GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

Developmental Disabilities Committee Meeting

LOCATION
Governor’s Council Conference Room
3601 C Street
Anchorage, Alaska
Teleconference

Meeting Date
July 23, 2012
1:00 p.m.

Attendees:
Kathy Fitzgerald, Chair
Ric Nelson, Chair
Kaleene Lamb
Steve Lesko
Art Delaune

Staff:
Carrie Predeger
Teresa Holt
Millie Ryan

Prepared by:
Sheryl Cobb, Administrative Assistant

No Call To Order

No Roll Call

READING OF THE COUNCIL MISSION

Not Read

INTRODUCTIONS, ANNOUNCEMENTS OR GOOD NEWS

Not Read

APPROVAL OF THE AGENDA

- Not Read

DD REGULATION DISCUSSION

Teresa – We thanked the review committee for increasing the supportive living back to 18 hours. We thanked them for changing the definition of Private Residence. We did all of our comments about the recipient disenrollment. They really didn't change any of that. The State can just kick people out, agencies can just kick people out. That is not appropriate. We gave comment about Critical Incident Reporting. Not only do they need to notify the State but they also need to notify the legal guardian of the person. That was not in there. We gave quite a few comments to page 17 of the new section.

They had a lot about Restraint and Seclusion. Basically it says that they can have Restraint and Seclusion as part of your behavior support plan. Teresa's comment was No, that Restraint and Seclusion should only be when it presents an imminent danger to someone's safety. Prevention of Restraint can be in someone's plan, but not Restraint. They should have an exclusion of some restraints. The provider may elect to exclude a type of restraint. I asked that there are always 2 people so that if somebody is doing the restraint, there is someone who is just watching and not involved. That was another thing that was in all of the reports. That person's job is to check and make sure that nobody is getting hurt, the person is able to breath, all those kind of things. I asked that not only they monitor and evaluate the use of restraint, but they debrief after each use so that they

can figure out how to prevent it. Not only that they track the time and date, but they track the duration because duration is probably more important than time and date. If you are restraining somebody for five minutes it is much less likely that somebody will get hurt than if you are restraining somebody for thirty minutes. We can add more but that is just highlights.

If people want to look over the page 17 of the new proposed regs, if you have any additional things we should cover, let us know.

On the issue of medication administration, we went with the same comments that we had drafted earlier. Same thing with termination of services, using screening, using strength based assessment tools. All of the draft comments, we used.

The Dayhab services, there is the new issue of you can't get transported to the Dayhab if you are going to the center. So our comment was that if they are not going to change that, then they need to have two rates. One that is the Center Dayhab rate and one that is for an individual. We tried to explain that most people don't use that in major areas. There is no way for an agency to support a hundred people coming in on one day, at different times, from different places. I don't know if they got it.

We gave the same supported employment regulations. The same IAT comments that we had drafted. Transportation, gave the same comments but we added "Round Trip". It has to be round trip. They will consider transportation services to cover round trip between the recipient's residents' home and the destination where home based community waiver services are provided. I used Ric as an example. I said so that means Ric's day goes like this. Say that he is going to school, then he is going to the Council office for a meeting, then he has a doctor's appointment. Does that mean that Ric has to go to UAA and go all the way home, then come to the Council office, go all the way home, and then go to the doctor's office and come all the way home. I said that is going to totally mess people up. Steve Lesko commented that is how he read it. Ric Nelson agreed. Teresa said that is not effective or useful. We gave some overall comments about the fact that these regulations really seem to be moving to the medical model and away from person centered services and that really concerns us. I chimed in with every single other person concerning standards of practice, that we were told they would be pulled out and be able to work on them as

a group. Steve Lesko said that this was very problematic.

Carrie commented that out of everyone who testified, there was only one person who testified on those specifically and her testimony was 20 minutes. Teresa said that nobody had a chance to look at them, because we didn't think we had to prior to this meeting.

Kathy Fitzgerald – Mark Regan, are you on line? No response. Teresa said that they asked to pull out standards of practice. There was no response. My guess is that they are not pulling them. Kathy said she thinks it is time for a major lawsuit. She said that she honestly thinks that as family, as councils, as provider agencies, as associations, we need to stand up and say enough is enough. We are not going down this medical model road. We want you to cease and desist and we will take it everywhere public we can take it. We take it to the Legislature, we harangue the Governor. I think we need to make a huge issue out of this. One of the things we should be demanding is stakeholder input, and it looks like this. Look at what Minnesota did. Minnesota doesn't make any kind of change without very significant stakeholder input. Teresa said that they are going to tell you that they did. Kathy said that we know that they didn't. Teresa said that the problem is that when you put out pages and pages of reg changes (I know I keep mentioning Dept of Ed, but they had 40 pages of reg changes). They divided it into sections and did it by sections and they didn't have this kind of problem. When you do a section, you can take comment, make changes. Kathy said this is really about money. Teresa said that Dept of Ed was all about money too. Kathy said that it was also about leadership. She said that you can have public comment but if you are not going to utilize any of it, it is all for show, which this is the second time, the second go round that what the hell have they changed? They changed the 18 hour and they changed who owns stuff only because there was such a huge outcry that it was an Olmsted violation. Nobody. Kaleene said that it is kind of expensive to bring people back and forth to their houses rather than going to the place that they have to go. Teresa said that Kaleene was right. Kathy said that it didn't make any sense.

Teresa – let's start on the conditions of practice because there are many. Let's start with the providers first. We are going to look first at Provider Condition of Participation. Teresa asked if Emily was on line. No answer. So what was interesting is there was one lady that went through the

Conditions of Participation. She went through the nine service principles. What I liked about her deal is that she used these nine service principles to totally diss the rest of the stuff in it. She would ask how does that make for fairness and effective management of services? How does that foster fairness of equity? How about honesty and integrity? Teresa thought that was very good. If we can use that tactic, it might help. Deliver through collaboration and community partnership. Kathy thought that they already collaborate with us too much. Ric agreed. Teresa said that an interesting fact was that people were actually upset about that quality services are provided.

Millie Ryan just joined the group. Teresa said that they fixed a few things, and they added 15 conditions of participations. Kaleene said that she came back to the Council to try to help fix things. Kathy said that she was glad Kaleene was back.

Kathy said that she didn't know how the process was, if you wanted people to pick out what was the most offensive or if you want to go through them as a group. Teresa suggested that they go through the brief comments.

The first deal is that it adds huge significant administrative burden. It obligates agencies to have additional staff time to comply with the regs. It doesn't take into consideration both the rural areas that don't have the resources to do this, so if you are a small agency with only a few people and you mostly provide direct service. It requires obligations that maybe are not appropriate for the provider types. That was the comment that someone said. She said that you take assisted living, senior services, group home services, supported employment, all of these things and you put them all in the same regulation package, they are all very distinct separate services that really need their own regulations. Kathy agreed. Teresa thought that was a really good comment. Kathy said that it was the same thing that we said all along. You can't write regulations for senior and DD regs, you can't write those regulations and not have a conflict and not have an issue.

Overall, there was no discussion of the appeal process. So if there is a minor violation, does that go through the same formal appeal process that is discussed in the regulations?

Provider conditions of participations – service principles, how do you document that you are doing that? Kathy commented that we do not have a quality assurance system any more. She said that they can do this if they want to institute another community site review system.

Service Principle 4 - Individuals have knowledge of and access to community services. That is not always true. The comment says Principle 4 includes obligation that individuals have knowledge of access to community services. This is appropriate for care coordinators and some providers but not for those who do meals, transportation, and others. Steve commented maybe this is my translation error. I'm looking it is and they are saying in terms of principle, these are things we would aspire to and should guide our services. Individuals should have knowledge of, should have access to, and I don't disagree with that. Kathy concurred. She said that means the recipient versus the provider.

Service Principle 2A3 – Steve commented it says this shall provide by some the collaboration of patient, community partnerships. That should always be the guiding affect. If for some reason you can't do it, which I can't conceive of, stay out of that. I don't get those kind of comments. I think they are suckling. That is a professional term.

Teresa liked the idea of using the service principles to show in here where it is not. Steve feels that it is a mistake and it leave us to say what fools are commenting on this. Teresa said that we would not include those. Steve said that he would not, that would be his inclination.

Teresa – under the Operations requirements – Conditions of Participation are part of the regulations because they are adopted by reference. So that means that they really do hold the same weight as a regulation. So it is not just like here are some guidelines. We you adopt them by reference, they become part of the regulations. That is why we are concerned about them and we thought they were going to go away and we were going to work on them.

Teresa said she is not sure how they are going to measure these. How do you measure practice open communication and cooperate with others? Steve said that the standard forms truly are memorandums of understanding.

The provider must grant SDS access to their location. Steve commented, that one I would say to you yes and no. You've got to, but all locations? Does that mean, for example, we provide services in your natural home? That is a site of service. Do they have a right to go into every natural home? I think no. If Ric has his own apartment or place, do they have a right to go in there because somebody provides a service for him? I don't think so. Too bad. That is where they go on and bring these generic things out and you can interpret them in an entire different way. Kathy commented that some of their reviews looking through an individual's closets and drawers. That is way overboard. Teresa commented that there would need to be a reason that they needed to. Kathy commented that they could be looking for drugs. Ric commented that they should not have the right to come in and look in my home. Kathy said that on the other hand, if it is care providers or in a group home such as Hope. Hope is there and they are providing a service, if they want to come in and make sure that it is up to code, but that is different than going through a private home. Steve commented that the difference is that it is licensed versus private. He thought that was a good benchmark.

Teresa – so on number 2, I read that to say that no provider or provider employee or contractee can provide services if they have been convicted of Medicaid fraud, sanctioned under Medicaid regulations or has been convicted of a crime. Kathy said that would mean that the state can't provide Medicaid services any more. She asked, is that not right? Ric replied yes. Teresa said that it should read un-corrected sanctions or something to that affect. She did not understand why they would put that part in there. Steve wanted to know why they would use the term owner, or provider employee. Kathy felt that it was because they were talking about assisted living homes where they have the mom and pop assisted living home and the owner is the live in staff. Steve said that the one he has trouble with is the word sanctioned. That is too broad. You can be sanctioned for the most miner thing. Teresa said that if you have been suspended or terminated I could see that. Steve commented that you can be sanctioned if you let a care coordinator's certification expire and you don't tell them either it is renewed or going to be renewed or it is forget it, they aren't here anymore. They can put you in for sanction, that is a fact. Teresa asked the group would be okay with the reading of has been suspended or terminated and take out that whole first part. Certainly having

been convicted of a crime is not going to be an issue. Ric asked, but what kind of crime? Steve confirmed that Ric's question was right too. Teresa asked if Carrie could look up these things on her iPad. Terms such as list of excluded individuals. Before hiring an employee or allowing a contractor to volunteer to work the provider must check the list of excluded individuals. Teresa said that the comment the lady made about this was there already is a list of people who can't come to somebody's home, why are they adding this additional listing? Teresa said that she didn't have a chance to look to see what it says.

Teresa suggested that the group skip number 3 and go on section C and later come back to the list since she didn't really know who was on the list. Carrie commented that a lot of the comments at the testimony about the 90 days funding source. Teresa asked if we know if that is a huge issue to people who just go into business and don't have funds? Kathy said she didn't know if it was so much in Alaska, but on the DD side, I don't know about the individual providers on the senior side.

Carrie – C1 – there were a couple of comments that there were to be at all times to be funding sources to cover 90 days. Steve said, notice it just says source, and I believe that 90 days is a long time. Kathy commented that she wants to know what Disability Law says about this, about being able to kick somebody out. You are eligible for service if you are receiving services, what is my right? What is your right to kick me out? Teresa asked what the policy was in the past. Kathy said that what it initially was that you did not have the right to kick somebody out of service if a provider agency was dealing with somebody who was too difficult to serve, they had to go back to the state and work with the state and find a more appropriate or better placement for the support services. Teresa said that is basically what our comment was. Kathy said that the individual was never allowed to just be thrown out on the street or kicked out saying that we are not going to serve you anymore. She said that most agencies have a no discharge policy. Steve said that in the early days, the only way you were going to make a point to the state is to put them out on the streets. Otherwise they never will believe you. Steve said that the more he thinks about the 90 day thing, he doesn't think he can do that. He feels that is impossible right now. He felt that 30 days was more appropriate. Ric, Teresa and Kathy agreed. Steve said that if it was cash, rather than line of credit, he didn't know of any agency that could do 90 days. Carrie suggested that it spell out cash,

assets, line of credit. We need to ask that. Steve said it should be any liquid, pliable asset. If it is cash in the bank, we are all in bad shape.

Teresa – 3 under B – we can't figure out what this is. On the comments, it said this was duplicative of Medicaid requirements already. Steve said that is probably true. Teresa said that we are not worried about that.

Teresa – what about number 3. Provider may charge fees for participant services at a rate no higher than what would be charged to private paid clients for comparable services. Kathy said that she thought that was part of Medicaid law. Provider must implement a financial system based on generally accepted accounting principles. Teresa said that seems normal. Steve agreed. Teresa read that they must maintain records, report to the Medicaid fiscal agent, cooperate in investigations. She felt that we should add under E that due to the many additional reviews, that they should be able to audit. Teresa said that there really is a list of people's names under B3 that is nationwide or worldwide. It has names and alias names. This includes felons, fugitives. There are over 4,000 pages of people's names.

Teresa – Let's move on to Section D, Quality Management. Kathy said that it is pretty standard in her opinion. Ric agreed. Carrie said that there were comments concerning some of the small providers that it could require a full time person. Steve disagreed with that. Kathy commented that they want quarterly because if it is a systemic thing, they want you to catch it now rather than at the end of the year. She does not feel that quarterly is unreasonable. Steve and Ric agreed. Kathy said that if you have that many incidents, there is a problem anyway.

Teresa – Section 2 – Quality Improvement Process. about their own agencies. She said, okay, I will do mine of you do yours. They don't do theirs.

Item E – Steve commented that providers must develop their systems around the state model. Teresa said that the state should have a model. Steve said that is a good idea. Ric agreed. Kathy commented that they will tell you that they do have a quality assurance process. Steve wanted to know where it is at. Teresa said that they have discovery, remediation, continuous quality assurance that engages monitoring data collection activities. Teresa comments on the self assessment report which should be

done annually. They talk about the grievance process critical incidence, reports of harm, medication errors, use of restrictive interventions, consumer satisfaction surveys, internal reviews of services

Ric asked if you have to do this every year. Steve said that it doesn't take that long because we do our quarterly report and then the annual one. He said to compile the annual report, it probably takes a half a day. You already have the data. Ric wanted to know what happens if somebody has a business and had to compile this. Kathy said that they have to do quarterly reports, it is required. The grant system requires quarterly reports. Teresa said that the state should provide an example of what is wanted.

E – Reporting Changes in Provider Status. Ten days prior to changing mailing address, email address, phone or fax, 60 days prior to changing of agency name, physical location, form of organization. Kathy commented that you may not always know 60 days in advance where your location is going to be when you are looking for a new spot. Would you have to say we can't move now because we have to wait 60 days? Teresa commented that it is 30 days for the change of a program administrator, or 1 day of an unplanned. Teresa asked, do we want to say 30 days prior to the change of a physical relocation? Ric that 10 days was better. Teresa felt that it was an intent to change. For example, if you are renting, you have to give a 30 day notice. She felt that 30 days seemed appropriate rather than 60. This stays when an individual care coordinator changes. She said that every time you change care coordinators, you have to notify them within 10 days. Kathy asked, and if we don't? Steve said that you would get sanctioned. Steve commented that he has not gotten a sanction yet, but he has been threatened with one. I don't know if they will go through with it or not, it was just this last week.

Kathy asked if Art had a comment. Art said that he was just curious if there has been problems with this sort of thing or what is the reasoning behind this? Kathy said that she felt if there was problems with care coordinators or agencies not notifying, it has more to do with the senior side than it does on the DD side because there are so many more of them. On the DD side, I'm sure that there are occasions. In fact I have a friend where their care coordinator just all the sudden decided they were not going to be the care coordinator any more. Literally no notice and they were in the process of renewing a plan. That was the professionalism of that care coordinator. It

didn't have anything to do with the agency or the family, it was an independent care coordinator. I don't think that on the DD side, Art, that it is really an issue as much, although we certainly can change care coordinators. I know that when I was with another agency, sometimes you would go through care coordinators like once every couple of months. Teresa comments that this has happened to Anna. Kathy said that it depends, but she doesn't think that it is the rule. Steve said that he thinks that part of the problem is that it has evolved into a fairly impossible environment . It is something not to take for granted. For example, they can put you in to Medicaid today for what they call a sanction for the littlest of things. Or, they can report you to Medicaid fraud unit for thing you wouldn't even think are fraud. The littlest things. The whole atmosphere has become a very negative one and when you say hey, is this the way to deal with people, they will say that we are required to.

Teresa said that her only comment on this section is that they have to report it to the state, but what about the person who is getting services? She said that happens to Anna all of the time. She just shows up to a meeting and there are all new people there. They say we just did this last week and she asks who are you? And they are her care coordinator. They will say, oh, I just started last week. The other person didn't say goodbye, there is no transfer. Ric said he thought she could chose her own care coordinator. Kathy said that no, it didn't work that way. She should be able to choose her own care coordinator. She said that it can be really hard. You can have a really good care coordinator in an agency, that person may get really overloaded and try to pass off some of their people to other care coordinators because people know they are good. They do a good job. But you have the right to ask for that person. Steve said that he is going to go with what Ric and Kathy just said. This is a key, we shouldn't lose this one. Care coordination is the ticket to everything. This is the person who is responsible with the individual and or the family for the whole plan. Making sure it is delivered correctly. That is the key position. With that being the case, there will be times in any agency, internal or external where a person has 93 people and 94 she is dead. Not going to happen. You are going to have a limited choice within a field, but if you don't like the agency, go to another agency and see if you like their care coordinators. You always must have a choice. Kathy commented that if they give you somebody you can't work with, you should have the right to say that and get somebody you can work with. You have a choice. It is the only mandated service. There is a

reason.

Teresa said that she felt that all the changes in the provider status are all things that the recipient should also be notified of. The rest of the group agreed. Teresa said that it does not state that, she has added and recipient.

Number 3 – Teresa – this is the one that gave me a little bit of heartburn. If you are an agency and you don't know this, if somebody has been charged with, convicted of an offense or is the respondent in a restraining order. The provider must notify SDS in writing within 24 hours or one business day, if an owner, business administrator, employee, volunteer, or agent or agency who is charged with or convicted of a criminal offense or who is issued as a respondent a protective or restraining order. You can't be responsible for things that you don't know. Do you run a daily background check on everybody? Steve said, if you don't know it, you aren't going to report it. Teresa commented that a protective and a restraining order happen more often than people think. Being convicted of a crime, I guess the person doesn't show up. Steve commented that you can get a TRO for just about anything. Teresa commented that it lists volunteers too. This is anybody who does anything for your agency. Kathy commented that if your employee gets a little snockered and has words with somebody and somebody calls the cops, and he gets reported it could be that it isn't anything significant. Steve said that they have to be charged or convicted or issued a restraining order. Ric stated that he didn't understand if it didn't affect the client. Kathy said that she feels the issue is if the person is significantly aggressive or in somebody's face enough that a restraining order is issued about that person. They might be dangerous to somebody else. I think that there are frivolous restraining orders and that is a real issue. On the other hand, if you honestly have somebody who beat his wife up or whatever. Ric said there is not one that fits all.

Sean commented that there are a lot of ways that you can handle this particular issue, but one thing that stands out for me is that there is a reasonable threshold of information that anybody can be aware of. Some of the categories that you just mentioned aren't even in the realm, for example, criminal charges. There is no system in Alaska or anywhere else in the country that I am aware of that a public member or agency member or anybody else can go in and see where charges have been filed. It doesn't show up in the official court system until a much later stage than

that. One of the points is when is it a reasonable point or threshold to start with from whatever information is even available and I hear that from some of the comments? If I was going to be a rebuttal person to this point, what I would find hard would be where you can make the distinction of where reasonable information could even be accessed. As part of the concern at the upper level that you guys are talking about that is reasonable and I know that could be another discussion, but I just wanted to add that an agency or provider has some safeguarding responsibility to the public with the main fact asked to be able to check court records and see what is in there. I know that we try to do that ourselves, to some extent but prescribing to the level that they are suggesting doesn't seem reasonable for all of the comments that you all have made. Definitely, the least of which is you can't know what you don't know. There is no way that you can know information that is at a level that you can't even get your hands on as well as the other comments that have been made. I just want to say that I have to go, sorry. You guys have really got a good handle on this and I don't think there is much more I can add. I was an ex probation officer and I had access to the system a lot and am very familiar with that system and I thought I'd just throw my two cents worth in there. I don't think I could contribute as much in the other areas as you guys have been doing. Unless you have any other questions, I think I will probably sign off.

Kathy said thank you Sean, we appreciate your comments. We like reasonable threshold. What is reasonable threshold? Sean asked what can people really know about to report on. Thanks you guys.

Kathy stated that she thinks they need to be really clear on that. Teresa said that she isn't sure how you pick what the threshold really is. Kathy said that there is no system to look at to see what charged have been filed. She felt that is what you had to say, reasonable threshold is if you give us a place to look that we can document that something has happened, then okay. Teresa asked, are you going to have to look every single day for every single person? Steve said that would be insane. Kathy said that you would have to hire somebody else just to keep up on that. Teresa said that if you had the knowledge of, then that kind of relieves the burden. Steve said that he thinks knowledge is good but if you really want to play it safe, you could say that if we have knowledge of, if this were at my office, the first thing we do is suspend the person. If they are exonerated so to speak, it is paid vacation. If they are not, it is another story, but that sounds

reasonable to me. The consumer or the person who receives services are taken out of the line of harm regardless of how liable we feel. I think agencies should have effective implementation policies and procedures when it comes to this. This is really to protect. Kathy said that the state should come up with some guidelines. Teresa said that she was thinking about the one lady who testified that she owns her own little deal. She does an assisted living home and it is just her. If the state is going to require all of these things, then they should give you examples. Here is what we want, here is what it should look like. Teresa said that if you have been in business for a long time, you would probably have a lot of this in place. Steve said that the downside to that is that you have it all sorted out and then somebody changes it all.

Teresa – next section – Personnel, program administrators. She said that she doesn't even understand this one. A provider may employ an individual as program administrator for more than one service if necessitated for the location of the agency office, given the size of the participant population and the number of direct care workers managed for each service except the program administrator or care coordinator service may not be employed or act as a program administrator for any other services. Teresa said that was very confusing. Steve said he thinks what it means is that you have different providers members for the different services you provide. Right? Except for this one, they say that you can be a program administrator, like administer Dayhab but somebody can't be designated as care coordinator, they kind of separate that one out. They would be fairly independent. Steve said to read the comments on page 2 on the legal analysis. That could affect the agencies. Is this based solely on qualifications? Kathy said that would be a good one to inquire about. Steve said that one made sense except for that part. Teresa said she didn't see why it should make a big difference. Steve said that they have the independent thing but have the precursor that says about the care coordinator. He said screw choice, if some people want that, it doesn't matter, they aren't going to let you do so with this reg. Kathy said that the independent care coordinator works so well on the senior side, right? Teresa asked if I read this right does this mean that okay if you are going to do this to just change the name from program administrator to program director or manager? Could you do that and it would be okay, is that what it says? That is how I read it, I don't know. Teresa said that it makes no sense and they might as well throw the whole piece out if you can just change your name from program administrator to

manager. Doesn't that just kind of negate the whole idea? Kathy asked if we use the Alaska Core Competencies. Teresa said that they are going to do trainings. Train the trainers. She said that she thinks it is a good tool. Steve said that he didn't know yet.

Teresa commented on D – that they are going to require on the job training and continuing education courses. Steve said that if they are going to pay for them, take your pick, but they usually don't. If it is a mandate, it should be a funded mandate. Kathy said that we should say that we are not going to do it because it is an unfunded mandate. The Governor said that we are not going to do unfunded mandates. Steve said that he liked it actually. Art commented that that approach has worked real well in the past, hasn't it? Kathy asked if we want to make some kind a comment about the cost burden? Steve felt that it was appropriate. Kathy said that we agree that education and on-going training should be available, but there needs to be a mechanism for funding the training.

Teresa said, going back to when she was with a subnational group this person talked about how their direct care workers had a base rate and they worked on the same base rate, that the state had developed all of these classes for on line training. You could work your way up to higher pay and eventually became a care coordinator. They had the whole thing with the pay system. To me that makes sense. Otherwise you have people who could go be baristas and make more money, they don't have to do these classes. That whole system just makes a whole lot more sense. To me it's not great, but I don't know. I you are going to start requiring training. Kathy said, well here is the problem, there is a national mechanism that you can go through, college for direct support workers, there is the TCC, there is competency stuff that you guys have been doing. It is good, especially the stuff that is for certification competency stuff. It is very good but there is really no way for agencies to be able to compensate that much for what people have done people because we have a flat rate of what we pay. So, until they allow for some kind of an increase. Hope can figure out where they can cut somewhere else to maybe cover the increase or Arc can decide to X and John has tried some stuff. Really and truly you can build a mechanism or system that does not support continuing training and education. In fact, it has made it more difficult, that is why we need a CBC. Ric said that he wants to know why they require more classes for direct care. Kathy said that it depends on if you are working with somebody who

has a lot of significant behavior issues or a lot of things going on, maybe that gets into acuity to other things. There are instances that maybe you need additional training or support, certainly more than most people come in from off the street with and are plugged in as a direct service worker. Kathy thinks that it gets back to not having a flexible pay system, have trained back up people when people do have to have training. We don't. Steve said that what we are all talking about is that we don't want to lose this issue. I think when just reading it, for example the apprenticeship program with the Department of Labor, we do increase salaries several times in the program, but that is a selective class. Roughly, it could be as high as twenty a year, which is nice but it is still limited. Now if they are going to require ongoing training or whatever they are going to require, they are bypassing the issue too and that is salary. Salaries are totally inadequate and until they address that, the more you are going to require, we are going to lose people. We are not going to retain them. We are going to lose more. Steve feels that generally speaking, you want a direct service professional to know their client. Anything else that is required, such as first aid, anything like that is needed, but they need to know the client first, the people they support. Kathy said don't forget blood borne pathogens.

Teresa said let's move on to first aid and CPR training. Just scan that and see if it seems appropriate, I didn't see anything there. Kathy commented that we are putting things like this in regulation. How can it be appropriate? What happens if you decide you want to change how you are doing something? Are you going to open up regulations again because you want to change your policy? Teresa said that is what happens if you incorporate these by reference, and then every time you update them, you have to go into the regulations. Kathy said that you are making it harder for yourself. Steve agreed. Teresa commented that for us, maybe that is better, because it gives us multiple opportunities to change it. Kathy said that it gives us multiple opportunities to gripe. They never change.

Teresa said how about the orientation and training section? The only thing I saw there was that direct care workers must have all information necessary to perform a service, for which the individual is responsible. The suggestion in the comments is to have all information needed to reasonably be able to do. Teresa said that she didn't know about that. She said that they have a lot of that "all". Steve said that he would go with the reasonable. Ric agreed. Ric said that there are times that a person can't do all of the things

that a client needs.
Teresa – under C – and this one seems a little scary. Kathy asked, what does this mean under her comment that training – providers have to provide, should also provide for. They encourage us to share training and knowledge and that is why you have the Trust Training Cooperative, that is why you do a lot of things that you may come together to do things to provide a training on whatever that other agencies go to. I mean is this saying that you can't do that? Carrie said that she thinks that it is just not being explicit. Ric agreed. Carrie suggested that maybe it should be provided. Kathy said that maybe providers should provide training in general, so as providers we are going to provide this. She said I don't know, I'm not a lawyer.

Teresa said that under supervision, it said the provider must monitor the direct care workers and volunteers. I'm not sure if that is possible. That depends on what they mean by monitor. Hopefully everybody is out in the community and does that. Kathy said that she feels they do monitor and if they don't they should, but they monitor through the care coordinator or through their own quality assurance staff. Teresa felt that monitor was just the wrong word. She asked if she was right. Steve said that he didn't know what it means. The comments kind of suggest that. It says that it is expected to go how often. You don't ask how often. They will give you a number. What do they mean by monitor, I don't know. Kathy asked if the word should be oversight. To provide oversight. Steve asked if it should be worded to provide reasonable oversight. Teresa asked about reasonably insure. Steve said that he could give an evaluation on Ric, he wanted to know if that would work. He said that he doesn't get what that means, monitor. Teresa asked, how about the provider supervises direct care workers to insure safety? Kathy said that every structure has a process or at least is supposed to have supervision in it. How it works, I don't know. Carrie said this is under supervision. Teresa said that so if you are a speech therapist and you are monitoring a worker who is not a speech therapist, it is direct line of sight. If you are in the hospital and you are a nurse and you are monitoring a patient, you are working in direct line of sight. Carrie asked, so if you are supervising me, how do would you say that works. Teresa said that she wouldn't be monitoring what you do. Kathy said that to her, monitor has more of a negative connotation that they are expecting to catch you doing something that you shouldn't be doing. Carrie said that they need another word for supervise. Kathy suggested oversee.

Carrie noted that this is under the supervision heading. Kathy suggested must provide oversight of. Teresa asked if you do this too if there is an allegation of abuse? Do you remove the person until you sort it all out? Steve said yes. Kathy said absolutely. Teresa said that it sounded reasonable to her. Steve commented that is why there are so many provider lawyer comments.

Teresa asked if any providers provide payee programs any more? Steve said that his office does not. Teresa asked if it is all private, separate. Steve said that it is too much of a conflict. Kathy said that the state would not allow you. That was too bad because the voucher program was a good program, I liked it a lot. Steve asked which program and Kathy responded the voucher program. She asked if that was what they were talking about and Teresa explained that she was talking about the payee program. Steve and Kathy both responded that they liked the voucher program. Kathy said yet another slippery slope. Steve said that there was cultural bias. Kathy suggested the use of the word oversee or oversight. Teresa asked if anybody had problem with conflict of interest.

Art announced that he had another meeting he had to take off to. Kathy said that she would be calling him.

Kathy read – represent or participate in a hearing appeals process could result in a personal or financial benefit. She said this is where she sees an issue. She said she could see the state doing this – saying if you can't be my coordinator and come in and represent me in the appeal process on behalf of my need for that if your agency is going to benefit from that because you are wanting more services. Do you see what I am saying? Ric said that is not right. Kathy said maybe she is just looking at it the wrong way. Steve said that he took it in the best of the ways. I kind of agreed with the state on this one, but I can see so many different ways that this could be taken. This one I thought, yeah, if I'm going to gain, it should not be there, there is a conflict. However if you interpret the conflict or gain, you are going to be there as part of the agency. Steve said what the heck? Kathy said how many times have I heard that it is the agency care coordinator's just write all kinds of things in there or the benefit of the agency to pad agencies budget or whatever. They don't really need those services. She said that she doesn't know. Steve said that if people are interpreting it like you are saying Kathy, it better not be in there because

you can't represent it for anything. Zip, it is all out. Kathy said that she would be very concerned. If that were a state care coordinator, I would be even more concerned. Teresa commented that a lot of times, people don't have anybody but their care coordinator. Kathy said that if you are going to exclude from 5 care coordinator or care coordination. Steve asked if you could say to better define that, what that gain is? If it includes something what like they mention here either higher waiver or continue at an agency, we don't support that. We think it is the people's right to do that part. If you think about it, if you are going to continue with our agency that means more money. The money is an A&G if there is any and A&G doesn't change, maybe a higher percentage of it, but most of that is going to if the client wants more of this or that or he needs something. Steve felt that it needs to be clarified like Kathy said. Teresa said that she didn't know how you would clarify it. Kathy said that she would ask how conflict of interest, the employee agency or an employer may not represent a participant at any hearing or appeal process if the decision could result in personal or financial benefits. Steve comments about the last 4 words. Teresa said that she though back to all of the people she care coordinated for, I did social security hearings with them, I did adult public assistance hearings, if their services got changed and they didn't like it, I helped them with those hearings. And they couldn't have done any of that without me because my paperwork was a substantiating factor in those. Kathy said that the care coordinator, truthfully has an obligation. Maybe they mean this in the clearest and most upright way, personal or financial benefit but I just would worry if I was an internal care coordinator and showed up to testify, being told that I couldn't testify. Of course that would be a nice lawsuit. Ric agreed. Kathy said that she didn't know if they wanted to maybe ask for more clarification. Steve suggested that they tell them what the group objects to. Kathy said our concern about intern care coordination, if that would be seen as one example. Teresa asked if we could just exclude the care coordinators from that. Then you would be okay because that is really the person who would end up doing that. Kathy commented that if you excluded care coordinators and I was a senior care coordinator and I was going to benefit by having you only attend so many Dayhab days because the provider agency that does the day habilitation program or the residential assisted living home only gets paid if you are in there so many hours, there could be conflicts if you had an unscrupulous person even with the independent care coordinators. I wouldn't want to say to exclude care coordination, I would just want to make sure that we are really talking about

people who are going to have personal or financial benefit. Steve said that is how they define that. Kathy asked if we just leave it alone and take the high road and assume that and the first time it gets addressed, then we sue their butts. She said I don't know. Steve felt that he would go with the legal one on this.

She said they are not permitted to represent at a hearing, appeal or results in financial benefit. Kathy asked where that was and Teresa said it was under conflicts of interest. She asked if continued services are a financial benefit. The provider gets paid, I think that is their question. Steve felt that he would go with that in lieu of saying nothing. Kathy agreed.

Teresa – let's move on to health safety welfare. Steve said number one, once again, what the heck does that mean? Teresa questioned the any/all phrase. Steve asked, does that mean, I get a cold, I get a sore throat, does that mean that? Kathy said, they are getting that nit-picky and I can talk long and hard about when can you give Monistat, when can you give Tylenol? She said really and truly, they are getting that nit-picky. Ric asked if they have to report when the client sneezes? Steve said maybe or maybe if you sneeze more than three times. Steve felt that we have to respond to that one. Otherwise, that could paralyze the system. Teresa felt that they need to add the word significant. Kathy commented that with someone like Kara, because Kara is non-verbal, you would want them to say, hey Kara is not acting her typical self, something is going on. Is she sick, did something happen? Teresa commented that for Kara, that would be significant, but for Ric, that is not significant. Steve asked who needs to know that. His parents? Do they need to know, or does the state need to know? Teresa stated that it says the care coordinator and/or representative. Kathy said that you need to contact the care coordinator and parents if Kara is not doing well. She also maybe she needs to notify Tonja who does the behavioral stuff. Teresa comments, say if Ric is walking down the hall and falls and he gets a scuff on his forehead. Kathy said call the hospital and let them know that he is coming. Teresa said it could be, because if Ric never falls and he totally fell, but if Ric falls all the time, I don't know. Carrie asked if we just need to add the word significant. Steve, Ric and Kathy agreed. Kathy said that she thinks the word significant is important because we all have changes in our attitude and our behaviors based on I had a bad day or I didn't like that driver cutting me off or whatever. Teresa said that normally all of the people who care for Kara sort of chat with each other to

say what is going on. She said she was thinking about the one where the lady wouldn't eat and it was because she had a cracked tooth. They did a whole behavior intervention, meanwhile she has a cracked tooth and nobody looked for the cracked tooth. She won't eat this food, she won't eat that food, she won't eat anything cold, well of course, she has a cracked tooth. To me it was common sense. Ric talked about sometimes you just have a bad day. Kathy said, yes, sometimes it is just leave me alone today. She also said it is true, but you are under a microscope and we are in such a huge medical model system now that people can't be free to be people. Ric said that everybody is different and maybe we should not be in the medical model because we are all different and we all have our own lives to live. Kathy said that is why we have waivers and waivers are so that you don't have to be in a medical model. She said that is not the intended purpose but that is what is turning out.

Participant Rights – Teresa seems okay. Steve said that it says it should apply to the client and/or their personal representative. That was the basic comment. Teresa said that under participant termination of services, I think we will add our comments that we added before because it doesn't really say that you have actually tried to do some behavior analysis. Steve agreed. Kathy said that what she would think, personally if they tried to terminate me for service because of my disability and my behavior because you are not supporting me in a way that I can be successful, that is a violation of ADA because you are not providing me with appropriate accommodations. There are any number of things that if providers just said I don't want to provide services for you, I don't like you. Kathy felt that it has a lot to do with Alzheimer's patients. They take them to PPR in legal. They won't come pick them up.

Teresa said one done and one more to go!

Care coordination – Ric asked if the group was going to get all of the work done today. Teresa said no. She said they had sort of put them in order of what they thought they should go through first.

Kathy asked if this has been in practice, always, the whole thing about oversight or care coordinator or administrative care coordinators. Has that always been required in the past? Steve said not that he knows of or he can recall.

Teresa asked about day-to-day, does that mean every day? To me that means every day. She felt that you could just take out day-to-day. The management of the program including the following. She felt that it is a very long list. Kathy asked about monitoring the amount, duration and scope of service to ensure delivery as outlined in the service plan. Assessing whether the services assist the participant to obtain goals. Steve said that now you are dancing with the medical model for sure. Kathy comments about evaluate the quality of care rendered, develop corrective action plans for identified problems and deficiencies. Teresa said that for that one you could just say document. Steve asked if they mixed this up with care coordinator. Why the administrator? Seriously. Carrie asked if this was a duplication. Steve said that if you really wanted to get into center versus planning, you could really get into it because the individual and/or the family have the right to say I would like the administrator as a part or my team or I wouldn't. Kathy said exactly. Steve asked why it required is. He said you can make a case for the care coordinator because it is a required service, but why an administrator? Teresa asked what if you don't have a care coordinator or an administrator? Like you are small and you don't have care coordinators. She asked if the state has an administrator. Kathy said that she is sure they do because they have care coordinators. She said that she can't help that I honestly have my suspicions of what the state does and what their intentions are. I never used to have that and I truly do now. I question their motive and I think it all has to do with money. She said it is not about whether or not you are getting the quality of care that you need. It is about are you getting too much. She said again, it is that medical model and it is more and more and more about layers and checks to make sure you aren't doing something bad. You might be taking advantage of something.

Teresa asked, so what about if you that this whole section and you have a comment that defines it at the beginning that says if you have an agency that has X number of care coordinators . Kathy asked if there was a cut-off and if there was, what would the cut-off be? And if you an agency like Hope, then you have offices around the state does that mean you have to have a supervisor at every site or is it like you say for every 10 care coordinators, you have a supervisor. Teresa said that to it would make more sense. Kathy said that it is micro managing agencies. Carrie said that she is sure that every single agency has their own process. Kathy

suggested that they put duplication and micro management. Ric agreed. He wanted to know why he has to have a care coordinator. Kathy said that if they are working for an agency and they are not doing their paperwork or they are not doing what they are supposed to be doing, then the agency will pick that up and they will address it and they will deal with it. She said if it is care coordination that it is independent then the family and the agency providing support will pick it up and it will come to light if they are not doing their job. So why do you need a supervisor? Teresa said that it is just another layer. The qualifications are pretty rigid. Where are you going to find someone to do that say in Dillingham? Carrie said that she felt they did need to make comments about that section concerning rural areas. Steve said that it smacks of a cultural bias. He said that gets people's attention sometimes. Teresa said that a lot of times a lot of people in a small community you get hired on experience. If you have been a care coordinator for XYZ years you could then supervise care coordinators.

Care coordinators – Carrie said maybe the same kind of comments applies as far as requirements. Ric asked why they are doing this now. Why didn't they do this 10 or 20 years ago? Carrie said that she thought they were required to from their directive. Teresa and Kathy said they were sanctioned. Steve said he felt we were involved in writing. Kathy said she was sure that we had a lot of input in that. Steve said that we knew we would pay for it and we said it back then.

Kathy said that a lot of this is just a repeat of the requirements from earlier. Teresa suggested that we just move this to the first one. Move this whole section and mesh them altogether. It really doesn't have anything particularly to do with care coordination. Teresa said that everybody should have a system to make sure that stuff gets in on time.

Kathy said that the back-up care coordinator may provide combined services for no more than 14 days if the additional work load results in responsibilities for 40 or more participants. She asked if we are talking about micro-management. She felt that this was telling agencies how to do their business, how to run their agency instead of saying we expect good service, go forth and do. Ric asked when they would use a back-up care coordinator. Kathy responded that agencies will, say if somebody is going to go on maternity leave and be gone or whatever. They will share their caseloads with other people. She said that she would want them to do that,

they have somebody trained to fill in. There is a process where they say, here is what you need to know about Kara, here is the nitty gritty. Agencies couldn't function if they didn't have that. Teresa said that something that isn't addressed in here is the exchange of information. The person needs to be brought up to date. Kathy asked about the 14 days, does that mean that I have to get a new care coordinator because my care coordinator is on maternity leave for 45 days? If they are on FMLA, do I have to get a new care coordinator? Teresa suggested that they take that entire section out. Kathy commented that she thinks we need to say that you are taking away the rights of the individual and family in choice and you are putting limited restrictions on agencies telling them how they need to function. What you really want is good outcome and good care coordination. Ric felt that we needed more explanation on those things. Kathy said that she didn't know why you needed more explanation because 14 days is ludicrous. She felt that there just needs to be a process so that if somebody is going to be gone, that the individual is receiving care. Teresa asked if your care coordinator interacts with you every single day. Ric said no. Kathy said no, not unless they need to. Teresa said that Anna never hears from hers at all.

Teresa read the provider may not make a claim for reimbursement for care coordinator services until the services have been rendered. Kathy commented that is Medicaid. Teresa asked why would they even have to say that? Why would you even expect to be paid for something that you haven't done yet? Is there a situation that I don't know about? Kathy asked if you can bill ahead. Steve said that he could almost see taking that one out from the rest. He said that he could see providers inadvertently billing on a monthly basis or whatever and then oopps, we didn't provide it.

Teresa read that monthly case management cannot be submitted until the first day of the month following the month in which the services were rendered. She felt that made sense if billing for a monthly flat fee. She said that some of the schools got in trouble because they had an IEP and it said OT/PT Speech and they were billing Medicaid for those services and then somebody came in and monitored and the kid was out sick but they just billed by however many number of sessions and the person wasn't even there. So I can see how that kind of a situation could cause a problem. Kathy said that is why with Medicaid you are only allowed to after the service has been provided. Steve said that there are systems where you can bill perspectively, the grant based ones.

Participant relationships – Teresa commented that it seems fairly straight forward. Kathy commented that she thinks B happens sometimes on the nursing side, on the assisted living side, for seniors. Ric asked where are you? Teresa responded they were on conflicts of interest. Kathy said under participant relationships, A1, B. Kathy said that when her mother went into an assisted living home, she had been going to Dayhab services and they said she can't do Dayhab services every day. The care coordinator told her she can only do 2 days a week or 2 half days a week. It had to do with the assisted living home being able to bill what they wanted to bill and if they were in Dayhab for more than that, they couldn't bill for that amount, so the care coordinator tells us that we are not allowed to do that and that wasn't really true. That was the home. So I think some of that goes on whether it is intentional or people don't understand.

Teresa asked what does 2 mean? That I can't sell you AMWAY? Is that what that means? The care coordinator man not offer, promote or sell products or non program services or engage in any commercial transactions without written permission from SDS.

Teresa commented on 3 – I think the comment that they made is good. Everybody should have a grievance procedure or process, you don't have to have a separate deal for this particular thing. Steve and Ric agreed.

Teresa commented on the first item under B. The care coordinator must meet in person at least once a month for each service environment for the plan year. That means that Anna's care coordinator has to go to the dentist one time and her work one time, her doctor, my office, UAA. Kathy said that she understands maybe wanting the care coordinator seeing the person in different environments but it needs to be appropriate and agreed upon by the individual. Say, I can meet you at my office at 5:30 or whatever. Ric said it should be up to the client where you should meet the person at. Teresa suggested that we say the participant or the team because some people are not able to tell you where. Teresa said that is another thing that happens with Anna, it is always at their office.

Teresa said she thinks there needs to be something in this section, maybe a D, under 2 and document if changes were needed, document that changes were made. Anna has told her care coordinator several times I

want you to do this or that and the next time we come, we are we want to this. She wants to have monthly meetings and they don't do it. She said that when the conversation is about is everything going right, do we need to make any changes? If changes need to be made, did you do it or how you did it. Teresa said that she is no longer invited to attend all of the meetings with the care coordinator. Kathy said that if you really wanted to enhance the outcome for people's plans of care, you would have at least a monthly team meeting. Kara has a monthly team meeting and that is our opportunity to say here's things you are doing really well here, lets add a new something or things are not going so well, let's back off a little bit. Teresa said that is what we used to do and now they have Anna and her care coordinator meet and nobody else.

Care coordination goal – Teresa asked why do they need this? Kathy said that there was something back a ways that she wanted the group to talk about, on page 3. Under quality management service plan tracking systems. Under A2 – address all needs identified in the participant's assessment. Kathy said that is huge. First of all, it is overwhelming when you have somebody who has significant functional issues, to say that you are going to address all of their needs identified in this assessment. You are going to pick and chose what you are going to work on. Steve asked what does it mean that we are going to address? Does that mean that we are going to prioritize these for the year? Which would make sense to some degree. Kathy said that you note them in your assessment and you note them under the ICAP domains, there are all kinds of stuff in there that talks about what is wrong. We shouldn't have to address all of the deficits. We are choosing to work on XY&Z this year or this quarter. Kathy said that the other thing she doesn' t think this address is from Ric's perspective, somebody who can direct their own lives is what is important to me not what somebody else thinks is important for me. She said that is a whole nother senario. I've had a couple of other people tell me they are wanting them to address more and more goals and more and more things in their plan and for people like Kara it actually is detrimental to try to put too many things in there. She feels that is the danger of having something like this in there as a policy in there rather than a regulation so that the idea is that yes you know there are deficits there, you are recognizing them to see them. You are not not addressing them because of financial issues, you are not addressing them because they are not a priority for this year. The family or individual does not want to at that time. Kathy said that this does not read

that way to me. Steve said that it could be interpreted in many ways. Steve said that the Feds can come in and say, it doesn't matter what Ric wants if he has 8 specifics, like the ICLF days if it were like the person were not toilet trained, they could say we don't care if it is medically impossible, you still have to work on it. Kathy commented that it is like telling her that she needs to go the university to learn to be an accountant. I could go every day and it wouldn't make any difference, it would never happen. I'm not going to learn it. Teresa said that what is really interesting is like Infant Learning Services have gone from the medical model where they do an assessment and they fix all of the things that are wrong to now they have to go and meet with the family and they say what do you want to work on? The child might not be able to speak correctly but the family wants to learn how to go out and eat in a restaurant. It is huge. It is very difficult, providers are really having a hard time and that is the same kind of deal. It is like Kara might not want to learn to read, she can't read, but so what? Or she might not want whatever it is. Kathy said that she might not want to ever be potty trained – 30 years of diapers, I'm telling you, I'm beginning to wonder if it is ever going to happen.

Service Plan Development – Teresa read, planning team integration or program services. She didn't see a whole lot but one of the things that I added was the care coordinator must deliver copies of service plans to all team members and providers instead of just the providers. Kathy said that she didn't know if she wanted everybody to have copies of Kara's plan. It was like when I was on a board of directors of an agency and they would give me the financial stuff, I didn't want to take that home. I just wanted to have it to look at there and I wanted to leave it there because I didn't want to be responsible. Teresa asked who would you not want to have it in the plan? Kathy said that if they are already in the plan, they should have access to the plan or Kara anyway so I wouldn't just want it out there so that if somebody is caring it around and it gets left at a coffee shop or in their car. I know it might sound kind of silly, but I don't want them out there. Teresa asked, so would you change this, so the care coordinator must deliver copies of service plan to all providers of service that are included in the plan. Kathy said that she didn't know. Teresa suggested, as determined by the team members. Kathy said that it goes to the agency and you share the information that is pertinent for the people to have in their plan of care for the direct service workers who are working with Kara. They need to know what her goals are, they need to know what the plan is, they need to

know what the activities are and that is what they need to know. Teresa commented that it says they must deliver copies. Ric asked what happens if you have 5 different direct care services? He said that he doesn't want them all to know the same information. Kathy responded she is always concerned about information floating around. That is one of the reasons that she hates ICAP. It says that Kara is 22 months old. Teresa asked about HIPPA. Carrie responded that all they had to do was sign the HIPPA form. Kathy said that she didn't know if there was any way of getting around it because we live in a glass ball of information when we receive federal funding and state funding. Teresa said that if she is getting services from Hope and she is going to ARC for Dayhab at the ARC center, they are going to need a copy of the plan. Kathy agreed that they need a plan for their Dayhab. Carrie said that they only need the applicable portion of the plan. Ric agreed. They don't need the whole thing. Whatever is appropriate for them to have. I just think that there needs to be some thought and discretion. Teresa said that the other opposite is she shows up and nobody knows what she is doing. And the person who is driving her in the car doesn't know that she might jump out of the car. That is your other scenario. And you aren't going to correct an agency that isn't doing what they are supposed to do. You are not going to correct that with this. It's not going to get down to that level.

Service Plan Implementation - Teresa said we are probably only going to get through 2 today. The comments on this one were – the care coordinator was supposed to teach the participant and the family how to evaluate the appropriateness of services should the plan not include the evaluation of the care coordinator. Would that be a conflict? Are they supposed to make the appointment for everyone? I think they are being sort of nitpicky. So the care coordinator only has to contact the participant once a month, they don't have to meet with them? Kathy said it depends on where you are. If you are rural you have much more leeway. Teresa said this says they only have to contact them once a month. Ric thought that they have to call them and see them once a month. Teresa said that isn't what the document said. Carrie said that was a face to face once a year. Teresa read the care coordinator must contact the provider of services every 3 years, contact the participant at least once a month. Carrie said that there was the thing we just went over about the one year in person meeting, She asked if we need to add something about rural areas or is that already taken care of? Teresa said there was the visit in all settings. That was in person with the

participant at least once in each service environment in the plan year. It says in each service environment during the plan year. Kathy asked where the corresponding comments are. Teresa said Page 4Bm Participant Contacts. Teresa thought that they should have a minimum of 4 times per year. Even thought might not be feasible. Having a care coordinator meeting in person with somebody. Steve agreed that monthly is tough, especially in the villages.

Kathy said that she thinks this is where they need to talk about the whole thing that Hope has the Cisco Service System where you can actually see the individual and talk with the individual or the team without being physically present. You are not going to be in all environments but it certainly is a way to have more contact with and be able to read people's body language. She feels that the telemedicine piece is so important because it really allows you to see the person. Teresa asked, but what about the village that doesn't have internet? Kathy said that there are not very many that don't have a school, clinic or a library. Teresa suggested that maybe it should be once a month visual contact or something and there be some kind of exempt out or something. Kathy agreed that it can be really expensive, but if you are really talking about quality assurance, and accountability, shouldn't the state be doing site reviews at lease to rural communities where you don't have access to care coordination? But instead, we are responsible for making this happen.

Teresa suggested monthly visual or in person with exception for those areas that do not have internet. There should be an option of some kind.

Residential – this is what we used to call in the old days supported living, where you came in and you came to the community living center where the services and you would help people to get them to live in their own places and such. Teresa said, let's look though this and skip to Dayhab first. Teresa liked the comments. You can have one staff for eight participant or four participants, but if you have more than one participant, you have to have two staff. So if you have 2 participants, you would have 2 staff but you wouldn't need another staff until you have 16 participants? Steve said that is one of their big concerns, where do they come up with the staffing ratios. Teresa asked if we even want them to have ratios. She also commented, that it is not for DD, it is for assisted living. She said that the whole thing about at least two staff must be present when one must be certified in CPR

and first aid, but when we were doing the other one, all staff had to be certified in CPR and first aid. Carrie commented that this is in a group setting so there are multiple providers rather than just one on one. Teresa quoted anther section where each direct care worker must have CPR and first aid training. Carrie said that it should be that every employee there would be the same as every employee at a Dayhab facility, right, cause they would be an employee. Everybody agreed that it did not make any sense.

Steve said that one of the big things is transportation. The suggestion is easily interpreted that the provider must transport participants to all settings, so they must and the transportation provided by the DH Services must comply with transportation services conditions of participation. You go to them and then with reference back to here you are going to find out that you are operating a transportation system. Teresa said so that means that instead of doing a coordination of transportation, each agency has their own. Steve said that is where a lot of people are interpreting it as. Kathy said that goes against everything. I had one program call that was doing day stuff and they said that if this is the interpretation and they were going to enforce it, we will shut down. We can't do it. I don't know how we would do it either, off the top of my head. Transportation system? So this one we are very concerned about. It will shut certain programs down, we believe. Kathy asked if it would jeopardize Hope. Steve said sure it would. Teresa said just imagine, a hundred people coming and going every day at different times to different parts of town. Are you kidding me? That is different than say Anna going out to the Cultural Center with Annie. That is appropriate that she transports her out there. Ric commented that he was interpreting that transportation might be included in Dayhab. Steve was concerned that it might be. Where, when, how?

Kathy commented on Age Appropriateness, under C, my mother, who had dementia, towards the end, liked to sit and color. She loved crayons. My Kara, while she doesn't really like to color, she likes to do little puzzles. What is age appropriate? When you talk about Kara and what she enjoys, she is never going to be age appropriate, in all regards. Ric commented that he wants age appropriate items and Kathy said that he is going to demand that he has age appropriate items. Ric said that there are some things that he is not allowed to do based on his age. Kathy said that on one hand she wants you to treat her like she is an adult because she is but if

she likes to sit down and color or watch the same Dora the Explorer over and over again, then whose business is it. Carrie suggested age appropriate for the individual's preference. Teresa said individually determined by the team. Carrie said so let's take out age appropriate. Teresa thought the key is that it needs to be individually determined. Kathy said that felt it is dangerous to say age appropriate because there are segments of this world that for them, it is appropriate.

Carrie asked about Transportation – do we have a blanket statement for this? Transportation provided by the Dayhab service program must comply with the transportation service conditions of participation. Steve said, yes, it is a transportation system. Teresa said that we should get rid of this whole section. Steve said that if we read that correctly, and he thinks you can argue whether they mean it or not, they are going to require people to provide that kind of a transportation service. Forget it, it is over. Teresa said and you would have to have a transportation manager.

Kathy feels it is funny because for years we have heard that there are too many levels of management in provider agencies and now they are telling me you have to have management for every service. Steve asked who will be the manager who will tie in the DD services that are now fragmented over X number of divisions. Nobody. Teresa said that transportation is very serious. This is only appropriate to coordinated transportation. Steve said that we have reason to believe that this will shut down certain Dayhab services if this is enforced as interpreted.

Ric asked if anybody was still on the phone. Kaleene answered that she was still on the phone.

Kathy asked if the group could go back to Dayhab services, and residential supported services. Dayhab – provider must provide services 4 hours or more one or more days a week on a regularly scheduled basis. Ric asked if it was four of more hours per day but you can only have 15 hours per week. That does not make sense. Teresa didn't understand why you have to offer four hours a day. Why don't you offer what is appropriate for the group of people you are working with? Kathy said she thought why they do that is because under senior day habilitation services, they do them in those units. Steve said here is where we hit the real medical model too, develop and maintain the monthly activity calendar. It must be posted.

Kaleene said that she had to go to take another phone call.

ADJOURN

The meeting adjourned at approximately 3:55 p.m.