Kupuna Caucus and Joint Legislative Committee on Aging in Place

Date: Friday, September 5, 2008
Time: 2:00 PM to 3:30 PM
Place: State Capitol, Rm 229

AGENDA

I. Welcome and Introductions

II. Universal Design – Bonnie Osaki, Graham Builders
Joan Riggs, Chaminade University

III. Case Management – Donna Schmidt, Case Management, Inc. and Sara Suzuki, President of the Case Management Council.

IV. Kupuna Care Program report by EOA

V. Grandparents Raising Grandchildren Task Force update

VI. Family Leave Working Group update

VII. Other Business

VIII. Announcements

IX. Next Meetings
a. October 10, 2008, 2 p.m., Conference Room 229
b. November 7, 2008, 2 p.m., Conference Room 229
c. December 5, 2008, 2 p. m., Conference Room 229

VII. Adjournment

Please RSVP attendance to Senator Chun Oakland's Office at 586-6130. Mahalo

- ❑ YES I WILL BE ABLE TO ATTEND
- ❑ SORRY I **WILL NOT** BE ABLE TO ATTEND
- ❑ SORRY I WILL NOT BE ABLE TO ATTEND, BUT **WILL SEND A REPRESENTATIVE**

Please FAX back to Sen. Chun Oakland at 586-6131

Please update info for our database.

Name: _____

Add: _____

City: _____ Agency: _____

ZIP Code: _____ Phone/Fax: _____

Email: _____

Joint Legislative Committee on Aging in Place
Hawaii State Capitol, Room 229
Thursday, July 31, 2008

DRAFT MINUTES

Members Present: Senator Les Ihara, Jr. (Co-Chair); Representative Marilyn Lee (Co-Chair); Senator Suzanne Chun Oakland; Representative Karen Awana

Members Absent: Senator Rosalyn Baker, Senator Gordon Trimble, Representative Joey Manahan, Representative Corinne Ching

Others in Attendance: Shawn Carbrey (Society of Human Resource Management - Hawaii), Al Hamai (Hawaii Alliance of Retired Americans), Sandra Morishige (Department of Human Services-Benefit, Employment and Support Services Division-FAF), Eudice Shick (Policy Advisory Board for Elder Affairs), Audrey Kubota, Josephine Reyes (Maui County Office on Aging), Sherry Menor-McNamara (Chamber of Commerce Hawaii), May Fujii Foo (Elderly Affairs Division), Felix Blumhardt (University of Hawaii - School of Social Work), Stephen Chong (Hawaii Health Systems Corporation - Oahu Region – Leahi), Craig Yamaguchi (Elderly Affairs Division), Jo des Maretc, Wes Lum (University of Hawaii-Center on Aging), Jackie Chong (Na Tutu), Kenny Fink (Department of Human Services-MedQuest Division), Eldon Wegner (Policy Advisory Board for Elder Affairs), Valorie Taylor (Child and Family Services), Pat Urieff (Queen Liliuokalani Children's Center), Jessica Horiuchi (National Federation of Independent Businesses), Collette DeVille (Representative Ching's Office), Pat Tompkins (Elderly Affairs Division), Lester Matsumoto (Neuro-Trauma Support), Lori Yancura (University of Hawaii - Manoa), Stan Michaels (Department of Health-Injury Prevention Division), Deborah Miyasaka-Gushiken (Deparatment of Health), Sesnita Moepono (Honolulu Committee On Aging), Coral Andrews (Healthcare Association of Hawaii), James Hardway (Department of Labor and Industrial Relations), Diane Terada (Catholic Charities Hawaii), Karen Miyake (Elderly Affairs Division), Laura Manis (American Association of Retired Persons), Audrey Suga-Nakagawa, Anne Chipchase (Ohana Health Plan), Tony Lenzer, Noemi Pendleton (Executive Office on Aging), Alan Parker (Hawaii Office on Aging), Rep. Barbara Marumoto, Thelma from the House Majority Communications Office, Ann Thornock (Representative Lee's Office), Heather Bolan (Senator Ihara's Office)

I. Call to Order/Welcome and Introductions

Senator Ihara called the meeting to order at approximately 1:10 p.m. Senator Ihara introduced the Senate members of the Joint Legislative Committee both present and absent. Representative Lee introduced the House members of the Joint Legislative Committee both present and absent.

Act 220 (2008) was reviewed: the veto override of the additional $500,000 for Kupuna Care, the change of name of the committee to "Joint Legislative Committee on Aging in Place" (JLCAIP), Audrey Suga-Nakagawa will report on Aging and Disability Resource Center, the Executive Office on Aging will report on cash and counseling, the county representatives will report on Kupuna Care, the two co-chairs of the Grandparents Raising Grandchildren Task Force are

present, and the Executive Office on Aging will provide an update on their respite inventory project.

The JLCAIP interim work plan is to monitor and support the six items on the agenda through the end of the year. There will be monthly meetings with project updates to be determined at the end of this agenda. The JLCAIP will facilitate at meetings.

There was a round-the-room introduction of everyone present. It was announced that minutes would be done by Senate Majority Office staff (not present at today's meeting) or staff from the office of one of the Co-Chairs.

The following handouts were distributed to the members and others in attendance:

(1) copy of the JLCAIP hearing notice/agenda;
(2) synopsis of Act 220 (2008);
(3) testimony from Al Hamai on behalf of Hawaii Alliance for Retired Americans; and
(4) Karen Miyake's report on the Kupuna Care Program.

II. Kupuna Care Program

The Executive Office on Aging will provide a complete update and statewide report on the Kupuna Care program at the next meeting. Briefly the fiscal year 2007-2008 appropriation was released in December 2007. $1.25 million is now available for the fiscal year 2008-2009. The 2007 legislature provided $475,000 extra funding for fiscal year 2007-2008 and $525,000 extra for 2008-2009; and an additional $500,000 for fiscal year 2008-2009.

The four county area agencies on aging were asked to make a report. Representatives from Honolulu, Maui and Hawaii were present. Kealoha Takahashi from Kauai was connected by speaker phone. Maui is still working on their report and asked for a deferral. The Executive Office on Aging was asked to compile all four county reports into their report for the next meeting.

Alan Parker from Hawaii had data but not in report form. Hawaii County provided the following statistics for Kupuna Care services: 1,834 personal care units, 308 day care units, 101 homemaker units, and 193 assisted transportation units. Case Management serviced 523 units. In the last two fiscal years, funding ran out prior to year end. This year it is anticipated that funding will run out by November. Without additional funds these services will be lost. The Caregiver Coordinator reports 20 people on the waitlist currently being served with Kupuna Care money which only covers a three month service period. There are no other options available for these clients so they will go without services. The current level of funding barely scratches the surface of keeping people out of institutions or other more expensive options.

Kealoha Takahashi reported by speaker phone that Kauai County had 55 people served for homemaker services as of June 30. Without an increase in funds only 27 of those will be able to continue and the other 28 will go without services. Personal care services would have to reduce

by 5 persons next year. Not included in these figures is the waitlist which currently has 5 persons requiring homemaker services and 2 for personal care services. Home delivery meals will have to drop 39 persons currently being served. Their entire base funding is used for homemaker, personal care, and meals. There is no money for anything else.

Karen Miyake passed out her report on Honolulu City & County. Oahu gets 60% of Kupuna Care funding and will run out of money in October. Service levels have dropped due to a lack of funds. A unit is a trip, a bath, a meal, an hour of service. The wait lists are growing. In addition the number of complex cases is increasing. Costs are rising. Volunteers are dropping off. Additional funds are needed just to maintain the current levels of services; even more would be needed to deal with wait lists. Honolulu closed their respite program to channel the money to other programs. The written report provides details on specific vendors, the services they provide, their problems related to staff especially due to the funding uncertainty, and their waitlists. The waitlists are growing both in number and in length of time spent on the list. The report also suggests folding supplemental funding into the base so that resources are not wasted on administrative requirements. The base funding for Kupuna Care has not increased since 2002.

For the next report, the committee requested details on how services are distributed (how it is determined which clients gets how many/what services), and voluntary payments received.

III. Respite Inventory Project

Wes Lum explained that the Executive Office on Aging had funded two University of Hawaii contracts with the School of Social Work and a draft report was distributed last year. At that time the Joint Legislative Committee on Family Caregiving requested additional information and that the inventory work continue with the addition of information for Grandparents Raising Grandchildren. Felix Blumhardt indicated that they have expanded the inventory, contacted all existing and new agencies for information on their waitlists and services. The report is 85-95% complete and she anticipates compilation to be completed within two to three weeks. They will then submit the data to the committee for more feedback. Lori Yancura of Family and Consumer Services –Family Resources (part of CTAHR) started later on the Grandparents Raising Grandchildren section and with student assistants has been contacting those surveyed last year to ask what kind of resources they need (eg: summer support, disability support). A web search has been done to find possible services available and calls have been made to agencies as well. Their report should be ready to present in eight weeks time – October.

There was discussion that yet to be figured out is how to get the final information to those who need it. A suggestion was made to have it in a similar format to the City & County of Honolulu's Senior Information booklet – maybe even added to it. It can also be added to the Aging and Disability Resource Center which will be accessible statewide.

For the October report it was also requested that a definition of respite care be provided.

IV. Cash and Counseling Project

Wes Lum reported that the Executive Office on Aging also funded two contracts with the University of Hawaii School of Social Work for this project. First research was done on cash and counseling to see if this was something the State wanted to pursue. A design concept was the next step. An advisory group is being formed and feedback will be sought. MedQuest will be using cash and counseling so there may be some way to partner. A final report should be available by year end to include a demo project and sources of funding. Illinois is the only state currently with cash and counseling for non-Medicaid clients. The program is housed with the Medicaid program but funded separately. The initial draft report was sent to the co-chairs in June and includes the design and demo project details with cost estimates based on $500 per month: $835,000 for fiscal year 2009-2010 and $1,350,000 for fiscal year 2010-2011.

V. Family Leave Work Group

James Hardway from the Department of Labor was present, and reported that the Department will assign two staff to support the family leave work group: one with knowledge of temporary disability and one with knowledge on leave. He will be providing the names to the co-chairs. Work group meetings could be held at the Department and alternatively at the Capitol during the interim. The Department is willing to convene the first meeting and have the group elect a chair. The Joint Legislative Committee would like this to happen in August. The work group is mandated by Act 243. The Office of Information Practices has determined that the work group is subject to the sunshine law. The Joint Legislative Committee requested progress reports be made at each subsequent Joint Legislative Committee meeting.

VI. Grandparents Raising Grandchildren Task Force

Co-Chairs Lori Yancura and Pat Urieff were present and reported that Act 220 outlines specifically what the Task Force is to identify: existing services, deficiencies, barriers, working on proliferation of services. The co-chairs will meet briefly after the Joint Legislative Committee with any members present to discuss a meeting schedule and a rough plan. Lori has an intern that will provide staff support. The Office of Information Practices has determined that the Task Force is subject to the Sunshine Law. The Joint Legislative Committee requested progress reports be made at each subsequent Joint Legislative Committee meeting.

VII. Aging and Disability Resource Center

Audrey Suga-Nakagawa, the ADRC's project coordinator was present. The Aging and Disability Resource Center (ADRC) is a national initiative to provide a one-stop shop for information on services. Honolulu is the second phase of a "virtual" website. They had a consultant evaluate various ways to streamline and found it was less expensive to build their own site which could be used for all four counties. The Kauai information/technology department will build the site and only needed the designer. There will be a portal link on the State's website. Each county will be able to manage and update its own sites. As Hilo is the pilot physical model site, they will have the option to use the web in addition or not. Honolulu expects staff training to happen by October and again this training will serve as a model for the other counties. The University of Hawaii's Travel Industry Management Program developed the curriculum for this specialized customer

service and they have lined up personnel from some five-star hotels to do the training. A phone component is also in the works.

Alan Parker from Hilo reported on their progress on the physical ADRC site. This has been in development for three years. They are renovating an old Chinese Restaurant and expect to receive occupancy August 1. The modular furniture is not yet in, but the contractor did an excellent job upgrading the building. The second floor interior is not yet complete. They expect a grand opening in October or November. The site will serve as a training facility as well as a resource library. The kitchen, restrooms, and training facility will be segmented from the Elderly Affairs Division offices and controlled with timers to hold down costs while allowing these facilities to be used at night and on weekends.

VIII. Calendar

The Joint Legislative Committee will hold its next three meetings jointly with the Kupuna Caucus to receive project updates as follows:

September 5 at 2:00 p.m. in conference room 229
October 10 at 2:00 p.m. in conference room 229
November 7 at 2:00 p.m. in conference room 229

Meetings in December will be announced later.

IX. Adjournment

The meeting was adjourned at approximately 3:50 p.m.

Minutes of the Grandparents Raising Grandchildren Task Force Meeting
Monday, August 25, 2008
10:00am
Executive Office on Aging, Conference Room B

ATTENDANCE

Members Present:
Lori Yancura, Co-chair (UH-CTAHR), Pat Urieff, Co-chair (QLCC), May Fujii Foo (EAD), Lawrence Sousie (CSEA), Carol Morimoto (Partners in Development), Sandy Morishige (DHS), Moya Gray (VLSH), Nalani Fujimori (LASH), Colin Fukunaga (DHS), Diane Stowell (PABEA), Frank Lopez (DPS), Helen Wagner (Grandparent Member), and Wes Lum (UH CARE).

Members Absent:
Daniel Hamada (DOE), Noemi Pendleton (EOA), Robert Brady (Judiciary), Jo Reyes (MCOA), Alan Parker (HCOA), Charlyn Nakamine (KAEA), and Jackie Chong (Na Tu Tu Coalition).

Guests:
Maryann Crowell (grandparent), Valorie Taylor (Child & Family Services), and Anne Chipchase (`Ohana Health Plan).

ESTABLISH COMMITTEE AND REVIEW ADMINISTRATIVE GUIDELINES

Lawrence made a motion to formally establish the Grandparents Raising Grandchildren Task Force. Wes seconded the motion. All members voted in favor of the motion and the Task Force was formally established.

Wes made a motion to nominate Helen Wagner as the grandparent member to the Task Force. May seconded the motion. During the discussion period, Helen introduced herself and explained that she is a grandparent who was responsible for raising her granddaughter from age 3 up to current age 15. As a result of accepting this responsibility, she immersed herself in community participation/civic affairs for support in this new role. Helen has been active with the Na Tu Tu Coalition and the Hawaii Family Caregiver Coalition, among other community groups to support GRG, and she has tracked issues and testified at Legislative hearings, at meetings for the Kupuna Caucus, and at the Joint Legislative Committee on Family Caregiving. All members voted in favor of the motion and Helen was confirmed as the grandparent member to the Task Force.

REVIEW SUNSHINE LAW REQUIREMENTS

It was confirmed that hearing notices/agenda must be posted at least six days prior to the meeting. Also, there are 19 members and therefore 10 members must be present to establish a quorum.

REVIEW THE SCOPE OF WORK AS PRESCRIBED BY ACT 220 (SESSION LAWS OF HAWAII, 2008)

The overall goals of the GRG Task Force are to identify:

1. Services that exist to meet the identified needs.
2. Any service deficiencies.
3. Barriers that prevent grandparents from accessing services.
4. What can be done to facilitate the provision of services to GRG.

The tasks of the GRG Task Force are to:

1. Review the 2007 *Needs Assessment of Grandparents Raising Grandchildren in the State of Hawaii.*
2. Review the most recent *Four Year State Plan on Aging* to the US Administration on Aging by the Executive Office on Aging (EOA) and the Area Agencies on Aging (AAA).
3. Review the testimony of the various agencies submitted to the Joint Legislative Committee on Family Caregiving at its hearing on August 16, 2007, regarding issues facing GRG.
4. Review laws relating to issues facing GRG and other kinship caregivers, including:
    a. Section 302A-482, HRS, regarding the affidavit for caregiver consent.
    b. Chapters 571, HRS, regarding child custody and support.
    c. Chapter 587, HRS, regarding child support and custody.
    d. The memorandum prepared by the DOE to guide school personnel when enrolling students who reside with caregivers.
5. Review the supports and services offered to caregivers by the DOE through its comprehensive student support system.
6. Investigate whether a need arises when a minor residing, formally or informally, with a grandparent requires consent for medical service, including when a student needs consent for programs and services under the Individuals with Disabilities Act or Section 504 of the Rehabilitation Act of 1973.
7. Investigate the issues that arise when a minor residing, formally or informally, with a grandparent is returned to the custody of a parent.
8. Investigate housing issues that may arise when a grandparent is raising a grandchild, particularly when the GRG resides in senior housing, and identify any state or federal laws that prohibit or prevent a grandchild from residing with a grandparent.
9. Review how each AAA allocates the federal funds it receives under the National Family Caregiver Support Program for grandparent programs.
10. Identify the agencies that collect data relating to GRG and whether the data can be more comprehensive, uniform, and readily available or exchanged.
11. Identify legal needs and whether these needs are being adequately addressed.

The GRG Task Force is required to submit:

1. An interim report which is due no later than twenty days prior to the convening of the 2009 regular session. The Task Force's goal is to submit the report to the Joint Legislative Committee on Aging in Place (JLCAIP) by December 1, 2008.

2. A final report to the Legislature and the JLCAIP no later than twenty days prior to June 30, 2009. The content of final report will consist of the following:
    a. A list of the services that exist in each county to meet grandparents' identified needs.
    b. A discussion of service deficiencies in each county.
    c. A discussion of identifiable barriers that prevent grandparents from accessing services.
    d. A synopsis of the Task Force's work and any findings regarding the Task Force's responsibilities as detailed in Section 2(b) of Act 220.
    e. Recommendations, including possible legislation.

SET THE AGENDA FOR THE NEXT MEETING

The agenda for the next meeting will consist of 10 minute presentations on the following issues.

1. Review the 2007 *Needs Assessment of Grandparents Raising Grandchildren in the State of Hawaii.* Lori Yancura will give a presentation.
2. Review the most recent *Four Year State Plan on Aging* to the US Administration on Aging by EOA and the AAA. Wes Lum will give a presentation.
3. Review the testimony of the various agencies submitted to the Joint Legislative Committee on Family Caregiving (JLCFC) at its hearing on August 16, 2007, regarding issues facing GRG.
4. Review laws relating to issues facing GRG and other kinship caregivers, including:
    a. Section 302A-482, HRS, regarding the affidavit for caregiver consent. Nalani Fujimori will give a presentation.
    b. Chapters 571, HRS, regarding child custody and support. Lawrence Sousie will give a presentation.
    c. Chapter 587, HRS, the Child Protection Law, including child support and custody. Nalani Fujimori will give a presentation including 2008 revisions to Act 587.

Members were also requested to identify issues that may need to be addressed through legislation. Additionally, it was suggested that subcommittees be formed to review the issues.

In preparation for the next meeting, a set of documents will be e-mailed prior to the meeting, including:

- 2007 Needs Assessment of GRG in the State of Hawaii
- Testimony submitted by various agencies to the JLCFC at its hearing on August 16, 2007.
- EOA's Four Year Plan on Aging
- E-mail links to the Hawaii Revised Statutes that are applicable to the presentations.

SCHEDULE MEETING DATES THROUGH 2008

Pat said that the GRG Task Force does not have a budget for airfare. However, she noted that the AAAs have included in their budget airfare from the neighbor islands to Oahu for the joint meetings of the Kupuna Caucus and the JLCAIP which meets at 2:00pm on

September 5, October 10, and November 7 at the State Capitol, Room 229. Pat suggested that the GRG Task Force meet on those dates to accommodate for the neighbor island participants who must fly to Honolulu.

The upcoming meeting dates for the GRG Task Force are:

- Friday, September 5, 2008 from 11:30am – 1:00pm at the State Capitol, Room 224.
- Friday, October 10, 2008 from 11:30am – 1:00pm at the State Capitol, Room 229.
- Friday, November 7, 2008 from 11:30am – 1:00pm at the State Capitol, Room 229.

Meetings in December will be set in the near future.

ANNOUNCEMENTS

Wes announced that EOA has prioritized the GRG issue and wants to conduct GRG outreach and education statewide in November 2008. EOA had co-sponsored a GRG workshop on Maui in May 2008, and will be co-sponsoring a GRG workshop on Kauai in November 2008.

EOA has set aside resources to coordinate additional workshops and Wes asked if anyone would be interested in helping to plan these events. Lawrence, May, Nalani, Carol, Moya, Anne, and Valorie indicated an interest in helping. Wes will follow up with these individuals.

Joint Legislative Committee on Aging in Place
Family Leave Working Group
Tuesday, August 26, 2008, 1:00 PM
State Capitol Conference Room 224

MINUTES

I. Meeting was called to order by James Hardway.

II. Attendance

Members Present

Aileen Befitel	DHS
Joy Kuwabara	HGEA
Eudice Schick	PABEA
Melissa Pavlicek	NFIB Hawaii
Anne Holton (for Adele Ching)	EOA
Sherry Menor-McNamara	Chamber of Commerce
Jacob Herlitz	DOTAX
Joanne Kealoha	ILWU
Jim Shon	Kokua Council
James Hardway	DLIR
Wes Lum	Hawaii Family Caregivers Coalition
Shawn Carbrey	SHRM Hawaii

Members Absent

Gerard Russo	UH Department of Economics
Glenn Ida	Hawaii Teamsters
Harold Dias	IBEW

Guests

Darwin Ching	DLIR
Noraine Ichikawa	DLIR
Ellen Kai	DLIR
Andrai Sato	DLIR
Joyce Tapia-Miyahira	DOH PHNB
Benjamin Ventora	Chamber of Commerce/Wal Mart
Jill Cooper	Governor's Office

III. Nomination and Election of Chairperson

A. Jim Shon nominated Wes Lum to serve as Chair. Seconded by Melissa Pavlicek. All members voted in favor of the motion. Mr. Lum's nomination was approved.

IV. Discussion and Review of Act 243

A. James Hardway suggested that the work of the group concentrate on the issue of funding since it would be a large enough task to accomplish in the time allotted. The intent is to come up with a bill for introduction in the next legislative session – if the group can come to an agreement.

B. It was suggested that the insurance industry should be asked for their input on the capabilities of expanding TDI.

C. Melissa Pavlicek suggested that the issue of medical privacy is also a concern and needs to be addressed. James Hardway indicated that he would contact an expert on medical privacy laws to make a presentation to the group.

D. Jim Shon suggested that availability of current support systems for caregivers should be looked at both in the public and private sectors. Both short term, i.e. caregiving needs in situations such as a surgery, or chronic caregiving needs should be discussed.

The issue of adequacy needs to be considered. We need to have some way of knowing what is available and where there are gaps. It was suggested that the insurance industry may have looked at this information when evaluating their risks in offering long-term care insurance. It is possible that insurers may have done surveys/questionnaires that could provide some information. Sherry Menor-McNamara will invite AIG to do a presentation before the working group.

E. The Legislative Reference Bureau will be invited to address the group on their January 2007 report, which included looking at other states' approaches to selected family and medical leave and caregiver support. James Hardway volunteered to ask LRB to do a presentation before the working group.

V. Next Steps:

A. The working group decided to explore the request to fund mechanisms for a paid family leave program after the other issues are addressed.

B. The next meeting is scheduled on Friday, September 12, 2008 at the State Capitol, Room 224. James Hardway will review the research findings of the Joint Legislative Committee on Family Caregiving conducted during 2007 legislative interim as it relates to a paid family leave program. Melissa Pavlicek and James Hardway will review paid family leave bills in California, Washington and New Jersey. The last item on the agenda is to have LRB summarize its report: Selected Issues in Work-Family Policy; A Brief Overview.

Melissa Pavlicek said that NFIB had resources in this area and she volunteered to share this with the group. Chair Lum will not be in attendance at the September 12 meeting; Jim Shon agreed to chair the meeting.

C. The following meeting is scheduled on Friday, October 17, 2008 at the State Capitol, Room 224. Wes Lum will review the 2007 family caregiver needs assessment to explain the factors affecting the well-being of employed family caregivers. He will also review an inventory of eldercare policies and practices that currently exist in the workplace. Sherry Menor-McNamara will invite AIG to do a presentation at this meeting. Additionally, James Hardway will invite an expert in medical privacy to do a presentation. The agenda for the November meeting, which is scheduled on Thursday, November 6, 2008, will be set at the October meeting.

D. James Hardway indicated a website where information concerning the work of the group, such as minutes, handout, and powerpoint presentations, will be available on-line.

VI. Meeting was adjourned at 1:40 PM.

VII. Announcements:
The Family Leave Working Group meetings are scheduled as follows:

- Friday, September 12, 2008, 1 PM, State Capitol Room 224
- Friday, October 17, 2008, 1 PM, State Capitol Room 224
- Thursday, November 6, 2008, 1 PM, State Capitol Room 224

Case Management

Presented by the
Sarah Suzuki, RN, BSN, MBA
President, Case Management Council

Definition - Case Management

The process of continuous assessment of the service needs of the "client" in a community care foster family home, expanded adult residential care home, or assisted living facility, the development, review, and updating, as necessary, of the client's service plan, and the locating, coordinating, and monitoring of an integrated and comprehensive combination, of services necessary to cost effectively maintain and support, and ensure the welfare of the client in the community, on a twenty-four hour basis.

CM is intended to assist the client to access needed care and services on a timely basis and to prevent inappropriate institutionalization through a thorough consideration of

Definition - Case Management

- CMSA defines case management (CM) as:
  - Collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes
- Case management is a human service
- Provided by professionals from diverse academic preparations and background
- Trained in and are licensed to perform assessments in their respective field

RACCP Program

- Provides residential placement in community care foster family homes (CCFFH), expanded adult residential care home (E-ARCH), or assisted living facility (ALF) as an alternative to institutional care for Medicaid eligible adults who have serious or chronic illnesses or disabilities and require long-term nursing levels of care, but who are not able to benefit from in home services because they have no caregivers or residence.

RACCP
Program Goals

- Assure that the health and welfare of all clients in the RACCP through assurance that only qualified providers are utilized in accordance with the standards of the State
- Assure that providers of service are accountable in their financial practices in accordance with State rules
- Clients whose need for care is identified as ICF/SNF are admitted to participate in RACCP
- Assure that each client is given a choice about participating in RACCP rather than an institutional setting, choice of CMA, choice of appropriate setting (CCFFH, E-ARCH, ALF)
- Assure that per capita expenditure of waiver clients does not exceed the average per capita expenditures paid in an ICF or SNF facility

RACCP Program

- Services covered under RACCP:
  - Respite Care
  - Private Duty Nursing
  - Specialized Supplies
  - Residential Care
  - Assisted Living
  - Adult Day Health
  - Foster Care
  - Case Management *

RACCP Program Eligibility

- Be eligible
  - Medicaid patient or private patient
  - 18 years
  - Require ICF or SNF nursing facility level of care
  - Average service costs that do not exceed the cost of institutional care
  - Be deemed appropriate for RACCP by a case manager based on medical and social situation, compatibility with family, and willingness to accept residential placement

Minimum Qualifications of a Licensed DHS CM

- Minimum of one year experience in providing care coordination for elderly or disabled individuals in HCBS
- Registered Nurse
  - Licensed RN
  - At least two years experience with client care coordination responsibilities
- Social Work
  - Licensed SW
  - One year experience with client care coordination responsibilities

Profile of the Licensed CM's in Hawaii

- 15 years (or more) professional RN or SW experience for most of the DHS Licensed CM agencies
- Diverse professional experience includes but not limited to:
  - Acute care RN and SW experience
  - Long-term care experience
  - Public health experience
  - Utilization management
  - Risk management
  - Health education
  - Performance improvement
  - Business administration
  - Community leaders and volunteers

Case Manager Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Assessment or Problem Identification

- Conducting assessment of the patient
  - Gather data and relevant comprehensive information via many sources
  - Gather info concerning client's health behaviors, cultural influences and/or value system
  - Determine patients needs to establish a plan that will overcome current or potential problems that is realistic
  - Synthesize information to prioritize care needs
  - Identify potential barriers

Assessment or Problem Identification

- Research alternative options
- Move patient towards a successful discharge and placement
- Care Planning Activities
  - The Service Plan is a living document
    - Written agreement that spells out problems, goals, interventions, timing
    - Can change as the health status improves or deteriorates
    - Individualized to each patient
    - Collaborative activity between with the team.
- Determine if it is CCFFH, E-ARCH, ALF
  - Provide choice of at least two caregivers, if possible

CM Responsibilities

1. Assessment or Problem Identification
2. **Development and Coordination of the Service Plan**
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Development and Coordination of the Service Plan

- Needs and services are matched into a seamless plan based on the comprehensive data gathered in the assessment stage
- The service plan is written so everyone understands
- Development of an individualized plan
  - Establish the goals
  - Prioritize needs and goals
  - Service Planning
  - Resource allocation

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. **Implementation of the Service Plan**
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Implementation of the Service Plan

- Putting the plan into action
- Communicate with client, family, treating physicians, and other service providers to include legal representatives, and payors
- Patient discharged to CCFFH, E-ARCH, and ALF
  - Implement appropriate service and treatment plan
  - Gaps are filled and with no duplication of services
  - Review Service Plan with the team to include the patient

Implementation of the Service Plan

- Patient discharged to CCFFH, E-ARCH, and ALF
  - Provide education, information, direction, and support related to care goals of the client
  - Providers, community care settings, and services are chosen and approved by patient, family, and the team
  - Patient, family, legal representatives, CM & MD approve the plan by signing the Service Plan.

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. **Nurse Delegation**
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Nurse Delegation

- Only a registered nurse (RN) has authority to practice professional nursing and only an RN has authority to delegate nursing tasks. The RN CM may delegate resident care and services according to the rules established by the State Board of Nursing and Nursing Care Task Delegation.
- Administration of medication is part of the practice of a RN. As such, the RN CM retains full responsibility for medication administration.
- The rules of delegation of tasks apply only in settings where an RN CM is not regularly scheduled and not available to provide direct supervision. The setting includes CCFFH, E-ARCH, and ALF.

Nurse Delegation

- RN CM may delegate the special task of nursing care to an UAP person. Using judgment, the delegating RN CM ascertains if the task can be properly and safely performed by a UAP person without jeopardizing the client's welfare.
- RN CM's are held accountable for the decision to delegate. The RN CM is accountable for the adequacy of nursing care to the client provided that the UAP performed the special task as instructed and directed by the delegating RN.

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. **Follow-up and Evaluation**
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Follow-up

- Ensures case continuity
- Sends a clear message to patient and family that someone cares for them
- Follow up may mean either a visit/s or a telephone call after admission
- Usually needed and appreciated (i.e. equipment not delivered, supplies)
- Patient may require more care than anticipated
- Caregiver may need additional support
- Sharing accurate information with loved ones empowers them so they can make informed decisions
- Answers questions, discuss possible solutions, prevent potential complications, readmissions, or unnecessary trips to the ER

Evaluation

Review of Service Plan allows the CM to evaluate the following:

- How well did the patient respond to the plan?
- How well did the family member respond to the plan?
- Were the goals realistic?
- Do the goals need to be readjusted?
- Were the interventions appropriate?
- Were all services delivered as planned? If not, why?
- Are there any new problems?
- What are the outcomes of the case management interventions? (i.e. was the patient able to ambulate 50 feet with a walker in three months?)
- Sometimes cases do not go smoothly!

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. **Monitoring, Reassessment, and Reevaluation**
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Monitoring, Reassessment, and Reevaluation

- Monitor the response to treatment plan
- Revise the Service Plan as needed
- Perform case management functions
  - 24/7 Licensed RN/SW coverage
  - Responsive administrative staff
  - Case recording & documentation
  - Report functions
  - Continue to coordinate community resource
  - Face to face contact with the resident at least once per month, with more frequent contacts depending on the resident's condition and the caregiver's capability

Monitoring, Reassessment, and Reevaluation

- Performing case management functions
  - Regular RN monitoring of the resident who has a medically complex condition, as determined by a physician or RN
  - Conduct ongoing evaluation of the resident's response to and satisfaction with services provided and follow up as needed
  - Conduct ongoing evaluation of the appropriateness, timeliness, adequacy, and quality of services, caregivers, and home-like environment provided

Monitoring, Reassessment, and Reevaluation

- Conduct ongoing evaluation of the caregiver's status, behavior, and skills competency and other caregiver responsibilities
- Assessment for, review, and follow-up activities on all reports of unusual occurrences involving the resident, such as adverse events, and inappropriate or lack of resident supervision
- Follow-up on activities to assure that substandard care and unsafe practices or conditions have improved

Monitoring, Reassessment, and Reevaluation

- Assure that a qualified caregiver is physically available to the resident twenty four hours a day, seven days a week. Done by surprise visits
- Facilitate and document conflict resolution of resident complaints or grievances about services, service providers, as well as conflicts between contracted personnel and the resident
- Monitor and document continued Medicaid eligibility for Medicaid waiver service recipients

Monitoring, Reassessment, and Reevaluation

- Perform Utilization Review (1147 LOC change annually and PRN)
  - ICF: Moderate assistance with ADL's and often restorative nursing supervision
  - SNF: Progressively more complex medical and functional need
- Secure respite services when caregivers' need time off (for vacations and emergencies)
- Report to the department any concerns about the home in which a client has to be placed, including but not limited to:
  - Changes in the composition of the household
  - Inappropriate activities on the premises

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. **Education and Training**
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Education and Training

- Opportunities to teach for CM's is unlimited
- Education given to patients, families, and caregivers
- Wide range of education topics to include but not limited to:
  - Program structure
  - Program policies and procedures
  - Patient specific documents
  - Information in the service plan
  - Medication administration (indications, side effects, contraindications)
  - Disease specific instruction and process
  - Insurance coverage
  - Business practices and ethics

Education and Training

- Careful assessment of teaching needs and education knowledge deficits is cost-effective and leads to > patient and caregiver satisfaction
- Readmissions due to non-compliance are reduced when patient or caregiver understand the disease process and treatment needed
- Education about what CM's do and what CM is
- The teaching process is repetitive and ongoing

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. **Crisis Intervention**
9. Conflict Resolution
10. Advocacy
11. Risk Management & Quality Improvement

Crisis Intervention

- Crisis intervention revolves around pure grief
- Some situations may be more difficult than others
- Fear and anger are emotions expressed by patients, families, caregivers, and also providers.
- It is inevitable that CM's will get involved in this especially when a patient's condition deteriorates
- Use strong interpersonal skills to deal with the crisis
- Stay objective and bring focus back to the patient

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. **Conflict Resolution**
10. Advocacy
11. Risk Management & Quality Improvement

Conflict Resolution

- Conflict resolution requires investigative work on the CM's part to get to the core problem
- Mediator when conflict occurs between the team
- Attentive listening skills
- Required to be a critical thinker and problem solver
- Use negotiation skills to reach an agreement
- Stay objective and bring focus back to the patient

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. **Advocacy**
11. Risk Management & Quality Improvement

Advocacy

- One of the most important roles for the CM
- Clients & families are reminded that they have a choice
- Assist patients to achieve autonomy and self-determination
- Assist the patient to become empowered
  - Help patients articulate their views and choices
- Advocacy for patient's and family with payors and service providers
- Protect privacy and confidentiality
- Requires CM's to provide emotional support

CM Responsibilities

1. Assessment or Problem Identification
2. Development and Coordination of the Service Plan
3. Implementation of the Service Plan
4. Nurse Delegation
5. Follow up and Evaluation
6. Monitoring, Reassessment, and Reevaluation
7. Education and Training
8. Crisis Intervention
9. Conflict Resolution
10. Advocacy
11. **Risk Management & Quality Improvement**

Risk Management and Quality

- Case management requires a wide array of management skills
  - Delegation
  - Conflict resolution
  - Crisis intervention
  - Collaboration
  - Consultation
  - Coordination
  - Documentation
- Astute CM's help avoid disasters by recognizing potential problems and resolving them before it goes too far

Risk Management and Quality

- QA proactive model
  - It is designed to monitor, prevent, and correct quality deficiencies.
  - Continuous effort to raise the organization's quality level
- Licensed CM agencies participate in QA in three ways
  - internally within the CM agency
  - externally with CTA & DHS
  - QM activities with the Case Management Council (CMC)
    - Falls Project – An Interagency QA Project

Risk Management and Quality

- RM is identifying potential risk areas
  - Identifying interventions that will enhance patient safety
  - Identifying interventions that will prevent loses before they occur
- Perform administrative and coordination functions related to the operation of the CM program
  - Work with CTA and DHS on difficult cases
  - Monitor adverse events and review/trend data
  - Implement programs to educate caregivers to ensure patient safety

Risk Management and Quality
Compliance with Medicaid Laws, Regulations, and Provider Manual

- Perform administrative and coordination functions related to the operation of the CM program
  - Abide by HAR Standards
    - Hawaii Administrative Rules Title 17, Subtitles 9 & 12
    - HAR 17-1704, Subchapter 3 (Provider Fraud)
    - HAR 17-1454 (Regulation of Home and Community Based Case Management Agencies)
    - HAR 17-1736 (Provider Provisions)
  - Abide by DOH E-ARCH Standards
  - Abide by Nurse Delegation Act

Risk Management and Quality
Compliance with Medicaid Laws, Regulations, and Provider Manual

- Perform administrative and coordination functions related to the operation of the CM program
  - Comprehensive Liability Insurance $1M for each occurrence
  - Professional Liability Insurance $1M for each occurrence
  - Automobile Insurance for $1M
  - Federal and State Laws that govern Medicaid providers
  - Policies and procedures in the Medicaid Waiver Services Provider Manual

Risk Management & Quality
Compliance with other laws and regulations

- HIPAA compliant
  - CM agencies agree to execute a business associate agreement in accordance with State regulations
- Employment and tax requirements imposed by State Department of Labor and Industrial Relations, Internal Revenue Service, and State Department of Taxation
- Federal Drug Free Act of 1988
- Smoking Policy as required by Hawaii Statues

Risk Management and Quality

- Education
  - Monthly VCC meetings
  - Other State and Federal sponsored meetings
  - Continuing education
  - Conferences
  - Certification

Summary

- Licensed DHS Case Managers can continue to help our community by:
  - Assuring continued coordination of care via quality case management services
  - Building on the already established community network
    - Established relationships with CCFFH, E-ARCH, and ALF
    - Established relationships with existing providers
    - Established relationships with community resources
  - Decreasing fragmentation and duplication of services
  - Continuing to build a program that incorporates quality and patient safety

Thank you!
from the Members of the Case Management Council

Ahonui Case Management (Oahu)

Aloha Health Care Providers Inc. (Oahu)

Blue Water Resources, LLC (Oahu/Hawaii/Molokai/Maui)

Case Management Professionals, Inc (Oahu/Kauai)

Case Management, Inc. (Oahu)

Catholic Charities (Hawaii)

Health Care Connection, Inc (Oahu/Maui)

Kaiser Community Case Management (Oahu)

Kupuna Alternative Care (Hawaii)

Ahonui Case Management (Oahu)

MB Case Management (Oahu/Maui/Kauai)

Nightingale Case Management (Oahu)

Ohana Alternative Care Services (Hawaii)

Ohana Case Management (Oahu/Kauai)

Quality Case Management (Oahu)

Queen's Community Based Programs (Oahu/Molokai)

Ramiro-Anderson Case Management (Oahu)

Residential Choices (Oahu/Molokai/Maui)

Talavera Case Management Agency, Inc (Oahu/Kauai)

TLC Case Management (Oahu)

Universal Case Management Agency (Oahu)

§§17-1454-14 to 17-1454-17 (Reserved).

SUBCHAPTER 2

HOME AND COMMUNITY-BASED CASE MANAGEMENT AGENCY REQUIREMENTS

§17-1454-18 Personnel. (a) The case management agency shall be responsible for:

(1) Having sufficient personnel to provide case management services to the client in a residential care facility, as provided in this subchapter;

(2) Locating, selecting, assigning, supervising, and training case management staff;

(3) Maintaining individual personnel files on all staff assigned to provide case management services to clients. The personnel files shall provide evidence of:

(A) Current Hawaii professional licenses, as applicable;

(B) Appropriate education and work experience;

(C) Current job description;

(D) Documentation of current blood borne pathogen and infection control training and cardiopulmonary resuscitation training for personnel in direct contact with a potential or current client;

(E) Current tuberculosis clearance that complies with department of health guidelines, for personnel in direct contact with a potential or current client;

(F) Current valid driver's license and access to an insured vehicle, as applicable;

(G) Orientation to the case management program, including operational procedures, agency policies and procedures, and case management responsibilities;

(H) A signed statement indicating the employee's understanding of the case management agency's background check policies; and

(I) Current background checks and signed statements, as provided in section 17-1454-7.1.

(4) Designating and authorizing an acting administrator who shall be responsible for the operation of the program in the absence of the regular administrator. The department shall be notified in writing when such designation is made, including the name and the period during which the acting administrator shall be in charge. The acting administrator shall be:

(A) A staff member of the agency;

(B) Qualified to carry out the responsibilities of an acting administrator;

(C) In compliance with personnel requirements for licensure, as applicable; and

(D) Assigned when the regular administrator is unable to perform the administrator's regular duties for one or more days.

(b) The case management agency shall have staff with a minimum of one year experience providing care coordination for elderly or disabled individuals in home and community-based settings, including but not limited to:

(1) The development and review of service plans; and

(2) Locating, coordinating, and monitoring comprehensive services to maintain and support individuals in the community.

(c) The case management agency shall employ qualified staff to provide case management services.

(1) Case managers shall be a registered nurse or a social worker.

(A) A registered nurse shall have:

(i) Fulfilled the State's licensing requirements for nurses; and

(ii) At least two years experience with client care coordination responsibilities in the United States; and

(B) A social worker shall have:

(i) Fulfilled the State's licensing requirements; and

(ii) One year of experience with client care coordination responsibilities

in the United States;

(2) Case managers shall have:

(A) Knowledge of current professional case management practices, standards, responsibilities, and procedures;

(B) Knowledge of the problems and needs of the targeted population, including social, health, and psychosocial factors affecting optimal functioning of clients and their support systems;

(C) Knowledge of client's rights, state and federal laws, and regulations, such as those relating to health services, confidentiality, and consent issues for the targeted populations; and

(D) The skills and abilities to provide case management services as provided in these requirements. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-19 REPEALED. [Eff 2/11/02, R 2/7/05]

§17-1454-20 Administrative requirements. (a) The case management agency shall have written policies and procedures that are consistent with the applicable requirements of this chapter and that relate to:

(1) Overall program management, including administrative, personnel, quality assurance such as continuous quality improvement, risk management, fiscal, assignment of an acting administrator when the regular administrator is absent, and program reporting requirements;

(2) Compliance with all applicable federal and state laws, including but not limited to those:

(A) Pertaining to adult and child protective services reporting; and

(B) Prohibiting discrimination against any person, on the grounds of race, color, national origin, religion, creed, sex, age, marital status, handicap, or arrest and court records;

(3) Having an alcohol and drug-free workplace;

(4) Services to clients, including the standards and requirements for application, eligibility, admission, waitlisting, suspension, discharge, transfer and readmission;
(5) Case management service responsibilities, such as but not limited to:
(A) Assessment;
(B) Development and authorization of service plans;
(C) Service coordination;
(D) Monitoring;
(E) Reassessment procedures;
(F) Client record and documentation requirements;
(G) Client budgetary procedures; and
(H) Confidentiality and client rights;
(6) Access to case management agency and client records upon request by the department or the department's designee; and
(7) Cooperation with the department when immediate removal of clients is necessary.

(b) The case management agency shall cooperate with the department when it is being evaluated for compliance with the licensing requirements, or the quality, adequacy and timeliness of services provided to clients. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-20.1 Contracting with Residential Care Facilities. The case management agency shall not enter into any agreement or contract with a residential care facility:
(1) If the residential care facility is a community care foster family home or expanded adult residential care home and the primary caregiver, substitute caregiver, owner of the property, holder of the certificate or license, or any other adult in the facility, except for clients, is related in any way to a paid or unpaid member of the staff or officer of the case management agency; or
(2) That requires the residential care facility to accept the case management agency's clients exclusively. [Eff and comp 2/7/05] (Auth: HRS §§346-14, 346-

333) (Imp: HRS §§346-14, 346-333)

§17-1454-21 Application for case management services. The case management agency shall:

(1) Provide information to individuals and agencies regarding its case management services, eligibility criteria, and its application, admission, and other processes;

(2) Utilize a standardized intake tool to request pertinent applicant information to determine eligibility for case management services;

(3) Ensure that all eligibility requirements for the placement of an individual with nursing facility level of care needs in a residential care facility are met prior to the individual's admission;

(4) Use a standardized assessment tool to assess the applicant's needs prior to being accepted as a client of the case management agency. This assessment shall include social and nursing evaluations that review the individual's health, functional, psychosocial, and financial situations and options for residential care; and

(5) Provide information about and referral to other community resources, as appropriate.

[Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-22 Service plan. (a) The service plan shall be based upon comprehensive assessments of the individual by appropriate case managers.

(b) The case management agency shall develop and authorize a service plan prior to the individual's admission to a residential care facility.

(c) The service plan shall be written in a language that is understandable to the individual, the individual's family, the individual's legal representative, and the primary and substitute caregivers.

(d) The service plan shall:

(1) Identify the problems and needs of the client, including any need to purchase specialized medical equipment and supplies;

(2) Establish realistic measurable goals to be

attained for each problem identified in the social and nursing assessments;

(3) Identify specific interventions and tasks to be implemented to address each problem and to ensure achievement of the goals specified in the service plan;

(4) Identify specific types of services needed, the number of units, duration, and the frequency of service provision;

(5) Specify the service provider or providers, primary and substitute, formal or informal, medicaid waiver or non-waiver, needed to address each problem and achieve each goal to safely maintain and support the client in a residential care facility;

(6) Be agreed to by the client or the client's legal representative;

(7) Establish the frequency of case manager contacts, with a minimum frequency of once a month face-to-face contacts with the client;

(8) Be reviewed, updated, and authorized, minimally once every six months or sooner when changes occur, to reflect the client's current status and needs; and

(9) Include a transportation plan to meet the non-medical transportation needs of the client as provided in subsection 17-1454-41(b)(5).

(e) The case management agency shall ensure that a current service plan is in place when a client moves from one residential care facility to another, and that if the client is moved into another community care foster family home, that the home has a current certificate.

(f) When a client chooses to transfer from one case management agency to another, a new service plan shall be developed by the new case management agency chosen by the client. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-23 Service coordination. (a) The case management agency shall promote continuity of client care, appropriate integration, and utilization of services by:

(1) Authorizing, locating, and arranging for services necessary to implement the client's

service plan;

(2) Providing caregivers, prior to the admission of the client, with all necessary forms, records, and information about the client and the client's service plan to ensure timely and quality service delivery;

(3) Assuring that the caregivers have the necessary skills to implement the service plan;

(4) Referring clients to the primary caregiver who, based on the case management agency's determination, has the ability to meet the health, welfare, and psychosocial needs of the individual, including care needs identified in a service plan;

(5) Conducting or coordinating caregiver training as necessary to ensure that the caregivers are skilled to care for the clients in their residential care facilities;

(6) Coordinating hospital discharge, respite, home transfers, transfers between case management agencies, and other services as appropriate;

(7) Using only appropriately licensed or certified residential care facilities;

(8) Advocating for clients;

(9) Facilitating and mediating the resolution of conflicts that may arise between clients and service providers;

(10) Arranging and participating in client care conferences, as appropriate; and

(11) Assisting the client or the client's family with obtaining a legal representative, such as a guardian, when necessary and appropriate.

(b) When two clients are served by different case management agencies and may possibly reside in the same residential care facility, the quality of services and compatibility of the clients who may share the residential care facility shall be ensured.

(1) Each client's case management agency shall:

(A) Obtain a written consent from its client for the release of the client's information for the purposes of this section;

(B) Share and discuss its client's assessment and service plan with the case management agency for the other

client for the purpose of ensuring the quality of services and compatibility of the clients;

(C) Keep the shared information confidential and use it only for the purpose of this section; and

(D) Not use or disclose the information obtained for this section except as allowed under section 17-1454-13.1.

(2) Placement of the two clients together shall occur only after all parties, including both case management agencies, the primary caregiver of the residential care facility in which the placement shall be made, and both clients, have agreed to the placement; and

(3) Any person who fails to safeguard confidential information or who violates rules governing the confidential nature of applicant and recipient information may be prosecuted for a violation, as provided in chapter 17-1401. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-24 Service monitoring. (a) The case management agency shall provide continuing, regular contact with the client, caregiver, and other service providers to ensure that:

(1) Services are being provided in accordance with the service plan and continue to meet the client's needs;

(2) The caregiver and residential care facility environment continue to meet the client's needs;

(3) Sufficient progress is made towards achieving desired goals and outcomes; and

(4) All of the client's rights, as provided in section 17-1454-50, are met.

(b) The service monitoring process shall include:

(1) Face-to-face contact with the client at least once a month, with more frequent contacts depending on the client's condition and the caregiver's capability. The frequency of this contact shall be specified in the service plan;

(2) Regular RN monitoring of the client who has a medically complex condition, as determined by

a physician or RN. The frequency of this monitoring shall be specified in the service plan;

(3) Ongoing evaluation of the client's response to and satisfaction with services provided and follow-up as needed;

(4) Ongoing evaluation of the appropriateness, timeliness, adequacy, and quality of services, caregivers, and home-like environment provided;

(5) Ongoing evaluation of the caregiver's status, behavior, and skills competency; substitute caregiver coverage and skills competency; and other caregiver responsibilities, such as child care or employment, to identify areas that may necessitate case management intervention;

(6) Assessment for, review, and follow-up activities on all reports of unusual occurrences involving the client, such as adverse events and inappropriate or lack of client supervision;

(7) Follow-up activities to assure that substandard care and unsafe practices or conditions have improved, or to arrange for alternative placement, as provided in section 17-1454-44;

(8) Assurance that a qualified caregiver is physically available to the client twenty-four hours a day, seven days a week;

(9) Facilitating and documenting conflict resolution of client complaints or grievances about services, service providers, as well as conflicts between contracted personnel and the client;

(10) Monitoring and documenting continued medicaid eligibility for medicaid waiver service recipients; and

(11) Reporting to the department any concerns the case management agency may have about the home in which a client has been placed, including but not limited to:

(A) Changes in the composition of the household; and

(B) Inappropriate activities on the premises. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-25 Reassessment. (a) The case management agency shall conduct face to face reassessments every six months or sooner, as appropriate, and shall use standardized assessment tools to reevaluate the client's:

(1) Diagnosis, health, functional, psychosocial, financial and environmental needs; and

(2) Compliance with the client's service plan.

(b) The case management agency shall have the client's physician re-certify the client's level of care on an annual basis or more frequently as needed. The medicaid medical consultant shall approve the re-certification for the client who is a medicaid recipient. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-25.1 Reduction and termination of services. The case management agency shall reduce or terminate its services to a client, as appropriate, when:

(1) Friends or relatives of the client express willingness and are able to care for the client without charge;

(2) A service provider refuses to provide requested services or the service provider contract is cancelled and no other options are available;

(3) The client no longer needs nursing facility level of care;

(4) The client or the client's legal representative chooses institutional care in lieu of community-based services;

(5) The client's case manager determines that the services necessary to assure the health and welfare of a client cannot be provided through placement in a residential care facility. Termination can occur after another viable alternative has been arranged for the client;

(6) The client moves out of the state of Hawaii;

(7) The client or the client's legal representative voluntarily requests termination from the program; or

(8) The client dies. [Eff and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-26 Grievance. The case management agency shall have policies and procedures by and through which a client may present grievances about the operation or services of the case management agency. The policies shall include a provision that a client may choose to present any grievance directly to the department of human services. The case management agency shall:

(1) Inform the client or the client's legal representative of the grievance policies and procedures and the right to appeal in a grievance situation;

(2) Provide a written copy of the grievance policies and procedures to the client or the client's legal representative, which includes the names and telephone numbers of the individuals who shall be contacted in order to report a grievance;

(3) Obtain signed acknowledgements from the client or the client's legal representative that the grievance policies and procedures were reviewed; and

(4) Ensure that operators of residential care facilities serving the case management agency's clients are aware of and comply with the case management agency's policies and procedures for clients' grievances. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-27 Records. (a) The case management agency shall maintain individual client records in a manner which ensures legibility, order, and timely signing and dating of each entry in black ink.

(b) Client records shall be kept in detail to:

(1) Permit effective professional review; and

(2) Provide information for necessary follow-up and care for the client.

(c) Client records shall contain:

(1) Information relating to the client's status regarding application, eligibility, termination, admission, suspension, transfer, or discharge activities;

(2) Information documenting the case management agency's efforts to find an appropriate match between a residential care facility and the

individual applying for case management services;

(3) Information documenting the case management agency's assessment, service planning, service coordination, monitoring, and reassessment activities;

(4) The initial skill competency of caregivers to perform the tasks necessary for implementation of each service plan and care of clients. Updates shall be documented as appropriate;

(5) All information and actions taken in response when changes occur in a client's behavior and functioning which may necessitate more or less services or other types of intervention and update of the service plan; and

(6) Written documentation of the case management agency's:

(A) Assessment of all verbal and written reports regarding the client received from the residential care facility, other agencies or from the client's family or legal representative;

(B) Use of the assessment to determine what action, if any, is needed;

(C) Actions undertaken, based on the reports and assessment; and

(D) Final disposition of the situation reported, as applicable. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-28 Fiscal requirements. (a) The case management agency shall have adequate resources to finance the operating costs of administration, maintenance, personnel, and to conduct its programs, including the provision of case management services in accordance with the provisions of this chapter.

(b) The case management agency shall maintain fiscal records, documents and other evidence that sufficiently and properly reflect all funds received, and all direct and indirect expenditures of any nature related to the case management agency's operation.

(c) All fiscal related material shall be maintained by the case management agency in accordance with generally accepted accounting principles, in a

form conducive to sound and efficient fiscal management and audit. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-29 Insurance requirements. The case management agency shall obtain, maintain, and keep in force through an insurance company authorized to do business in the State, or that meets the requirements of section 431:8-301, HRS, if using an insurance company not authorized to do business in the State of Hawaii, the following liability insurance, as appropriate:

(1) General;
(2) Automobile; and
(3) Errors and omissions.

(b) All policies shall contain an endorsement that such insurance may not be cancelled except upon thirty-calendar-days written notice to the State. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-30 Quality assurance. (a) The case management agency shall have internal policies and procedures for continuous quality improvement. The program shall include at least annual monitoring of the case management agency's compliance with licensing requirements, and plans for corrective action measures and their implementation dates, as appropriate.

(b) The case management agency shall have internal risk management policies and procedures that provide for ongoing monitoring and assessment of reports of adverse events, and analysis for trends in adverse events. The policies and procedures shall require:

(1) All service providers serving the client to verbally report adverse events to the case management agency within twenty-four hours of the occurrence.
(2) A written report to be sent to the case management agency within seventy-two hours, excluding weekends and holidays, following the verbal report required in paragraph (1).
(3) An evaluation of each report of adverse event by the case management agency to determine the appropriateness of actions taken and

completion of the report and follow-up process;

(4) A copy of the original report and a summary to be provided to the department of the case management agency's evaluation of any report of adverse events and any action taken by the case management agency, including adjustments to the client's service plan, as appropriate. The original report and summary shall be received by the department within seventy-two hours, excluding weekends and holidays, after the case management agency receives a written report of adverse event; and

(5) Quarterly assessment of reports of adverse events by the case management agency to determine trends and to document preventative actions taken when significant trends are noted.

(c) The case management agency shall have policies and procedures requiring all service providers serving the client to inform the case management agency of any changes occurring in the client's behavior and functioning that may necessitate a change and update of the client's service plan.

(1) The case management agency shall require a verbal report from all service providers serving the client within twenty-four hours of the occurrence of any of the following:

(A) Changes in the client's condition requiring emergency treatment;

(B) Hospitalization of the client;

(C) Environmental changes or disasters affecting the delivery of services to client; and

(D) Death of the client.

If any of the preceding events also constitutes an adverse event, the requirements of subsection (b)(1) shall be apply.

(2) A written report shall be sent to the case management agency within seventy-two hours, excluding weekends and holidays, following the verbal report required in paragraph (1).

(3) The case management agency shall have procedures for handling reports required in paragraph (1).

(d) The case management agency shall be subject to investigation by the department at any time. The

investigation may be announced or unannounced and may include, but is not limited to, one or more of the following:

(1) Reviews of administrative, fiscal, personnel, and client records;
(2) Inspection of service sites;
(3) Service site visits to interview clients and to observe personnel and sub-contractors providing services; and
(4) Interviews with case management personnel, and service sub-contractors. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14, 346-333) (Imp: HRS §§346-14, 346-333)

§17-1454-31 REPEALED. [Eff 2/11/02, R 2/7/05]

§17-1454-32 REPEALED. [Eff 2/11/02, R 2/7/05]

§§17-1454-33 to 17-1454-36 (Reserved).

SUBCHAPTER 3

COMMUNITY CARE FOSTER FAMILY HOME REQUIREMENTS

§17-1454-37 Operation of a community care foster family home. Any person, agency, or organization that wants to operate a home as a community care foster family home shall obtain a certificate of approval from the department. The person, agency, or organization shall:

(1) Not have had a previous certificate or license to provide residential, social, or health care services that was revoked and not successfully appealed within twelve months of the current application for a certificate of approval to operate a community care foster family home; and
(2) Comply with all applicable requirements set forth in this chapter. [Eff 2/11/02, am and comp 2/7/05] (Auth: HRS §§346-14,