Frequently Asked Questions
July 1st 2013 HCBW Regulations
7AAC 130
(Revision Date: Aug 21, 2013)

General Information

Where can I see a copy of the new regulations?
A link is located on the SDS web-site face page in the Headlines section dated 6/3. Another link is located in the right margin under the "Of Interest" header.
http://dhss.alaska.gov/dsds/Pages/regulationpackage.aspx

Are these proposed regulations?
No, they became effective July 1, 2013.

Where can I see the Conditions of Participation (COP's)?
A link is located on the SDS web-site face page in the Headlines section dated 6/3. Another link is located in right margin under the "Of Interest" header.
http://dhss.alaska.gov/dsds/Pages/regulationpackage.aspx

Are the Conditions of Participation proposed or are they also effective 7.1.13?
The Conditions of Participation are adopted by reference in the new regulations and consequently have the same authority as regulations. They are also effect July 1, 2013.

What are the new waiver types/names?
ALI= Alaskans Living Independently (formerly OA and APD)
APDD= Adults with Physical and Developmental Disabilities waiver
IDD= Intellectual and Developmental Disabilities waiver
CCMC= Children with Complex Medical Conditions waiver

Who can be a paid provider? What immediate family cannot provide paid support? What family members can provide paid support?
Anyone who has a legal duty to support the person cannot be a paid provider. Examples include a spouse or guardian. For guardians, an exception is made in cases where the court has indicated in guardianship documents that the guardian can be a paid provider.
Immediate family members who cannot be paid supports are a spouse, minor siblings of the recipient and a parent or guardian of a minor child. 7 AAC 130.319 (8)

I have recipients that were using the APD waiver but do not have an intellectual/developmental disability. Which waiver will they now have?
The Alaskans Living Independently Waiver (ALI).

How do I email items to SDS?
Make sure you are using your DSM (Direct Secure Messaging) account if you are sending attachments with protected health information. Secure communication is available through Alaska Health Information Exchange. All providers may request a DSM account through the Alaska eHealth Network (AeHN) at 1-866-966-9030 or email info@ak-ehealth.org.

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Adult Day Services

Are providers permitted to bill the rate listed in the new rate chart for the Adult Day half day? It's higher than the old rate.

Yes, effective July 1, 2013, providers will receive the new rate for Adult Day services. The practice of billing for "two half days" is no longer allowed. Providers may bill for a half day that consists of 1-4 hours of service. For services that exceed 4 hours, providers must bill in 15 minute units up to an additional two hours per day. The maximum reimbursement for Adult Day Service from all providers combined may not exceed 6-hours per day.

Why are the Adult Day services capped at 6-hours a day?

This is not a change in the total hours of Adult Day Service that may be reimbursed in a day. Previous service provision allowed up to two "half days" which were three hours each, or a total of six hours. While recipients may remain at an Adult Day center longer than six hours, Medicaid reimbursement is only available for a total of six hours in a day.

7 AAC 130.260(b)(2) states that Day Habilitation includes transportation "if the recipient's plan of care reflects that transportation will be provided by the day habilitation services provider." Does the word "if" mean provider agencies are exempt from providing transportation if the recipient's POC states the transportation will be provided by other means?

Providers of Day Habilitation services are first and foremost responsible to include transportation as part of the service in all environments per 7 AAC 130.260. SDS recognizes that there are instances where recipient parent/guardians prefer and choose to provide transportation to and/or from day habilitation activities. For cases where parents/guardians are making an informed decision to provide transportation, the POC must document that choice. Under no circumstance should a provider make or infer that private transportation of the recipient is required in order to receive day habilitation services.

Environmental Modifications (EMODS)

What is the new cap for EMODS?

$18,500.00 for each 36 month period starting July 1, 2013

If a person has some of the previous regulatory allowance of $10K left on July 1, is that added to the $18,500?

No. EMOD services for all waivers will start over on July 1, 2013 with the amount of $18,500.00 available for recipients regardless of the status of any prior modifications made. Currently authorized EMOD's that have not yet begun do not need to be re-submitted.

I noticed that there are no regulations stating that EMODS require cost estimates. What is the expected procedure to request an EMOD?

SDS is developing *Conditions of Participation* to address cost estimate requirements that will mirror the previous process of requiring three cost estimates for EMOD requests of $1,000.00 or more. The plan for SDS to take over the administration of EMOD's is not yet implemented so care coordinators are still responsible for the administration of the EMOD process.

If an individual leases an apartment from a HCB service provider and needs modifications (lights/vibration) for a smoke detector, can they request this through the waiver?

Per 7 AAC 130.300(j) (2) Environmental modifications, EMODs are not available to a residential facility that is owned or leased by a home and community based waiver services provider. Since leasing an apartment from a HCBW provider means that the provider owns the property, EMODs are not allowed. However the adaptive

device described (an accessible smoke detector) is not an environmental modification nor is it considered specialized medical equipment. It could be available as part of the rental agreement to the client to meet ADA requirements (outside the waiver services). These types of devices are readily available on the shelf in home improvement stores.

Care Coordination (CC)

In this transitional period, I have an example in which the care coordinator has submitted the renewal plan of care 30 days before the expiration of the previous plan of care, and the client has an assessment after that. What if the client does not meet level of care at that point? Will the care coordinator be paid for creating the Plan of Care? What happens next?
The care coordinator will be reimbursed for the renewal Plan of Care. If there is already a Plan of Care submitted and the client subsequently is assessed and enters the material improvement review process, SDS reviews the Plan of Care as part of entire client record.

How will the care coordinator know what the "set plan of care" dates are for his or her clients?
Set Plan of Care Dates will be indicated on the Care Coordinator Status Report sent by SDS.

Regarding the E-Alert that was sent out on June 13th, (CC & Related Form Revisions), it states that new regulations prohibit a care coordinator from providing any other home and community-based service while providing care coordination services. Are CCs prohibited from providing any other service entirely or are they prohibited from providing any other service to their specific clients?
A care coordinator who has been appointed by an individual may not provide other home and community services for that individual but may provide services other than care coordination to recipients who have not designated him or her as their HCBW care coordinator.

What training is required for care coordinators?
All care coordinator applicants for initial certification must complete Basic Care Coordination training and Critical Incident report training. After one year of certified care coordination experience the care coordinator must repeat the Basic Care Coordination course. At any time after certification, a care coordinator can take the Plan of Care Workshop. To recertify after 24 months of certification the care coordinator must complete any one form of Care Coordination training – Basic, Advanced, POC Workshop, or the Self-Paced Basic Care Coordination course with an exam score of 80 percent or higher -will qualify a care coordinator for recertification.

Will there be new plan of care forms for all HCB waivers?
The new Plan of Care form is now required for all waivers. It's currently available for download/use on the SDS website face page in the right margin under the "Of Interest" header, in the "Approved Program Forms" section.

What recipient identification numbers, if any, are carried over from OA and APD to ALI after July 1st?
SDS will continue to use the same SDS ID number on documents. All SDS ID, CCAN and Medicaid numbers will remain unchanged.

Are all providers expected to sign the Plan of Care?
Yes, providers with the following exceptions must indicate agreement to provide the services included the Plan of Care by signing it. Multiple signature pages are acceptable. Specialized Medical Equipment (SME), Intensive

Active Treatment (IAT), Environmental Modification (EMOD) providers may indicate agreement to provide their services on a different document such as a signed cost estimate for SME/EMOD or a treatment plan for IAT submitted by the provider to the care coordinator as part of the planning process.

Which providers need to sign the POC Amendment?
Providers of new, changing, or ending services must sign the Plan of Care Amendment. With the exception of providers of Specialized Medical Equipment (SME), Intensive Active Treatment (IAT), and Environmental Modification (EMOD) who indicate agreement to provide services on other documents such as the cost estimate for EMOD and SME, the treatment plan for IAT provided to the Care Coordinator as part of the planning process.

Do all waivers need to have a planning team that meets in person?
The care coordinator must consult with the planning team. This could include in person meetings, but other ways to collaborate are acceptable, e.g. by telephone, or through email. All recipients must have a planning team that consists at a minimum of the recipient, the recipient's legal representative if applicable, and a representative of each provider who will be providing services on the Plan of Care. Exceptions: Providers of transportation, Environmental Modification (EMOD) and Specialized Medical Equipment (SME) are NOT required to be on the planning team.

Why would a meal provider need to be on the planning team and does the provider need to be part of a meeting?
A Meal provider would need to be part of the planning team as seen in 7 AAC 130.217 (2)(a) (iii) which shows the minimum planning team to include a representative of each certified provider who will be providing services in the plan of care. The Meals provider does need to be part of a consultation with the planning team which the Care Coordinator may hold in person, by email, by teleconference, or by videoconference.

As a Care Coordinator for a multi-service agency, can I sign the POC on behalf of my entire agency?
While the care coordinator cannot sign for services on a POC, a representative by a single agency can sign for multiple services if the agency has granted that authority to the individual.

Does the care coordinator send a renewal Plan of Care packet 60 days before renewal date?
No. The care coordinator helps the recipient to reapply for the waiver by submitting a Waiver Application for ALI/APDD/CCMC or the appropriate Interim ICF LOC or ICAP Assessment Information form for IDD waiver with supporting documents no later than 90 days before expiration of the current level of care. 7 AAC 130.213(c) New Medicaid coupons/stickers are not required however the recipient must remain eligible for Medicaid). New guardianship documents are not required if there has been no change from the previous year and the documents were previously submitted.

Is a screening still required for ALI and APDD? Is the screening form still section 1-3 of the Plan of Care? Yes, screening is still required. The screening form is incorporated in the Waiver Application for ALI, APDD, & CCMC waivers. This form is also used to annually reapply for ALI, APDD, and CCMC waivers.
http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx

Do current recipients need a new Plan of Care immediately based on the new waiver type name changes?
No. Use the new forms upon renewal. The care coordinator must use the new POC form and POCA (amendment) no later than August 1st. Forms already submitted to DSDS do not need to be re-accomplished unless updates need to be made or are directly requested by the department. We will accept the prior version of forms until August 1st, 2013.

Do the new regulations require two Care Coordinator contacts per month to include one in-person contact?
Yes. The care coordinator must contact the recipient twice a monthly with one contact being in-person. The other contact may be by other means such as phone call or email.

Are recipient screenings allowed every 6 months?
An additional screening can only occur if an applicant supplies comprehensive documentation of a material change in medical and functional limitations to their condition that is to the extent SDS would likely make a different decision. Other than these conditions an applicant maybe screened only once in a 365 day period.

What if the applicant experiences changes in his or her medical condition to the extent that he or she would likely meet NFLOC, and the screening was done less than 365 days ago? Does the applicant have to wait a year for another assessment?
No. The department will pay for another screening if a material change in the applicant's condition occurred and comprehensive documentation is submitted with a new application after a prior screening.

Regarding the new ALI/APDD Application which contains a statement that the care coordinator believes the person needs HCBW services: What does a care coordinator do if the person insists on receiving an assessment even though the care coordinator does not observe that the individual will need waiver services?
7 AAC 130.211(b) states that if a care coordinator conducts the screening, the care coordinator shall …. 7 AAC 130.211(b)(2) - provide to the department appropriate and contemporaneous documentation that (A) addresses each medical and functional condition that places the applicant into a recipient category listed in 7 AAC 130.205(d); and (B) indicates the applicant's need for home and community-based waiver services. Knowingly signing an application for someone you do not professionally believe would meet level of care for a nursing facility could lead to the sanctioning process.

Is it possible for a care coordinator to provide direct services and be reimbursed in the event of an emergency need for staffing?
Providers must have protocols in place to ensure services are rendered when regular staff is unavailable for work. The Care Coordinator cannot be part of a backup plan to provide reimbursed direct services. Nothing prohibits the Care Coordinator from providing unreimbursed limited coverage for services when the direct care staff is suddenly unavailable.

Since we are now working 90 days ahead of the next level of care duration, we are concerned that the Verification of Diagnosis (VOD) will become an issue. Some CC's have been told to provide a more current VOD. These can be difficult to obtain with physicians unhappy with constant requests. How long is a VOD good for concerning the waiver process?
The VOD needs to reflect the person's current diagnosis(es). While it is not possible to put a set expiration date on the VOD, because conditions and diagnoses can and do change quickly, the VOD should be no older than sometime after the date of the last LOC determination and needs to be reflective of current diagnoses at the time of application or re-application. It is possible that CCs are asked to obtain newer VODs because the one offered does not indicate newer diagnoses.

Supporting documentation is required for a screening. If the person tells us they have been in the hospital 7 times in the last year, are we to include information on each one of these or may we report what the client has told us?
If you are doing a screening it means this is a new applicant. The CC would have to report what the person tells

them and provide medical and functional documentation that is current. This includes providing all information about what the person is reporting, for example- the name of the hospital, the dates of admit and discharge, the diagnosis/condition, the discharge summary, medical reports- and any/all factors about the hospital encounter that supports the request for long term care services through the waiver. Include any functional and medical documentation that is available. Please be aware there is a new screening form. It is no longer the sections I, II and III of the Plan of Care. You will see that the CC needs to provide a statement that the need for long term care is observed by the CC.

Regarding Critical Incident Reports, may we say, for example, 4 Critical Incident Reports were made in the last year. Do we have to include these or can SDS look at their own state records to confirm these CIRs?
If you are referring to CIRs in helping a person apply or re-apply it means that the person is most likely either a PCA recipient, a General Relief recipient, a grant funded service recipient, and is applying for the waiver for the first time, or is a waiver recipient who is re-applying. It is not necessary to include copies of the actual CIRs. The CC should indicate the dates of the CIRs and what about the incidents supports the requests being made for long term care through the waiver.

For the Planning Team (page 11 of the POC), a category of "Natural Supports" is listed. Why would we include this information since they are not certified waiver providers?
Because the person may invite the natural support person(s) to be included as part of the planning team.

How are plans of care billed if the assessment is late and the plan of care is due?
The Care Coordinator can bill for one POC development per year based on the most recent level of care determination (even if that LOC has expired--as long as the case is not in material improvement review). Use the last most recent level of care determination to write the plan. Continue to request amendments as needed by the recipient. Prior authorizations (PAs) are extended until the next LOC determination.

What if the person did not meet Level of Care and is in the material improvement review process? Does the Care Coordinator just go ahead and create a new Plan of Care?
No. PAs are extended in this case until the material improvement review process reaches its conclusion. The care coordinator would not create a new plan of care until the decision is reached.

Do I have to do the re-application part of the ALI waiver if my client will be assessed in the next weeks/months?
Yes, for those renewing after July 1, create a reapplication using form found on
http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx
The recipient requests a re-assessment for their continuing need for home and community based waiver services. A reapplication is required per 7 AAC 130.213 (c) for ALI, APDD and CCMC, this is done on the form called "Waiver Application for ALI/APDD/CCMC." Please note that for CCMC, this form is used by the care coordinator only for reapplication to the CCMC waiver. For ALI, and APDD, this form replaced the "screening form" formerly in use.

Is SDS doing away with screening for the ALI and APDD waivers?
No. The Care Coordinator fills out the Waiver Application for ALI/APDD/CCMC form. This replaces the former screening form.

I understand that per 7 AAC 130.213 (c) that reapplication is required for all waiver types. Can the Care Coordinator bill for the re-application?
No. Reapplication is part of the ongoing Care Coordination service unit per 7 AAC 130.240 (c) (6)

What is expected for the required plan of care planning team meeting?
A meeting is best understood as an exchange of dialogue in which each participant is aware of and responds to the other meeting participants. Meetings typically include some form of agreement and/or action items. The team may meet using email, phone, videoconference or a face to face meeting. The meeting should be documented so that attendance and interaction is recorded. An example could be meeting notes, or email records.

What does "yes" and "no" mean on the ALI/APDD Application/CCMC reapplication as found here:
"7 AAC 130.217 and 7 AAC 130.240 protects you from conflict of interest by putting definitions around who can serve you as Care Coordinator. Has your Care Coordinator informed you of any employment or family relationship to a certified provider agency (per 7 AAC 130.217 (1)(A) ?
Applicant please initial"

Yes_____ No _____

This is how the person indicates that they were informed by the CC of any familial/business relationships to a certified provider so that the person understands that he/she has choice between and amongst providers. "Yes" means the applicant/recipient has been informed of the CC familial/business relationships with HCBW providers. "No" means the applicant/recipient has not been informed of the CC familial/business relationship with HCBW providers.

Nursing Oversight and Care Management

Can any nurse become a provider of Nursing Oversight and Care Management (NOCM)?
A nurse providing NOCM needs to be licensed in the State of Alaska, and employed by a Home and Community Based (HCB) waiver services provider. The NOCM nurse should have a background in developmental disabilities- a DD Nurse. Training is available to nurses who are employed by HCB Waiver agencies and who would like to provide the service of NOCM through the waiver. Contact SDS Assessment Unit 907-269-3666.

Can Nursing Oversight and Care Management (NOCM) be requested for all waiver service types if it is justified in the Plan of Care?
No. 7 AAC 130.235 requires NOCM for individuals with the CCMC waiver; NOCM is available to those who have the IDD waiver when they also meet the criteria for the recipient category of CCMC (7 AAC 130.2050 (d) (1) except for age. NOCM is not currently available to those with the ALI and APDD waivers

Chore

7 AAC 130.245(c)(3) states, "The department will not authorize chore services if…the provider that is certified under 7 AAC 130.220 to provide a chore service resides in the same residence as the recipient of chore services."
The restriction under 7 AAC 130.245(c) (3) does not prohibit an individual from receiving chore services when a caregiver lives in the home; it only prohibits payment of that resident caregiver for chore services. Resident caregivers *(other than legally responsible relatives)* can still be paid to provide services under personal care services (PCA), and nonresident caregivers can be paid to provide chore services under HCBW.

Day Habilitation

Will an agency already certified for Day Habilitation need to apply for certification to be able to do both group/individual day habilitation or will there be some sort of automatic enrollment?
An agency already certified to provide day habilitation services may provide both group and individual services.

For current active plans of care, (active prior to July 1, 2013) are amendments required to separate and identify "group" vs. "individual" day hab. service units or will this distinction be made after July 1?
No amendments are needed. The provider must indicate which form of day habilitation was provided and request reimbursement for services accordingly. Upon renewal of the plan of care after July 1, 2013 the care coordinator must request the specific form of day habilitation, group or individual, with the expected frequency, scope and duration.

When preparing plans of care, it's sometimes hard to estimate the percent of individual vs. group day habilitation. For example, many individuals have health problems and emotional difficulties that impact when they need 1:1 day habilitation. In some cases, people become more independent and can move into group day habilitation. Is there a mechanism to transfer day habilitation hours between the two service options during the plan year or will there need to be an amendment each time needs change?
An amendment to current plans (submitted prior to July 1, 2013) is not required for the individual to access both types of day habilitation. Upon renewal of the Plan of Care after July 1, 2013 the Care Coordinator and other planning team members can refer to the documentation about the day habilitation service which was provided

for the recipient during the previous plan for information about how to plan this service going forward. The Care Coordinator must request the correct provision of day habilitation with the correct expected frequency scope and duration, differentiating between the two types of day habilitation - group or 1:1. If adjustments outside the approved amounts are needed for POC's approved after Aug. 1, 2013, the care coordinator will need to submit an amendment.

Is transportation from home to the day habilitation site and back home again required of the day habilitation provider?
While this requirement is not new, yes, round trip transportation from home to the Day Habilitation site is still included in Day Habilitation. Unpaid natural supports such as the family may choose to provide transportation to and from home to the Day Habilitation service. This choice must be documented in the day habilitation service section of the POC.

In the group home, the regulation states that services rendered by the group home habilitation staff, whether in the group home or in the community, may not be billed separately as day habilitation services under 7 AAC 130.260. Does this mean that persons employed by a group home cannot be employed to provide both group home as well as day habilitation services? Must these be separate employees of an agency or can they be employed in both capacities?
7AAC 130.265 (g)(2) says SDS will not pay separately as day habilitation under 7 AAC.260 for services (activities) that should be provided as group-home habilitation services, whether in the group home or in the community. This rule keeps a clear distinction between expectations that group home staff have already to include community integration as part of routine group home services. As a rule of thumb, group home staff "can" provide day habilitation on alternate days that they are not working as group home staff.

If a person is in a group home and they have day habilitation who is responsible for transporting to the day habilitation?
The day habilitation provider. However it may be in the best interest of service utilization for the group home to provide transportation to the day habilitation. It is acceptable for the group home to provide transportation in this case.

Supported Employment

If someone has a current POC with Day Habilitation and they are using it to work or look for a job, (something that would qualify under SE's new definition), do you want us to submit an amendment or just wait until the renewal POC is written?
Pre-Employment is a new service effective for use as of 7.1.13. SDS will expect providers to make the shift from day habilitation to the more appropriate Supported Employment services as plans renew after 7.1.13.

Since there are now group and individual services & billing codes, do we wait to specify which work situation they are in with the renewal POC?
The Supported Employment provider must bill according to the service delivery and document the correct format of service as of 7.1.13. Upon renewal of the Plan of Care after July 1, the care coordinator must specify whether Supported Employment services are for group or individual services, indicating frequency, scope, and duration. Use separate service request boxes for each service provision requested on the Plan of Care form.

Is volunteering still considered a pre-employment service? It is usually done during Day Hab. Volunteering is a day habilitation activity. Pre-employment consists of activities leading to obtaining a job for the recipient.

Is using the services of Division of Vocational Rehabilitation required before requesting Supported Employment?
Individuals must access supports and services outside the waiver before implementing waiver services. This is because the waiver cannot duplicate or supplant supports utilized by the person regardless of funding source. Waiver supports should complement other supports and provide continuity in transitions. According to 7 AAC 130.270 (c) (6) Supported employment services, " (c) the department will not pay for (6) a service that is available under a program funded under 20 U. S. C. 1400-1482 (Individuals with Disabilities Education Act) or 29 U. S. C. 730 (Rehabilitation Act).

Can Supported Employment take place in any setting depending on the person's employment goals?
From 7 AAC 130.270(5)(b) Supported Employment Services: The department will consider supported employment services to be those which prepare a recipient for work; provide support, if needed to enable a recipient to be employed, at a worksite where individuals without disabilities are employed; or the recipient is self-employed.

Does Tribal Vocational Rehabilitation count too instead of DVR?
Generally, yes. Individuals should use supports outside the waiver system regardless of funding source prior to and along with utilizing the waiver supports. Waiver supports cannot duplicate or supersede other supports.

Temporary Absence

Does temporary absence include a recipient in assisted living who is on vacation for 2 weeks?
No. 7 AAC 130.231 limits the services that could be requested while temporarily absent from the recipient's community to day habilitation, supported living habilitation, in-home support habilitation, hourly respite, and adult day services.

Transportation and Escort

Why are intermittent stops no longer allowed?
Under 7 AAC 130.290 (b) and (c), transportation is defined as a round trip between the recipient's residence and a service or community location. Intermediate stops are allowed, but cannot be billed separately by transportation providers.

Is HCBW transportation allowed only for medical appointments?
No. HCBW transportation may be authorized for travel to and from services/resources in the community. Transportation for medical needs is covered under regular Medicaid 7AAC 120.400 - 7AAC 120.490 and must be arranged and prior-authorized by the medical provider.

If a husband has PCA, can he be the escort during transportation for his wife, who has a waiver? Can they both ride in the transportation van, one as participant and the other as escort?
Yes. The husband could serve as escort if he can meet the definition of an escort as a person who accompanies a recipient in order to meet the recipient's mobility needs.

Can transportation be billed if the staff uses their own car?
No. According to 7 AAC 130.290 (4), the department will pay for transportation if it is provided in a vehicle that is owned or commercially leased by an agency that is a home and community based provider agency.

Who can transport and what can be billed for getting children to medical appointments if parents cannot?
The Early and periodic Screening, Diagnostic and Treatment Program (EPSDT) can assist with this type of transportation. http://dhss.alaska.gov/dhcs/Pages/epsdt_hcs.aspx
This transportation to and from medical appointments would be billed to Medicaid (regular Medicaid rather than Home and Community Based Waiver Medicaid). Inquire with Xerox for additional information: (800) 770-5650 or (907) 644-6800 (Recipient Services).

Could you please clarify the codes on the overview for Transportation. Beside the code T2003 there are two added letters, TN and CG. Can you tell us what this means? Also what does Paratransit mean?
The codes are modifiers for trips that are either up to 20 miles or greater than 20 miles in length. You can see all codes for the Home and Community based Waiver and PCA Services here:
http://dhss.alaska.gov/dsds/Documents/pdfs/PCA-service-waiver-rates201307.pdf
Paratransit means a government (such as a municipality or borough) provider of transportation.

Medication Administration

7 AAC 130.227(b) lists the factors that require the provider to be responsible for medication administration. 7 AAC 130.227(5) lists the "individual that provides medication administration has completed the training requirements of (f) of this section" as one of the factors. Are Adult Day Services providers required to have all direct service staff trained in medication administration? Medication administration is not listed as a certification requirement on the Adult Day Services Conditions of participation. Would it be possible to opt out of offering med administration if there is no staff trained to do it?

Providers may **not** opt out of offering medication administration services. See 7 AAC 130.227 (a) (1) Adult day services provider shall offer medication administration as an integral part of its services. This means the provider must have someone trained (not necessarily all the staff) to administer medications unless some other arrangement is made, e.g., an RN to administer medications [see (c)] or a recipient administers his or her own meds [see (i)(2)] or someone designated by a recipient or a recipient's representative comes to facility to administer meds [see (i)(3)]. Providers must have a medication administration policy and procedures as indicated in the *Provider Conditions of Participation* (applicable to all providers in addition to specific service *Conditions of Participation*) as a certification requirement.

If staff are not providing medication assistance under respite, Supported Living , In Home Supports, or Day Habilitation is it still required for the staff to attend Medication administration training?
Only staff who provide medication administration or assistance with self-administration of medication are required to receive training.

Does the general Medication administration training have to be done by a registered nurse?
If a nurse is providing the delegation, he or she is taking responsibility, and it is the nurse's decision on who does the training. If the recipient or their representative gives the delegation, anything provided by a nurse is fine; if not being provided by a nurse, SDS must approve the training. By policy, SDS will use criteria found in the Alaska Board of Nursing *Medication Administration Course Requirements* to approve a course.

If a recipient or recipient's POA does written delegation for med administration or assistance, does the staff still have to have the general medication administration training? And does that training have to be done by a registered nurse?
Yes, they still must be trained. The training for assistance with med administration can be decided by the agency but this training must be approved by SDS. The training for administration of medication is approved by the Board of Nursing (as found on their website) and is trained by a nurse.

Respite

What are the training requirements for respite workers?
Refer to the Respite Conditions of Participation, which lists the required qualifications of the respite worker.
http://dhss.alaska.gov/dsds/Documents/regspackage/RespiteCareServicesCOPS2.pdf

Can PCA be provided on the same day as daily respite? Can Day Habilitation be provided on the same day as daily respite?
Generally, no. According to 7 AAC 130.280 (5), respite, PCA and habilitative services may be approved "only if the lack of additional care or support would result in risk of institutionalization because (A) the recipient has inadequate supports from unpaid caregivers; or (B) appropriate out-of-home daily respite care services are unavailable"

Residential Supported Living and Group Home

Can an assisted living home compel a resident to stay in the home for the convenience of the provider?
No. That would be an unauthorized restrictive intervention.

Is there a new regulation that requires Assisted Living Administrators to be in the facility for a required amount of hours - and if they have multiple homes they are required to hire a "Manager" to be at the home those required hours?
Recent discussion around this topic was held through provider and stakeholder outreach from Certification and Licensing. Please contact Certification and Licensing for this information.
http://dhss.alaska.gov/dhcs/Pages/cl/all/default.aspx

Restrictive Intervention

Are seatbelt locks considered a restrictive intervention?
Yes. The use of seatbelt locks, and trays on wheelchairs which the individual cannot remove are examples of restrictive interventions. A provider may use these to support a recipient as outlined in 7 AAC 130.229 Use of restrictive intervention. The regulation covers safe use of allowed restrictive interventions, requires the agency to have a policy and procedure about their use, and correct documentation about their

use. The regulation also covers prohibited restrictive interventions.

What are some resources to find out more about the correct implementation of restrictive interventions?
Commonly use restrictive interventions include but are not limited to The Mandt System http://www.mandtsystem.com/ and Nonviolent Crisis Intervention http://www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention . Inclusion of these resources does not indicate endorsement or approval in any way, they are resources to help start your research into what training may be appropriate for your agency.

SDS POC Forms

I don't see screening as an option on the Services Overview sheet any more.
Screening is not a service for the waiver plan of care as it must occur before any assessment and plan development. A care coordinator who conducts a screening will be reimbursed in the amount specified on the Chart of PCA and Waiver Reimbursement rates.