incorporate the following principles:

- Empowerment;
- Community inclusion;
- Health and safety assurances; and
- Use of formal, natural, and community supports.

The case manager shall work closely with the participant to assure their ongoing expectations are addressed and the participant is satisfied with their lives in the community, the processes and outcomes of services, and availability of resources.

Case management shall be provided in a conflict-free climate and participants shall be given the opportunity to exercise freedom of choice of service providers. To be considered conflict-free, the case manager does not work for an agency which is responsible for the provision of other waiver services for the participant. An exception process is available to those participants who wish to retain a case manager who is employed with an agency providing other services to the participant if one of the following criteria is met:

1. The Request for Case Management Exemption provides evidence there is a lack of qualified case manager within thirty (30) miles of the participant's residence; or
2. There is a relationship with the participant's case manager.

If an exemption is approved, the case management agency shall document and demonstrate that the participant receives the same level of advocacy and exercises free choice of services. If the case management agency fails to demonstrate or provide ongoing assurances that advocacy efforts have paralleled that available

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from a conflict free case manager, the exemption to conflict free status shall be revoked. Exemptions shall be requested annually.

Case management involves face-to-face and related contacts to make arrangements for activities which assure the following:

1. The health, safety, and welfare of the participant is met;
2. The participant has freedom of choice;
3. The desires and needs of the participant are determined;
4. The services desired and needed by the participant are identified and implemented;
5. The participant's housing and employment issues are addressed;
6. The participant's social networks are developed; and
7. The participant's appointments and meetings are scheduled.

The case manager shall facilitate the Person Centered Team (Team) meetings that assist a participant to develop, update, and monitor the participant's person centered POC. Throughout the process, the case manager shall:

- a. Utilize person centered guiding principles;
- b. Ensure the POC is developed and prior authorized within thirty (30) days of the initiation of services;
- c. Include the objectives, interventions, goals and outcomes in the POC that meet the participant's identified needs from all assessments, participant input, and Team members' input;
- d. Include documentation of participants in the development of the POC by the participant, guardians (as applicable), family members, other providers, and other people the participant has identified as important in their life and as members of their Team;
- e. Ensure the person centered planning process includes the following information:
  1. What is important to the participant;
  2. What the person centered plan will help the participant to accomplish;
  3. What people like and admire about the participant;
  4. Identification of the characteristics of people who support the participant should be identified;
  5. What people need to know or do to help the participant stay healthy and safe;
  6. Instructions for those who support the participant;
  7. Identification of barriers that block the participant's progress toward their goals;
  8. The action steps that are required to ensure a participant's goals are reached;
  9. Identification of who is responsible for each action step; and
  10. When the action will or is anticipated to be accomplished.

The case manager role is essential to the person centered process and the coordination and monitoring of the services provided to the participant. The case manager shall assist a participant to gain access to and

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maintain employment; membership in community clubs, groups, activities, and opportunities at the times and frequencies the participant chooses; assist a participant in the planning of resource use; assure the protection of resources to include clearly outlining the participant's insurance options and availability; and exploring of potential availability of other resources and social service programs for which the participant may qualify. The case manager is responsible for the coordination and monitoring of all waiver and non-waiver services which shall include:

- a. Monthly (or more frequently as required) face-to-face contacts with the participant to determine if their needs are being met at locations where the participant is engaged in services, both formal and natural. **(NOTE: Person Centered Team meetings shall not constitute the required monthly face-to-face visit with the participant);**
- b. Responsibility to initiate a Team meeting to ensure that different or additional supports are identified in the POC and the services are prior authorized within fourteen (14) days of the face-to-face contact, if changes are required in order to meet the participant's needs;
- c. Assistance with Participant Directed Services as specified in 907 KAR 12:010 and in this Policy Manual;
- d. Utilizing the current quality assurance monitoring tools located on the DDID website to identify that person centered practices are demonstrated by the service provider and that the participant's health, safety, and welfare is not at risk and for collection of information about the participant's satisfaction with their services to inform the case management summary note;
- e. Use of information gathered to guide the person centered planning process; and
- f. Monitoring Incident Reports and medication error reports.

The case manager maintains the authority to require immediate remediation of identified deficiencies that impact the health, safety, and welfare of a participant without formally calling a Team meeting until the case manager is sufficiently assured the participant is not endangered. The case manager's actions are only made on behalf of the participant. The case manager does not determine the certification status of the provider.

The case manager shall use the MAP-24C form found in this manual to notify DBHDID, DMS and DCBS of the status change of the participant. During the time of transition, the case manager shall monitor the services to ensure these continue if a participant has been terminated from services until an alternate provider, if needed, has been chosen by the participant and the services have been approved (prior authorized).

The case manager shall be responsible for the following documentation standards of services and to be knowledgeable of other documentation standards throughout the SCL Program for which they may be responsible:

1. A monthly Person Centered Quality Assurance Monitoring tool;
2. A detailed monthly summary note which shall include:
  - a. The month and year for the time period the note covers;

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- b. Analysis of progress toward the participant's outcome(s);
- c. Identification of barriers to achievement of outcomes;
- d. Projected plan to achieve the next step in achievement of outcomes;
- e. The signature and title of the case manager completing the note;
- f. The date the note was written; and
- g. The signature, title, and date of the case manager supervisor reviewing the summary; and

3. Other quality indicator tools as identified by DBHDID.

### A. *FUNCTIONS OF A CASE MANAGEMENT SUPERVISOR*

The Case Management Supervisor shall be responsible for the provision of the following:

1. Training to case managers regarding the documentation flow necessary to ensure payment for services for participants.
2. Assurance of the competency of case managers within their own agency or those for whom they provide supervision.
3. Support for case managers to increase their personal competencies in the area of person centered processes.
4. Monitoring of the Quality Assurance Monitoring Tool which shall include determining the accuracy of the rating given by the case manager, whether appropriate follow-up was addressed in a timely manner, and ensuring that the intentions and functions of the Quality Assurance Monitoring Tool are maintained within a person centered system of supports;
5. Ongoing supervision and evaluation of case managers, to include continued monitoring efforts, which shall be outlined in a Quality Assurance Plan; and
6. Monitoring Case Management service provision through the use of quality indicator tools as identified by DBHDID.

Case manager supervisors may also fulfill the following responsibilities as deemed necessary by the agency's Executive Director or Program Director:

1. Assess participants in order to determine which services are appropriate and available to the participant.
2. Match referred participants with potential case managers.

## 5.2 COMMUNITY GUIDE

Community Guide (CG) services are designed to empower participants to define and direct their own services. These services are only available to those participants who choose to Participant Direct services for either some (blended) or all of their support services. The participant will determine the amount of CG services, if any, and the specific services the Community Guide will provide.

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The CG services shall not duplicate Case Management services and the CG shall not be an employee of the Case Management agency or of any agency that provides other direct waiver services to the participant without seeking prior written approval from the DBHDID. The CG shall not provide direct waiver services to any waiver participant.

A copy of the monthly summary shall be forwarded to the participant's Case manager only when recommendations or identification of additional support needs are noted that impact the participant's current POC.

## 5.3 COMMUNITY TRANSITION

Community Transition services are defined as non-recurring set-up expenses for participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the participant is directly responsible for their living expenses.

Community Transition services are furnished only to the extent they are reasonable and necessary as determined by the participant's Team through the Person Centered Plan of Care process. The services shall be clearly identified in the participant's POC and it shall be clearly documented the services cannot be obtained from other sources.

When services are furnished to participants returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the participant leaves the institutional setting and enters the waiver program. The participant shall be reasonably expected to be eligible for and to enroll in the waiver program. If for any unforeseen reason the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to DMS as an administrative cost.

## 5.4 CONSULTATIVE CLINICAL AND THERAPEUTIC SERVICES

Consultative Clinical and Therapeutic services provides expertise, training, and technical assistance to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions specified in the participant's Person Centered Plan of Care (POC). Through this service, a professional shall complete an assessment of the participant, the environment and the system of supports, and present a written summary of findings and recommendations for the participant and their Team. The professional shall actively work with the participant and their Team to develop, provide, and revise therapeutic interventions that are:

- Consistent with the assessment results and diagnosis;

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- Evidenced based or current best practice;
- Facilitate improvement, maintenance, or prevention in the decline of the participant's skills.

The service may include:

- Consultation;
- Assessment;
- Development of a home treatment/support plan;
- Training and technical assistance to carry out the plan;
- Monitoring of the participant and the provider in the implementation of the plan; and
- Psychological treatment as indicated by the condition of the participant.

Consultative Clinical and Therapeutic services shall include, as necessary, the coordination of program wide support addressing assessed needs, conditions or symptoms affecting a participant's ability to fully participate in their community. The provision of training and technical assistance to implement recommendations and plans which shall occur within the settings in which the recommendations, home treatment or support plans are to be carried out.

The qualified professional shall monitor the following:

1. Fidelity of data reporting and plan implementation;
2. Effectiveness of the plan(s); and
3. Impact on the participant, their environment, and system of supports.

All monitoring activities shall be conducted in the settings where the plan is implemented and through discussions and observations of individuals responsible for implementing the plan and reporting data.

### *A. Functional Assessment*

A functional assessment as defined in 907 KAR 12:010 may be conducted by a licensed or certified psychologist or a positive behavior support specialist who meets the qualifications and personnel requirements specified in 907 KAR 12:010. The functional assessment shall include the following:

1. A specific target behavior of concern that is defined in clear, observable and measurable terms, such as what the participant says or does that people find problematic;
2. Baseline estimate of behavior in terms of objective measures to include rate, frequency, duration, and intensity;
3. Review of pertinent records including incident reports;
4. Interviews with the participant and people who often interact with the participant within different settings and activities;
5. Observation of the participant in a minimum of two (2) different settings;

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6. Use of relevant assessment tools to produce objective information regarding events preceding and following the behavior of concern, as well as communicative intent of the behavior and ecological and motivational variables that may be affecting the participant's behavior;
7. Identification of patterns obtained from the data collected that include:
  - a. Circumstances in which the behavior is most and least likely to occur; and
  - b. Specific functions that behavior appears to serve for the participant;
8. Identification of broader variables that may be affecting the participant's behavior, such as activity patterns and sleeping patterns;
9. A written summary of patterns and/or hypotheses that are clear and based on data collected; and
10. Recommendations for the participant and the Team, such as:
  - a. Environmental adaptations;
  - b. Involvement in meaningful and fulfilling activities;
  - c. Practice of coping skills; and
  - d. Therapeutic and/or behavioral supports.

### 5.5 GOODS AND SERVICES

Goods and Services are defined as services, equipment, or supplies that are individualized to the participant who chooses to Participant Direct their services. This support may be utilized to reduce the need for personal care or to enhance independence within the home or community of the participant.

For purposes of the SCL Waiver Program, Goods and Services shall not be otherwise provided through the Kentucky Medicaid State Plan.

The specific Goods and Services provided shall be clearly linked to a participant need that has been identified through a specialized assessment, established and included in the Individualized Budget, and documented in the participant's POC. All Participant-Directed Goods and Services purchased from the Participant Directed Budget shall be prior authorized. Goods and Services purchased under this coverage may not circumvent other restrictions on waiver services, including the prohibition against claiming for the costs of room and board. Experimental or prohibited treatments are excluded.

The participant shall submit a request to the Case Manager for the Goods or Services to be procured. The request shall contain the following information:

1. Supplier/Vendor name;
2. Identifying information; and
3. Cost of the Goods and Services.

The supplier/vendor shall have the applicable Kentucky business license as required by the local, city or county government in which the suppliers are provided.

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## 5.6 PERSON CENTERED COACHING

Person Centered Coaching is an individualized service of monitoring, training, and assessing effectiveness of person centered planning. These services provide for modeling, monitoring, assessing, and implementing the person centered Plan of Care (POC). The services are delivered by a Person Centered Coach who assist the participant and the participant's Team in the implementation assessment of the effectiveness of the POC. The Person Centered Coach models person centered thinking and is responsible for training the participant, family, guardian, natural, and paid supports as well as other Team members who are recognized as an integral part of the person centered planning process when barriers challenge the success of the participant in achieving their POC goals.

If the Person Centered Coach develops staff training, the training shall be developed in conjunction with appropriately qualified personnel. For example, if a participant encounters a challenge or barrier related to a sensory integration issue, the Occupational Therapists who evaluates or treats the participant should be actively involved in the development of the training. If the participant's targeted behavior is related to a mental illness, then an appropriately qualified mental health professional knowledgeable of the participant's manifestation of the mental illness should be actively involved in the development of the training.

The Person Centered Coach operates independently of a Residential or Day Training provider. The Person Centered Coaching service may include the development of a structured coping plan, wellness plan, or recovery plan. Dependent on the assessed needs of the participant, the Person Centered Coach may complete assigned duties related to the completion of a functional assessment of behavior which would be utilized to make modifications to the environment, person centered POC and all designated components thereof.

The Person Centered Coach shall work under the direction of the Positive Behavior Support Specialist or other licensed professional in the settings where the POC is implemented.

A Person Centered Coach shall not be considered as part of a staff ratio, plan, or pattern as the coaching duties are separate from those of a Direct Support Professional.

The Person Centered Coaching service is not intended to be an indefinite part of the participant's support system but may come in and out of their circle of supports as needed, i.e., utilized when there is a significant change in status or change in the person centered POC. The POC, which includes Person Centered Coaching services, shall be outcome based and a plan for gradual withdrawal of services shall be established.

Monitoring and the assessment of Person Centered Coaching services and person centered planning shall be conducted and demonstrated by the support system's implementation of the participant's POC or designated components of the POC across the array of service settings. The Team shall utilize the data collected through required reporting documentation to make modifications to the environment, POC, or

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services as necessitated. The Person Centered Coaching services shall not duplicate case management or any other service utilized by the participant. This service shall not supplant educational services available to the participant under the Individuals with Disabilities Education Act (IDEA) found in 20 U.S.C. 1401 et. seq.).

A copy of the monthly summary shall be forwarded to the participant's Case Manager only when recommendations or identification of additional support needs are noted that impact the participant's current POC.

## 5.7 POSITIVE BEHAVIOR SUPPORTS

Positive Behavior Supports (PBS) are services designed to assist the participant with significant, intensive challenges that interfere with activities of daily living, social interaction, work or volunteer situations. These supports utilize evidence based and best practices in behavioral techniques, interventions, and methods to assist the participant to reach their goals and dreams outlined in their person centered Plan of Care (POC). These services utilize data collected during the functional assessment of behavior that is the basis for the development of a person centered positive behavior support plan. The plan shall be developed for the acquisition or maintenance of skills for community living and behavioral interventions for the reduction of maladaptive behaviors. The positive behavior support plan is intended to be implemented across settings and by individuals (both paid and natural supports) assisting the participant in meeting their dreams and goals.

Intervention modalities described in the PBS plan shall relate to the identified behavioral needs of the participant and shall be related to broad goals of interventions, such as greater participation in activities and enhanced coping or social skills. Specific criteria for remediation of the behavior shall be established and specified in the plan. Therefore, the PBS plan shall include the following components:

1. A description of the behavior, patterns identified through the functional assessment, and goals of intervention;
2. Modifications to the social or physical environment that may prevent the behavior and/or increase the likelihood of alternative adaptive behaviors;
3. Identify specific skills to be taught and/or reinforced that shall:
  - a. Achieve the same function as the behavior of concern; and
  - b. Allow the participant to cope more effectively with their circumstances; and
  - c. Be documented when they occur;
4. Identify strategies for managing consequences to maximize reinforcement of adaptive or positive behavior and minimize that for target behavior;
5. Delineate goals of intervention and specific replacement behaviors/skills that are incorporated into the participant's total plan of care;
6. If necessary to ensure safety and rapid de-escalation of a targeted behavior, outline de-escalation techniques and scaled response with criteria for use and documentation requirements;
7. Specific criteria for how data including rate, frequency, duration, and intensity will be recorded;

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8. Specific criteria for re-evaluation when data does not demonstrate progress; and
9. Specific criteria for fading or discontinuation as adaptive, positive behaviors improve.

For a participant with a dual diagnosis, the plan shall utilize evidenced-based best practices regarding treatment of the behavioral health condition. In this instance, the behavioral health condition shall be considered the primary support service, with behavioral interventions as supplemental services as needed. The plan shall utilize both behavioral health and positive behavior supports in a collaborative manner.

Positive Behavior Supports shall be provided by professionals who meet the qualifications for PBS Specialist as defined in 907 KAR 12:010. For those individuals who are paid or natural supports assisting the participant, it is essential that they are familiar with and appropriately trained on the proper implementation of the interventions.

The PBS Plan shall be revised whenever necessary by the participant's Team based upon the participant's needs or recommendations from the Behavior Intervention Committee and/or the Human Rights Committee. Revisions to the PBS Plan may be covered through the service Consultative Clinical and Therapeutic Services when recommended by the Team and approved by the prior authorization authority.

Documentation of the provision of PBS shall be the approved PBS Plan which shall be incorporated in the participant's overall person centered Plan of Care.

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## 5.8 RESIDENTIAL SUPPORT SERVICES

### A. INTRODUCTION

Residential Support Services are authorized for a participant based upon information from the participant's Supports intensity Scale (SIS), Health Risk Screening Tool (HRST), and the approved person centered Plan of Care (POC). Residential Support services are broken down into the following categories:

1. Level I Residential Supports;
2. Technology Assisted Level I Residential Supports; and
3. Level II Residential Supports.

### B. LEVEL I RESIDENTIAL SUPPORTS

Level I Residential Supports are targeted for participants who require a 24-hour intense level of support. Services are individually tailored to assist with the acquisition, retention, or improvement in skills related to living in the community. Supports available throughout Level I shall assist the participant to reside in the most integrated setting appropriate to their needs, and may include:

- Adaptive skill development;
- Assistance with activities of daily living which include:
  - Bathing,
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence;
- Community inclusion
- Adult educational supports; and
- Social and leisure development.

Level I Residential Supports also include protective oversight and supervision, transportation personal assistance, and the provision of medical and health care services that are integral to meeting the daily needs of the participants.

Residential support may include the provision of up to five (5) unsupervised hours per day per participant as identified in each participant's person centered Plan of Care (POC) in an effort to promote increased independence. The amount of unsupervised time, if any, shall be based on the individual needs of each participant as determined by the participants person centered Team and reflected in the POC. The supports required for each participant in a Level I Residential setting shall be outlined in the participant's POC.

For each participant approved for unsupervised time, a safety plan shall be included in the POC based upon the participant's assessed needs. The Case Manager, as well as other Team members, shall ensure the participant is able to implement the safety plan. Ongoing monitoring of the safety plan, procedures, or

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assistive devices required by the participant shall be conducted by the Case Manager to ensure relevance, ability to implement, and functionality of devices if required.

If a participant experiences a change in support needs or status, the Team shall meet to make the necessary adjustments in the participant's POC and the appropriate adjustments in Residential Services shall be made to meet the support needs. If the changes are anticipated to be chronic, which means they are anticipated to last longer than three (3) months, the resident provider may request a reassessment to determine if the residential needs have changed.

Level I Residential Supports are furnished in a provider owned or leased residence which shall be in compliance with the Americans with Disabilities Act (ADA) based upon the needs of the participants supported.

Reimbursement of services are not made for the following costs:

- Room and board;
- Building maintenance; and
- Building upkeep and improvements.

Level I Residential Supports shall be documented by a:

1. Daily note which shall include:
  - a. Information about how a participant spent the day including any effort toward meeting any outcome identified in the participant's POC;
  - b. The date of the service;
  - c. The location of the service;
  - d. The signature and title of the individual providing the service; and
  - e. The date the entry was made in the record;
2. Detailed monthly summary note which shall include:
  - a. The month and year for the time period covered by the note;
  - b. An analysis of progress toward a participant's outcome or outcomes;
  - c. A projected plan to achieve the next step in achievement of an outcome or outcomes;
  - d. Pertinent information regarding a participant's life;
  - e. The signature and title of the individual writing the note;
  - f. The date the note was written;
  - g. The signature, title, and date of documentation review by the direct support professional supervisor providing supervision to the direct support professional.

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### C. *TECHNOLOGY ASSISTED LEVEL I RESIDENTIAL SERVICES*

Technology Assisted Level I Residential Services, hereafter referred to as Technology Assisted Residential Services, are designed for participants who require up to 24-hour support but who are able to increase their level of independence with a reduced need for onsite staff. Technology is used by the provider agency to assist the participant in residing in the most integrated setting appropriate to the participant's needs. The levels and types of services required are determined by the participant's Team and outlined in the participant's POC.

Technology Assisted Residential Services shall include, to the extent required, protective oversight and supervision, transportation, personal assistance, and the provision of or arrangement for medical and health care services that are integral to meeting the participant's daily needs. The intent and primary purpose of Technology Assisted Residential Services is to increase the participant's independence without undue risk to the participant's health and safety. The Team shall give careful consideration of the participant's medical, behavioral, and psychiatric condition(s).

The use of technology to reduce the need for residential staff support in the home may be utilized if there is an individualized person centered POC which has been developed to promote increased independence based on the participant's needs as indicated in the scores and results of the SIS, HRST, and as recommended by the person centered team. Technology Assisted Residential Services is a real-time monitoring system with a two-way method of communication linking the participant(s) to a centralized monitoring station. Technology devices may include the use of the following:

- Electronic sensors;
- Speakers and microphones;
- Video cameras (which shall not be located in bedrooms and bathrooms);
- Smoke detectors; and
- Personal emergency response systems.

These devices shall link each participant's home to remote staff employed to provide electronic support. The residential provider shall have a plan established to ensure staff is available 24 hours a day, seven (7) days a week.

If a participant experiences a change in support needs or status, the residential provider shall immediately adjust supervision (up to and including on-site to the resident) to meet acute needs. The provider shall reassess the appropriateness of these services and adjustments shall be made to meet chronic support needs. All adjustments shall be made in collaboration with the participant's Case Manager and person centered Team if anticipated to be implemented longer than what was determined by the Team when developing the POC.

Technology Assisted Residential services shall be furnished in a participant's residence to three (3) or less participants who reside in the residential setting with 24-hour staff support. A participant's residence where

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residential services are furnished shall be compliant with the Americans with Disabilities Act (ADA) based upon the needs of the participants supported in the residence.

The agency providing residential services is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations. Furthermore, payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement.

The provider agency shall employ staff for Technology Assisted Residential Services who meet the qualifications of Direct Support Professionals and Direct Support Professional Supervisors as defined in 907 KAR 12:010. Individuals employed in these positions shall also demonstrate proficiency in their ability to operate all monitoring devices utilized in this service area and shall demonstrate the ability to respond as appropriate to the needs of participants in a timely manner.

Technology Assisted Level I Residential Services shall be documented by a:

1. Daily note which shall include:
  - a. Information about how a participant spent the day including any effort toward meeting any outcome identified in the participant's POC;
  - b. The date of the service;
  - c. The location of the service;
  - d. The signature and title of the individual providing the service; and
  - e. The date the entry was made in the record;
2. Detailed monthly summary note which shall include:
  - a. The month and year for the time period covered by the note;
  - b. An analysis of progress toward a participant's outcome or outcomes;
  - c. A projected plan to achieve the next step in achievement of an outcome or outcomes;
  - d. Pertinent information regarding a participant's life;
  - e. The signature and title of the individual writing the note;
  - f. The date the note was written;
  - g. The signature, title, and date of documentation review by the direct support professional supervisor providing supervision to the direct support professional.

A copy of the monthly summary shall be forwarded to the participant's Case Manager only when recommendations or identification of additional support needs are noted that impact the participant's current POC.

### *D. LEVEL II RESIDENTIAL SERVICES*

Level II Residential Services are targeted for participants who require up to 24-hour levels of support and are individually tailored supports that assist the participant with the acquisition, retention, or improvement in skills related to living in the community. The services provided are designed and implemented to assist the participant to reside in the most integrated setting appropriate to his or her needs.

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Level II Residential services provide support for a participant up to 24-hours a day. If a participant experiences a change in support needs or status, adjustments in residential services shall be made to meet the service needs.

Level II Residential Services shall be documented by a:

1. Daily note which shall include:
  - a. Information about how a participant spent the day including any effort toward meeting any outcome identified in the participant's POC;
  - b. The date of the service;
  - c. The location of the service;
  - d. The signature and title of the individual providing the service; and
  - e. The date the entry was made in the record;
2. Detailed monthly summary note which shall include:
  - a. The month and year for the time period covered by the note;
  - b. An analysis of progress toward a participant's outcome or outcomes;
  - c. A projected plan to achieve the next step in achievement of an outcome or outcomes;
  - d. Pertinent information regarding a participant's life;
  - e. The signature and title of the individual writing the note;
  - f. The date the note was written;
  - g. The signature, title, and date of documentation review by the direct support professional supervisor providing supervision to the direct support professional.

A copy of the monthly summary shall be forwarded to the participant's Case Manager only when recommendations or identification of additional support needs are noted that impact the participant's current POC.

### 5.9 SHARED LIVING

Shared Living services are designed to serve as an alternative to residential services by allowing the participant to live in their own home, apartment, or condominium with a roommate or live-in caregiver who agrees to provide some of the participant's services. The roommate or live-in caregiver shall not be related to the participant to any degree.

Shared Living is a Participant Directed service whereby the caregiver agrees to provide some of the participant's supports in exchange for the caregiver's share of room and board. The caregiver shall not receive any other financial reimbursement for the provision of this service and shall enter into a contractual agreement with the participant which outlines the supports to be provided in accordance with the participant's person centered Plan of Care (POC). The caregiver shall agree to complete all training requirements as specified in 907 KAR 12:010 related to PDS providers of supports and as stipulated by the participant. Furthermore, the caregiver shall agree to meet all personnel requirements as set forth in 907 KAR 12:010 pertaining to providers of PDS and must meet the qualifications to serve as a Direct Support

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Professional. The participant's Team shall determine and assure the proposed caregiver has the experience, skills, training, and knowledge appropriate to the participant and the type(s) of supports needed.

A participant who receives Shared Living services may also receive other approved waiver services as long as the services do not overlap in type of service or in delivery of service.

In a Shared Living arrangement, the caregiver may provide overnight supervision and necessary personal assistance to the participant. During waking hours, the caregiver may provide assistance according to the needs of the participant and as outlined in the participant's POC. The caregiver's living expenses are the portion of the room and board that may be reasonably attributed to a live-in caregiver who also provides unpaid assistance with the acquisition, retention, or improvement in skills related to activities of daily living. These skills may include, but are not limited to:

- Personal grooming;
- Household chores;
- Learning the preparing of food;
- Supervision required for safety; and
- Social and adaptive skills necessary to enable the participant to reside safely and comfortably in their own residence.

The supports must be provided to a participant living in his or her personal residence, and the caregiver shall reside in the same residence. The services shall complement other services the participant receives and enhances increased independence for the participant. The services must address the needs identified in the person centered planning process and shall be outlined in the participant's POC. The caregiver shall not receive payment for Shared Living services if the participant lives in the caregiver's home or in a residence that is owned or leased by an SCL provider or sub-contractor.

If two (2) or more participants choose to live together in a home, they may share a caregiver. If the caregiver provides support to two (2) or more participants, the POC for each participant shall be taken into consideration in determining the total amount of room and board.

Under Medicaid § 1634 and SSI criteria rules, in order for the payment not to be considered income to the participant, payment for the portion of the costs of room and board attributable to the unrelated caregiver must be routed through the Financial Management Agency, specifically for the reimbursement of the participant.

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## 5.10 SUPPORTED EMPLOYMENT

All Supported Employment (SE) services shall first be provided through the Office of Vocational Rehabilitation (OVR) unless the participant is no longer has access to Vocational Rehabilitation services. In the event the participant has used their OVR services, all defined SE services may be obtained using SCL waiver funding.

Regular, ongoing transportation provided for a participant to travel to and from a work site is not billable as a SE activity. With the exception of scenarios depicted in “Examples of Billable Activities for Supported Employment Services” located in this manual, transportation is included in the cost of doing business and incorporated in the provider’s administrative overhead.

Providers who are OVR vendors but have not provided a supported employment service in over one year are required to attend the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky.

Supported Employment shall be services that enable a participant to engage in paid work which occurs in an integrated community setting with competitive wages and benefits commensurate to the job responsibilities and consists of:

1. ***Person Centered Job Selection (Discovery)*** which provides:
  - a. A respectful way to get to know people who are seeking jobs: a way to break past preconceived notions about what a participant can and cannot do; and a way to discover new and positive job possibilities with the participant learned through personal conversations with those who know the participant well, time with the participant (first in familiar activities where the participant is doing things they enjoy do well, and later in new activities), and a review of records.
  - b. A thoughtful framework for planning job development and job negotiation – a means by for service providers to “get ready” for job development and to consider the nature of an ideal job for the participant using customized employment methods and including self-employment as an option to be considered.
  - c. A framework for the development of a Person Centered Employment Plan (PCEP) which is based upon the participant’s:
    - i. Life experiences;
    - ii. Interests;
    - iii. Talents;
    - iv. Contributions;
    - v. Impact of disability;
    - vi. Vulnerabilities; and
    - vii. Support needs.

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- d. Information for the development of a PCEP completed by the SE Specialist, and updated as needed, provides the foundation for seeking appropriate employment, and includes job planning meetings which involve:
  - i. Meeting and networking with trusted people;
  - ii. Matching job characteristics with job tasks and then with types of employers and finally with specific employers.
- e. For SCL Person Centered Job Selection funding, the participant may access up to 120 units.
- f. Prior to the initiation of Job Development services, the participant and their person centered Team shall review the content of the PCEP and ensure the plan:
  - i. Represents an accurate description of the participant's interests, goals, and objectives;
  - ii. Is based upon the development of a career rather than short-term employment; and
  - iii. Is incorporated into the participant's Plan of Care (POC).

### 2. ***Job Development and Analysis*** is conducted to:

- a. Determine skills the participant will need to successfully contribute in a specific workplace which focuses upon:
  - i. The culture of the business;
  - ii. Possibilities for customized employment;
  - iii. How employees typically learn their jobs;
  - iv. Who teaches them; and
  - v. How long training typically takes.
- b. Determine the roles of the participant and the employment specialist.
- c. Decide how to talk about the impact of the participant's disability in relation to the contributions they have to offer the employer.
- d. Facilitate the development of natural supports based on ordinary social relationships at work and in the community which allow the participant to work in ways similar to non-disabled employees by:
  - i. Using co-workers as job trainers for the supported employee;
  - ii. Promoting mentoring relationships between the supported employee and others in the environment; and
  - iii. Using the environmental cues (lighting, workstation accommodation, audiovisual aids) as a means to sustain the supported employee's job performance.
- e. The assessment of potential employers for customized employment possibilities by determining how the opportunities available are related to the PCEP for a specific participant.
- f. Prior to the initiation of Job Development services, the participant and their person centered Team shall review the content of the PCEP and ensure the plan:

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- i. Represents an accurate description of the participant's interests, goals, and objectives;
  - ii. Is based upon the development of a career rather than short-term employment; and
  - iii. Is incorporated into the participant's Plan of Care (POC).
- g. For SCL Job Development Services, the participant and their employment specialist may access up to 90 units.

### 3. **Job Acquisition with Support.**

Job Acquisition with Support is the actual acceptance of a position by the participant; along with Stabilization Services which includes services needed to maintain a participant in an integrated, competitive employment site.

- a. During this phase, the participant will receive training on how to perform the job tasks. Training could include, but is not limited to the following:
  - i. Social interaction;
  - ii. Chain of command;
  - iii. Conflict resolution;
  - iv. When and from whom it is appropriate to seek assistance;
  - v. Documentation of time (timesheets, clocks);
  - vi. Personnel policies;
  - vii. Personal presentation (clothing, hygiene, medication scheduling); and
  - viii. Mobility and transportation.
- b. Ongoing support includes services needed to maintain the supported employee in an integrated, competitive employment site. The expectation is for systemic fading of the SE Specialist to begin as soon as possible without jeopardizing the job. Before a success can be determined there shall be confirmation that the employee is functioning well at the job. Consideration should include:
  - i. The participant's general satisfaction;
  - ii. The performance of job duties and other basics;
  - iii. Their comfort level on the job;
  - iv. Interaction with coworkers and supervisors;
  - v. The number of hours worked; and
  - vi. Other less visual, but essential aspects of the job, which if unattended could jeopardize the participant's future;
- c. For SCL Job Acquisition and Stabilization Services, the participant and their SE Specialist may access up to 800 units
- d. Prior to the initiation of Long-Term Support and Follow-up Services, the participant and their person centered Team shall review the Supported Employment Long-Term Support Plan and ensure:
  - i. The job is consistent with the participant's PCEP.

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- ii. The participant has been successfully employed in the job at least sixty (60) calendar days;
- iii. The participant is functioning well in the job in terms of general satisfaction, number of hours worked, performance of job duties, and other basics;
- iv. The participant is comfortable in the job, in interacting with coworkers and supervisors; continues to perform job duties through the use of natural supports; and
- v. The Long-Term Support Plan has been completed and integrated into the participant's POC.

#### 4. *Long-Term Support and Follow-up.*

Long-Term Support and Follow-up is provided to maintain the job and continued success after the participant is fully integrated into the workplace and the SE Specialist is no longer needed on a regular basis.

- a. The SE Specialist shall continue to be available, if and when needed, for support or assistance with job changes/job advancements. Activities could include, but are not limited to the following:
  - i. Problem-solving;
  - ii. Retraining;
  - iii. Regular contact with employer, employee, family, co-workers, or other SCL staff; and
  - iv. Reassessment of an employee with regard to career changes or position upgrades.
- b. For SCL Long-Term Employment Supports, the participant and their SE Specialist may access up to twenty-four (24) units of SE per month. Any increase in units must be justified in the long term employment support plan and approved by the participant and their team.
- c. In order to maintain the delivery of high quality services, the person centered Team shall ensure that:
  - i. The participant indicates satisfaction with their job;
  - ii. The employer indicates satisfaction with their employee;
  - iii. The participant successfully maintains appropriate social communications, job skills, and productivity expectations;
  - iv. The use of natural supports has been effectively integrated into the workplace.

## SECTION 6

### PARTICIPANT DIRECTED SERVICES

#### 6.0 INTRODUCTION

The Participant Directed Services (PDS) option is based upon the principles of Self-Determination and Person Centered Thinking. As noted previously, a person-centered system acknowledges the role of families, guardians, or representative in planning for the participant who may need assistance in making informed decisions. The principles and tools of Self-Determination are used to assist participants in the creation of meaningful, culturally appropriate lives embedded in their community in which they can develop relationships, learn, work and earn income, and actively participate in community life. These principles include:

- Freedom;
- Responsibility;
- Authority;
- Support; and
- Confirmation.

Participants have the following resources and tools available to ensure their person centered supports follow those principles. The basis for all supports is results of the HRST and SIS as well as the Person-Centered Plan of Care (POC):

- Community Guide;
- Financial Management Services;
- Individualized Budgets

The Supports for Community Living (SCL) waiver program promotes personal choice and control over the delivery of waiver services by building in opportunities for participant direction. SCL participants have the opportunity to direct some or all of their non-residential, non-medical waiver services. Traditional service delivery methods are available for participants who decide not to direct their services. Case managers shall provide assistance and information or informed decision-making by participants and their families or guardians regarding the election of participant direction. The information shall include training on the roles, risks, and responsibilities assumed by those who choose participant directed services. The following entities shall provide supports to participants who choose to direct their own services:

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- Case management agencies that shall be independent of service delivery. Case managers shall assist with the development of the person centered team (Team), person centered Plan of Care (POC) development, and identification and availability of resources.
- The Community Guide, if chosen, shall provide direct assistance to the participant in brokering community resources and directing their services. This may include assistance with inclusion, recruiting employees, and being a part of the team on POC development and implementation.
- The Financial Management [~~Services~~] agency shall manage the budget, ensure Kentucky wage and hour laws are met (including Worker's Compensation), ensure that all Internal Revenue Service (IRS) withholding requirements are met, and shall submit claims to the Kentucky DMS fiscal agent, receive, disburse, and track funds for services authorized in the POC.
- Participants may choose SCL provider agencies who will train and support qualified staff for services of the participant's choosing.
- Participants can hire their own employees that meet qualifications and sign contractual agreements regarding the services to be provided. If needed, the case manager or community guide shall assist the participant in recruiting alternate or additional providers.

### 6.1 CASE MANAGER RESPONSIBILITIES

Participant Directed Services (PDS) is facilitated when information and assistance are available to support participants in managing their services. The case manager is responsible for educating participants regarding PDS. Case managers meet with participants to:

- Detail the PDS options at the time of initial POC and at least annually thereafter or at any point of participant or guardian inquiry;
- Provide and explain the participant's responsibilities related to participant directed opportunities;
- Provide guidance regarding Community Guide services which will assist with employee recruitment and hiring procedures;
- Coordinate and facilitate the Team to develop the new POC and establish the participant's budget allowance; and
- Assist the participant with any other questions they may have regarding participant direction.

Case managers shall conduct a monthly face-to-face contact with the participant and the participant's guardian (if applicable) to ensure the participant's needs are being met in an appropriate manner and monitor health, safety, and welfare. The case manager shall monitor the service delivery in the settings in which the participant receives services and shall verify with the participant and the participant's representative that services are being delivered in a manner that is satisfactory to the participant.

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The case manager shall record the information from the face-to-face visits on the quality assurance monitoring tool and monthly summary note.

## 6.2 PARTICIPANT RESPONSIBILITIES

The participant and their representative, assisted by the Case Manager, decide which services are to be participant-directed. The participant shall be the employer of record and may have decision-making authority over the support workers who provide the utilized supports.

The participant and their representative shall also work with the case manager, the Team, and the Financial Management agency with regard to the establishment, management, and review of the Individualized Budget.

For purposes of this service, a representative is defined as an individual designated by the participant to assist the participant in decision-making, planning, and implementation of the POC and budget and who is not eligible to provide a paid service, have a vested interest in an agency or SCL provider, or work for a provider who will be delivering supports or services.

The case manager may assist the participant in the selection of a qualified representative who will serve the participant's best interests. Whenever an adult waiver participant chooses a representative, the case manager assures at least annually whether the continued direction of waiver services by the representative is in the best interests of the participant utilizing waiver services.

The following criteria may be used by the Case Manager to assist in the determination if the participant may benefit from Participant Directed Services:

1. SCL Participant Directed Services may only be utilized by a participant who is not inpatients of a hospital, Skilled Nursing Facility, ICF/IID facility, and who:
  - a. Is able to communicate effectively with the case manager and, if applicable, any provider of SCL services eligible for PDS, or has a representative with the demonstrated ability to assist with this responsibility; and
  - b. Is able to understand and perform, if applicable, the tasks required to employ qualified providers of services (including recruitment, hiring, scheduling, training, supervision, and termination) or has a representative with the demonstrated ability to assist with this responsibility; and
  - c. Is able to complete and submit all required timesheets/invoices and assist with the monitoring and management of the individualized budget for PDS services or has a representative with the demonstrated ability to assist with this responsibility.
2. Prior to enrollment in Participant Directed Services, the case manager shall confirm the ability of the participant to utilize these services. A participant's ability to participant direct services may be

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reassessed at any time, as determined by the case manager, in response to objective evidence indicating changes in capacity or supports.

3. Participant serves as employer of record and shall coordinate with the representative (if applicable), case manager and community guide (if Community Guide service utilized by the participant) for the following Participant-Employer Authority Responsibilities:
  - a. Recruit employees in accordance with specific service requirements as specified in the Supports for Community Living regulations and policy manual;
  - b. Hire employees;
  - c. Verify employees qualifications;
  - d. Obtain all required background checks and drug testing requirements with the assistance of the Financial Management Services agency;
  - e. Determine employees duties consistent with service specifications;
  - f. In collaboration with the Financial Management Services agency, determine employees' wages and benefits subject to applicable State limits;
  - g. Determine employees duties consistent with service specifications in the POC;
  - h. Schedule employees;
  - i. Orient and instruct employees in duties
  - j. Supervise employees;
  - k. Evaluate employees performance;
  - l. Verify time worked by employees and approve time sheets;
  - m. Discharge employees;
  - n. Select vendors for specific services such as Environmental Accessibility Adaptation Services, Goods and Services, Natural Supports Training, Transportation, and Vehicle Adaptation Services as specified in 907 KAR 12:010.

### 6.3 QUALIFIED SERVICES

In PDS services, it is the intent that those supports provided will facilitate the participant's independence as determined in the POC. All non-residential, non-medical waiver services may be participant directed.

The following SCL Covered Services as outlined in 907 KAR 12:010 shall be eligible for participant direction:

- Community Access;
- Community Guide;
- Day Training;
- Environmental Accessibility Adaptation Services;
- Goods and Services;
- Natural Supports Training;
- Personal Assistance;

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- Respite;
- Shared Living;
- Supported Employment;
- Transportation; and
- Vehicle Adaptation Services.

### 6.4 FINANCIAL MANAGEMENT AGENCY

The entity that provides Financial Management Services only handles payroll for employees and provides reimbursement to vendors and employees for services specified and approved in the participant's POC that the participant has chosen to self-direct. In collaboration with the Case Manager, the Team, and the participant, the Financial Management Services agency will monitor the provision of services in relation to the participant's PDS budget. The prior authorized services may be participant directed and provided by a person hired by the participant.

### 6.5 EXCLUSIONS AND SPECIAL CONDITIONS

An individual serving as a representative for the participant utilizing PDS is not eligible to be a provider of services.

Services provided by qualified individuals, including family members or legally responsible individuals as noted previously in this policy, may be covered only if:

- a. Allowed to do so per 907 KAR 20:010;
- b. The participant, family member, or legally responsible individual meets the qualifications and training requirements as stipulated in the SCL regulation and accompanying policy manual;
- c. A contractual agreement shall be in place between the participant and employee before services are rendered;
- d. The rate reimbursed for a PDS service may not exceed the SCL upper limit for that service;
- e. The service must not be an activity that the family would ordinarily perform or is responsible to perform;
- f. An individual caregiver shall not provide more than 40 hours of paid SCL services in a seven (7) day period. For participants that have employed a family member as a caregiver, 40 hours is the total amount that can be paid to the caregiver; and
- g. All required documentation for services provided shall be maintained with time sheets and submitted as determined by the case manager and Financial Management agency.

**SECTION 7**

# APPENDICES

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## Appendix A – D: Forms

<b>MAP 24C – Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program</b>
<b>MAP 350 – Long Term Care Facilities and Home and Community Based Program Certification Form</b>
<b>MAP 531 - Freedom of Choice and Case Management Exemption</b>
<b>MAP 532 - PDS Request Form for Immediate Family Member, Guardian, or Legally Responsible Individual as Paid Service Provider</b>
<b>MAP 620 – Application for SCL and Intellectual/Developmental Disability (I/DD) Services</b>
<b>Participants Rights and Responsibilities</b>

Forms may be obtained at the following websites:

<http://www.chfs.ky.gov/dms/forms.htm#scl2>

<http://dbhdid.ky.gov/ddid/scl2.aspx>

## Appendix F

### Kentucky Exceptional Supports Protocol

# Supports for Community Living Policy Manual

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## *Kentucky Exceptional Supports Protocol*

In extraordinary circumstances related to the assessed needs of a participant, they along with their Team may request the payment of a rate or units of service that exceeds the ordinary amount for waiver services. Any approval of an exceptional support is time limited with periodic review and documentation of effectiveness required.

Exceptional Supports Funding shall be utilized to provide extraordinary services to a participant experiencing challenging medical, behavioral health, or maladaptive behavioral issues. The assessment tools utilized by DDID have the capability of identifying exceptionally high levels of supports needs in these areas as well as specific risk factors for a participant. Data would suggest that 7-8% of individuals enrolled in the SCL waiver will most likely fall within these parameters. These exceptional supports needs require a professional standard of care, meaning certified or licensed clinical professionals are required to routinely provide direct support or to provide on-going training and technical assistance to those providing direct support. Both on-site monitoring and review of information is also required by a professional to ensure supports are delivered consistently and effectively across environments to assist the participant in obtaining what is important to them and for them.

The increased rates and units have been established to accommodate the range of exceptional service delivery needs. The rate are extended **up to** 1.25, 1.5, 1.75 or 2 times the maximum; however, corresponding claims submissions shall be based upon actual cost of exceptional supports rendered.

The following items shall not be included in the Enhanced Support Request: room and board and related items, utilities, household supplies, vehicles, personal products, personal spending, or purchase of positive reinforcements.

### **Services eligible for exceptional supports rates:**

- Residential Level I, Level II (12 or more hours)
- Community Access
- Personal Assistance
- Respite
- Day Training (non ADHC)

### **Services eligible for exceptional supports units:**

- Consultative Clinical and Therapeutic Services
- Person Centered Coach
- Personal Assistance
- Respite

### **Request Process**

The process for an exceptional supports request requires submission of a Plan of Care (POC) that reflects a higher level of supports as determined by the Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST). If applicable, the request shall include medical justification by a physician. Exceptional supports are authorized based on specific information concerning the participant's needs and the plans to address those needs. DDID management staff shall review and authorize any exceptional requests.

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The exceptional support needs identified through the robust assessment process, are not intended to become an indefinite part of a participant's support system. These supports may come and go throughout a person's life. A plan for gradual withdrawal of these exceptional supports, shall be established and accompany the plan of care with all exceptional support requests.

Prior to requesting consideration for Exceptional Supports, the team shall evaluate the effectiveness of the POC and its components to greatly reduce, or eliminate the impact of triggers, precursors, and environmental factors. Preventive services from the regional Community Mental Health Center (CMHC) DD Crisis Service and the regional ICF/IID

Mobile Crisis Team should be sought to assist in this process as needed to ensure that appropriate preventive techniques and person centered planning are in place before exceptional supports are requested.

## **Consideration of exceptional support requires submission of the following documentation to DDID:**

1. Cover letter stating the participant is currently in an institution awaiting finalization of transition/discharge planning to the community; or the participant is at risk of not maintaining their life, friends, home and work in their community; and the assessed needs of the participant based upon the SIS and/or HRST indicate an intense level of supports is required to promote their health, wellness and stability.
2. Team approved Plan of Care documenting the enhanced service delivery needed (e.g., specific enhanced training requirement or credentialed employee, time of day enhanced staffing ratio required, number of hours of professional staffing, or oversight required) including any support needs for which enhanced professional treatment and oversight is warranted. (to include dietary, psychological, or positive behavior support services)
3. The POC shall include frequency of data review by team and consideration of criteria for reduction of these supports; and information about alternative measures attempted.
4. Cost analysis or projected budget for the supports provided for participant.
5. Requests for additional supports needed in the area of **skilled nursing shall include the following additional documentation:**
  - a. Specification of hours of necessary RN direct support required for delivery of identified nursing care that is not delegable per 201 KAR 20:400.
  - b. Plan to obtain and monitor clinical outcome data with criteria for reduction of supports as relevant to medical condition.
  - c. Specification of additional direct support staffing requirements in amount and time of day with criteria for reduction of these supports; including completion of the expanded requirements for credentialed DSP in the areas of Health Support if appropriate; and
  - d. Assessed exceptional needs of the participant documented by the SIS and the HRST with a copy of physician's orders when applicable.
6. Requests for exceptional supports based on the exceptional **behavioral health or behavioral support needs** of the participant must also include the following (as applicable):
  - a. Documentation of completion of the expanded requirements for direct support professional (DSP) credentialed in the area of positive behavior support;
  - b. Documentation of the providers' ability to support people with exceptional behavioral health or behavioral support needs which may include implementation of specialized programs, established arrangements with network of community supports. This documentation pertains to a provider's overall or system wide capacity to provide these types of supports;
  - c. A functional assessment and any supports developed based on that assessment to include a positive behavioral support plan;

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- d. Any notes from HRC and BIC for plans reviewed;
- e. The form of communication utilized and, as appropriate, specified communication techniques/use of technology. Include a description of efforts toward functional communication;
- f. Quantitative data in the form of frequency, rate, or duration should be provided for each target behavior identified in the positive behavior support plan. This data must include the most recent three (3) month period of continuous data collection for each targeted behavior or behavioral health symptom. Data should be in an objective, numerical, and graphical form; and
- g. Documentation, which may include clinical notes, to indicate that ongoing behavioral health services are necessary to achieve the desired outcomes specified in the Plan of Care (POC); and
- h. Behavioral Health Plan, Crisis Prevention Plan and notes from debriefing sessions with CMHC and ICF/IID Mobile Crisis Services.

### **Requests for exceptional supports shall be in accordance with the following procedures:**

The team, through the case manager, is responsible for submitting a written request for an exceptional support for a participant with exceptional needs, along with required supporting documentation, to DDID.

The specified enhanced service delivery requirements for a participant with exceptional needs shall become part of case management monitoring of service delivery.

Data should be reviewed by the person's team at regular intervals to determine if continuation of exceptional support meets all the above stated requirements. Information shall be submitted to DDID as outlined:

Exceptional supports above the established standard rate or unit limit will be prior authorized for a maximum of six (6) months and requires a minimum review by the person centered team and written summary of progress submitted to DDID.

No Prior Authorizations for exceptional supports will be automatically extended.

If the needs of the participant change prior to the review date (change in needs such that the person needs more or less supports), DDID must be notified and a new exceptional request must be submitted.

In order to ensure continuity of care, prior to any transfer to a new provider, a new request for exceptional support shall be submitted to DDID meeting all above requirements. Approval of this new exceptional request support by DDID is required prior to any reimbursement above the Medicaid ordinary rate or limit for the waiver service.

## Appendix G

### Examples of Billable Activities for Supported Employment Service

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## *Examples of billable activities for Supported Employment Services in SCL*

**John Dean**

### **Supported Employment Notes**

3-2-2009 2:50 pm – 4:00pm: Left my office at 2:15 and arrived at John's home 35 minutes later. I met with John and his mother, Mary Dean, to discuss his interview at Slocum's grocery on Wednesday. Mary will see that John has clean and pressed khaki's and a blue shirt, shined shoes and is shaved for his interview. Talked with John and Mary about the interview process, reminded John to shake hands as we have practiced, talk about why he'd like to work in the bakery stocking (John's likes to bake) and to look at the interviewer, Ms. Grainger, as he answered her questions. Also reminded John not to tell the interviewer how pretty she is; this is nice and appreciated by family and friends but not at an interview. John asked if he would get the job on Wednesday.....I said we might know that day but more than likely the interviewer would want to call his references from the resume we developed, his pastor, his neighbor, and his friend at church, and other applicants might also be interviewed. I told him we would call if we'd heard nothing by Friday, March 6. Left John and his mother at 4:00 pm and arrived at the office at 4:35, and completed the documentation

**One hour (4 units) of the above time (3:00-4:00 p.m.) is billable since travel time and time to write service notes are not billable and rounding up is not permitted.**

3-3-2009, 10:20 -10:30: received a call from Ms. Grainger at Slocum's grocery changing John's interview from 1:30pm to 3pm. Telephoned John and Mary to let them know the new time and let them know I would pick John up at 2:15pm.

**No billable time. Documented time is not a complete 15 minute unit and they may not round up.**

3-4-2009, 2pm – 4:30pm: Left my office to pick up John at his home for his 3pm interview at Slocum's grocery, arrived at John's house at 2:30pm, and we left for the interview. John asked me what he should say if Ms. Grainger asked about his previous

3-4-2009 (continued): employment since this will be his first job. We talked about his helping at church during dinners, both baking and serving, and also serving at the shelter and packaging food for God's Pantry. Asked him to repeat the do's and don'ts we discussed on Monday and he did. Arrived at the store and met with Ms. Grainger. She began the interview by taking John to the back of the bakery and talking about what was prepared in the store, and what was purchased and needed only to be shelved. John was very interested and asked if the pies were made in the store or shipped in. Ms Grainger showed us the freezer where the pies are stored before baking and the commercial range where they are baked. Ms. Grainger let John know that he would be helping prep baked goods including cookies and bread, packaging, pricing and shelving baked goods. John was very excited but remembered our discussions and answered her questions appropriately. She ended the interview by shaking his hand and letting him know that she would decide by Monday. John told her that he really wanted the job. I dropped John off at his home at 4pm and returned to the office and completed the service note.

**One and half hours or 6 units are billable since travel time to and from John's home and time to complete notes is not billable.**

3-9-2009, 10:15 am – 10:35am Ms. Grainger called to say that John can begin on Wednesday, March 11 at 8am and work Tuesday through Saturday from 8am until noon. She asked that we come into the store to complete the I-9 and other paperwork and pick up his shirts and hat on Tuesday at 2pm. Called John and Mary; Ms. Grainger had called John first.....he is very excited.

**Fifteen minutes or 1 unit is billable.**

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3-10-2009, 2pm –4:20pm: Picked John up at 2:30pm and helped him complete the paperwork at Slocum's, picked up his shirts and hat to be worn with khaki's and sneakers or other comfortable shoes. Talked with Ms. Dean who will drop John off and pick him up while he is training, and then when he has permanent hours, I will help him learn the bus route. I will pick John up on Wednesday and meet him at Slocum's the rest of the week. Dropped John off at home at 4:20, and returned to office by 5:00.

**7 Units are billable (2:30-4:15), travel time to go to John's house and to return to the office from John's house is not billable and may not be rounded up.**

3-11-2009, 7:00am – 1:15pm: 7:30-12:30 Picked up John and drove him to Slocum's grocery. Talked with John about clocking in at the station at the front of the store by scanning his new ID card and remembering to always have it with him. Complimented him on how nice he looked in his uniform. We clocked in and went to the bakery. John met his co-workers Wendy and Sam and immediately began to help Sam package cooled cookies after washing his hands and putting on plastic gloves. Sam priced the cookies and he and John stacked them on the table in the deli-bakery. Sam let John know that they shouldn't get in a big hurry and drop the cookies because the cookies would have to be discarded, and the mess cleaned up. John wanted a cookie and Sam let him know that he could have one cookie on his break but could not eat while he was working. We watched a DVD about the baking operation at Slocum's which included safety tips, and I asked for a copy for John to watch at home. John took his break at 10:30 for 15 minutes and spent the rest of the time helping Wendy mark down day old bread and rolls and rearranging stock for room to add the baking bread and rolls. John remembered to clock out at 12:00 after he completed his shift. John was quite excited about his first day at work and we discussed how it went on the ride home to John's house arriving at 12:30. I returned to office by 1:15.

**20 Units are billable (7:30-12:30). The time driving to John's home, 7-7:30, and returning to the office from John's home, 12:30-1:15 is not billable time.**

3-16-2009, 6:30-8 am; 9:30 am – 1:30 pm: Met John at home at 7:00 to begin training to ride the bus to work. Walked two streets over to Popular Street to the bus stop and waited for the bus. John scanned his bus pass and we rode the eight blocks to Slocum's. John is learning to package pies this morning after helping Wendy straighten the bakery displays and mark down as needed. I left to return at 9:30 when the pies have cooled. Worked with John and Wendy to package pies; John got the containers and lids from storage and stacked them on the bakery table. Wendy showed him how to set the pies into the container, to tape the lid, and place the label. John had trouble placing the labels because they are several inches long and very sticky, but managed to place the labels correctly after the second batch of pies. John completed his shift at 12:00 and we went to McDonald's for lunch from 12:15-12:45 before catching the bus home and walking the last two blocks. During the bus ride, I helped John identify the block with the house on the corner with the lavender door where he gets off. John arrived home at 1:30 after he successfully followed directions from the bus stop to his home.

**7 total units from 7:00-8:00 and from 12:45-1:30 are billable as bus training. 14 total units for on-the-job training from 8:00-9:00 and from 9:30-12:00 are billable. Time spent eating lunch is not billable.**

3-18-2009: John's case manager, Tim Smith, invited me to his ISP meeting on Friday, 3-27 at 2pm at his home.

**No billable time.**

3-25-2009, 2:30-5:15pm: Drove to John's home and arrived at 3:00 in order to drive him to a meeting at the grocery store that began at 3:30. John was nervous about the meeting during the drive and we talked about that. We are meeting with Mary, Tim, and Wendy to discuss two problems he's having at work. Generally, John is doing well at his job at Slocum's. He has learned to package and label pies, cakes and cookies, to straighten bakery shelves, and has begun to interact with customers. John got upset yesterday when Wendy asked him to return to work after he followed a friend from church over to the vegetable aisle, talking and left the cart with packaged cookies in the middle of the department. Wendy called me and we talked with John and he finally

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understood that he created a safety hazard and also potentially annoyed a customer. We developed an outcome for his ISP meeting next week to maintain employment by speaking to but not engaging in conversations with friends at the grocery store, remembering to clock in and out since he's forgotten to complete this 3 times in 3 weeks, and not going for coffee at McDonald's and forgetting to be on time for work which has occurred twice when he got to the bus stop early and caught an earlier bus. Meeting ended at 4:15 and I drove John home from the meeting arriving at 4:45. During the drive, John and I talked about how the meeting went. He was sure he would be able to remember how to attend to his job better than before.

**3:00-3:30 and 4:15-4:45 (4 total units) are billable for driving John to and from the meeting. 3:30-4:15 (3 units) are billable for the actual meeting time because this meeting was to discuss work related issues. A total of 7 units would be billable.**

3-27-2009, 2pm – 3pm: Attended John's ISP meeting and discussed the objectives we developed on the 25<sup>th</sup>.

**No billable units as ISP meetings are not billable.**

## Appendix H

### HRST Protocol

# Supports for Community Living Policy Manual

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## ***Kentucky Health Risk Screen Tool (HRST) Protocol***

Revised March 26, 2013

The Health Risk Screening Tool (HRST) is used to determine where an individual is likely to be most vulnerable in terms of the potential for health risks. It is understood that the greatest vulnerability to health risk is exhibited or experienced among those individuals whose services are periodic or less intense than for someone who needs daily nursing care. The HRST assigns scores to rating items. The total points result in a Health Care Level with an associated Degree of Health Risk. The Health Care Levels are 1 through 6; Level 1 being the lowest risk for health concerns and Level 6 being the highest risk for poor health. It is important to understand that the HRST measures health risk not disability.

### **Why use the HRST?**

- Early identification of health risks reduces and prevents complications
- Increases monitoring of a person's health
- Identifies additional training needs of staff

### **Who completes the HRST?**

- Residential providers shall be the lead provider to complete the HRST. If the person does not receive residential services the designated provider shall be the provider identified in the person centered plan of care (POC) that is providing the greatest quantity of service.
- The initial HRST will be completed by a nurse (RN or LPN) contracted or employed by the provider agency. Subsequent HRST updates shall be completed by provider staff.
- State operated hospital staff will complete the initial HRST for each person transitioning from state operated hospital services to community services.

### **When does the HRST have to be completed?**

- The initial HRST is completed for each person within 30 days of the initiation of SCL services.
- The HRST shall be updated at least annually by the designated provider within 90 days of the expiration of the POC.
- The HRST shall be updated by the designated provider within 3 days of any significant change in a person's health, functional or behavioral status such as:
  - Medication change
  - Hospitalization
  - Emergency room visit
  - Significant behavioral change
  - Communication by person of changes to how they feel
- The case manager shall be notified by the provider when an HRST is completed.

# Supports for Community Living Policy Manual

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## Kentucky Health Risk Screen Tool (HRST) Protocol (cont.)

### What to know and do with the HRST?

- The designated provider will complete the HRST online at: <https://kydd.hrstonline.com>.
- The completed HRST shall be provided to the person's case manager within 3 business days for inclusion into the person's SCL record and POC.
- If a person's HRST health care level is a score of 3 or higher, the case manager must contact the DDID regional nurse within 3 business days for review and follow up.
- Individuals with an HRST level score of 3 or higher are considered higher risk thus require increased monitoring and supervision.
- Reports will be available from the HRST website to trend health related issues across the system and by provider.
- HRST information is available for downloading and printing, with a person's consent, and taken to their health care appointments to use in the ongoing review of the persons health history.

### What steps must be taken for an HRST Health Care Level of 3 or higher?

- The case manager shall notify the DDID regional nurse for further review within 3 business days.
- DDID regional nurse shall review and provide technical assistance to the person's team of providers.
- The person's team shall identify increased monitoring and additional staff training requirements that are required in order to mitigate the risk and meet the person's needs.
- Case manager shall request Supports Intensity Scale (SIS) reassessment from DDID, as appropriate if there is a significant change in the person's overall support needs.

### What about the tracking log?

- The case manager shall maintain the tracking log for all identified risk issues as part of the monthly monitoring visits.

### Case Management Responsibilities

- Case managers will monitor during monthly visits to ensure appropriate monitoring and additional staff training is occurring.
- Any deviation from the identified action approved by the person's team shall be noted in the case management summary and on the tracking report.
- Case manager will request explanation for deviation and shall take appropriate action to notify the person's team members and follow up.