COMMENT DUE DATE: February 17, 2022

Date: January 18, 2022

Darrin Thompson, Programs Manager **405-301-2895**
Holli Kyker, Policy Specialist **405-982-2217**
Brandi Smith, Legal Secretary III **405-982-2703**

It is important that you provide your comments regarding the **draft copy** of policy by the comment due date. Comments are directed to *STO.LegalServices.Policy@okdhs.org. The proposed policy is **PERMANENT**.

SUBJECT:

Subchapter 1. General Provisions
340:100-1-2 [AMENDED]
Subchapter 3. Administration
Part 1. General Administration
340:100-3-8 [REVOKED]
Part 3. ~~Operations~~ Administration
340:100-3-27 [AMENDED]
340:100-3-40 [AMENDED]
340:100-3-40.1 [REVOKED]
340:100-3-41 [NEW]
Subchapter 5. Client Services
Part 1. Admission and Safeguards
340:100-5-2 [REVOKED]
Part 3. Service Provisions
340:100-5-22.7 [NEW]
Part 5. Individual Planning
340:100-5-57.1 [REVOKED]
Subchapter 11. Admissions to Robert M. Greer Center
340:100-11-1 [REVOKED]
340:100-11-2 [AMENDED]
340:100-11-3 through 340:100-11-7 [REVOKED]
Subchapter 17. Employment Services
Part 4. Community Integrated Employment Services
340:100-17-25 [AMENDED]
(Reference WFs 20-09 and 22-100)

SUMMARY:

The proposed amendments to Chapter 100, Subchapters 1, 3, 5, 11 and 17 amend rules to implement changes recommended during the annual Developmental Disabilities Services (DDS) rule review process. The proposed rule adds provisions for Developmental Disabilities Services (DDS) to supplement room and board costs for individuals with exceptionally low income. These new provisions ensure that provider agencies are not paying room and board costs with Medicaid funding.

PERMANENT APPROVAL: Permanent rulemaking is requested.

LEGAL AUTHORITY: Director of Human Services; 56 O.S. §§ 162 and 1025 et seq., and the 21st Century Cares Act; and1915(c) of the Social Security Act.

Oklahoma Human Services
Rule Impact Statement

To: Programs Administrator
Legal Services Policy

From: Beth Scrutchins, Director
Developmental Disabilities Services (DDS)

Date: December 15, 2021

Re: **CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES**
Subchapter 1. General Provisions
340:100-1-2 [AMENDED]
Subchapter 3. Administration
Part 1. General Administration
340:100-3-8 [REVOKED]
Part 3. ~~Operations~~ Administration
340:100-3-27 [AMENDED]
340:100-3-40 [AMENDED]
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340:100-3-41 [NEW]
Subchapter 5. Client Services
Part 1. Admission and Safeguards
340:100-5-2 [REVOKED]
Part 3. Service Provisions
340:100-5-22.7 [NEW]
Part 5. Individual Planning
340:100-5-57.1 [REVOKED]
Subchapter 11. Admissions to Robert M. Greer Center
340:100-11-1 [REVOKED]
340:100-11-2 [AMENDED]
340:100-11-3 through 340:100-11-7 [REVOKED]
Subchapter 17. Employment Services
Part 4. Community Integrated Employment Services
340:100-17-25 [AMENDED]
(Reference WF 22-100)

Contact: Darrin Thompson 405-301-2895

A. Brief description of the proposed rule:
Purpose.

The proposed amendments to Chapter 100, Subchapters 1, 3, 5, 11 and 17 amend rules to implement changes recommended during the annual Developmental Disabilities Services (DDS) rule review process.

Strategic Plan Impact.

The proposed amendments: (1) position Oklahoma Human Services (OKDHS) DDS to improve services to individuals with intellectual and developmental disabilities; (2) support DDS goals of improving the quality of life of vulnerable Oklahomans by increasing individuals' abilities to lead safer, healthier, and more independent, productive lives; and (3) comply with federal requirements.

Substantive changes.

Subchapter 1. General Provisions

Oklahoma Administrative Code (OAC) 340:100-1-2 is amended to (1) update terminology; (2) add a definition for enabling technology; (3) update the definition for prescription medication to account for prescriptions from nurse practitioners and physician's assistants; and (3) update the definition of family homes to include adoption.

Subchapter 3. Administration

OAC 340:100-3-8 is revoked because the rule is no longer applicable. The policy applied to individuals working in the public facilities, which are now closed. The revocation aligns with the Governor's executive order to reduce unnecessary rules.

OAC 340:100-3-27 is amended to update terminology and add rules regarding virtual monitoring by a case manager as requested with changes to the Home and Community Based Services (HCBS) waivers effective 07/01/21.

OAC 340:100-3-40 is amended to: (1) update terminology; (2) remove requirement to use Form 06HM039E, Continuous Medical Record, as it requires agencies to duplicate documentation being maintained in other locations; and (3) remove references to Form 06HM006E, Health Status and Medication Review, as this form is revoked and combined with Form 06HM005E, Referral Form for Examination or Treatment.

OAC 340:100-3-40.1 is revoked because Form 06HM039E, Continuous Medical Record, is being discontinued as it requires agencies to duplicate documentation being maintained in other locations and aligns with the Governor's executive order to reduce unnecessary rules.

Subchapter 5. Client Services

OAC 340:100-3-41 is created to provide rules for telehealth service delivery as requested with changes to the HCBS waivers effective 07/01/21.

OAC 340:100-5-2 is revoked because the rule is no longer relevant and doing so aligns with the Governor's order to reduce unnecessary rules.

OAC 340:100-5-22.7 is amended to: (1) remove requirement for use of Form 10AD012E, Claim Form; (2) add requirement for provider to submit a written budget when requested; and (3) add clarifying language to criteria for when a service recipient may reimburse DDS.

OAC 340:100-5-57.1 is revoked because the rule duplicates procedures outlined in other rules and contains references to groups that are no longer required or used. Revocation of this rule aligns with the Governor's executive order to reduce unnecessary rules.

Subchapter 11. Admissions to Robert M. Greer Center

OAC 340:100-11-1 is revoked to reflect current practices and to align with the Governor's executive order to reduce unnecessary rules.

OAC 340:100-11-2 is amended to reflect current practices and processes for admission and discharge and to align with the Governor's executive order to reduce unnecessary rules.

OAC 340:100-11-3 through OAC 340:100-11-7 is revoked to reflect current practices and to align with the Governor's executive order to reduce unnecessary rules.

Subchapter 17. Employment Services

OAC 340:100-17-25 is amended to: (1) update terminology; and (2) update the definition of group placement to match the job coaching rule and the rate change that was effective October 1, 2020.

Reasons.

The proposed amendments update and clarify DDS rules, per Section 1020 of Title 56 of the Oklahoma Statues (56 O.S. § 1020).

Repercussions.

The proposed amendments contribute to the health and safety of vulnerable Oklahomans and position Oklahoma to continue to improve service provision.

Legal authority. Director of Human Services; 56 O.S. §§ 162 and 1025 et seq., and the 21st Century Cares Act.

Permanent rulemaking approval is requested.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the Agency from any private or public entities: The classes of persons affected by the proposed amendments are individuals receiving DDS services, who bear no costs associated with the implementation of the rules.

C. A description of the classes of persons who will benefit from the proposed rule: The classes of persons who benefit are individuals receiving DDS services.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change: There is no economic impact on individuals who receive DDS services.

E. The probable costs and benefits to the Agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule and any anticipated effect on state revenues, including a projected net loss or gain in

such revenues if it can be projected by the Agency: The probable OKDHS cost includes the cost of printing and distributing the rules, estimated less than $20.

F. A determination whether implementation of the proposed rule will have an impact on any political subdivisions or require their cooperation in implementing or enforcing the rule: The proposed amendments do not have an impact on any political subdivisions or require their cooperation in enforcing the rules.

G. A determination whether implementation of the proposed rule will have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act: The proposed amendments do not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the Agency has taken to minimize compliance costs and a determination whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule: The proposed amendments do not increase compliance costs. There are no less costly, non-regulatory, or less intrusive methods.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk: The proposed amendments bring the rules into compliance with federal and state law, thereby increasing program effectiveness positively impacting the health, safety, and well-being of affected individuals.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented: If the proposed amendments are not implemented, the rules will not comply with federal regulations and state laws. Therefore, the proposed amendments comply with federal regulations and state laws, thereby contributing to the health, safety, and well-being of vulnerable Oklahomans.

K. The date the rule impact statement was prepared and, if modified, the date modified: Prepared July 2, 2021; modified December 15, 2021.

Oklahoma Human Services
Rule Impact Statement

To: Programs Administrator
Legal Services Policy

From: Beth Scrutchins, Director
Developmental Disabilities Services (DDS)

Date: December 15, 2021

Re: **CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES**
Subchapter 5. Client Services
Part 3. Service Provisions
340:100-5-22.7 [NEW]
(WF 20-09)

Contact: Darrin Thompson 405-301-2895

A. Brief description of the proposed rule:

Purpose.

The proposed rule adds provisions for Developmental Disabilities Services (DDS) to supplement room and board costs for individuals with exceptionally low income. These new provisions ensure that provider agencies are not paying room and board costs with Medicaid funding.

Strategic Plan Impact.

The proposed rule improves Oklahoma Human Services (OKDHS) DDS services to individuals with intellectual and developmental disabilities; supports DDS goals to improve vulnerable Oklahomans' lives by increasing individuals' abilities to lead safer, healthier, and more independent, productive lives; and comply with federal requirements.

Substantive changes.

Oklahoma Administrative Code (OAC) 340:100-5-22.7 is created to set forth rules for supplemental room and board payments. To ensure Waiver funding is not used for room and board expenses when the service recipient has exceptionally low income, a room and board payment is provided with State General Funds.

Reasons.

The proposed rule updates and clarifies DDS rules in accordance with federal and state laws. The changes align rules with Section 1915(c) of the Social Security Act to provide home and community-based services (but not room and board) to individuals who require institutional level of care. Federal Medicaid dollars are not available to pay for the room and board expenses of non-institutionalized persons who receive DDS services.

Repercussions.
The proposed rule contributes to: (1) the health and safety of vulnerable Oklahomans who are in need of additional funding to support participation in community living; (2) the amendments to bring practices in line with Section 1915(c) of the Social Security Act; and (3) ensure that DDS is in compliance with federal regulations.

Legal authority. Director of Human Services; Section 162 of Title 56 of the Oklahoma Statues and 1915(c) of the Social Security Act.

Permanent rulemaking approval is requested. The rules listed in this Rule Impact Statement were approved by the Governor as emergency rule on February 22, 2021.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the Agency from any private or public entities: The classes of persons affected by the proposed rule are individuals receiving DDS services, who bear no costs associated with the implementation of the rules.

C. A description of the classes of persons who will benefit from the proposed rule: The classes of persons who benefit are individuals receiving DDS services.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change: There is no economic impact on individuals who receive DDS services.

E. The probable costs and benefits to the Agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the Agency: The probable OKDHS cost includes the cost of printing and distributing the rules, estimated less than $20.

F. A determination whether implementation of the proposed rule will have an impact on any political subdivisions or require their cooperation in implementing or enforcing the rule: The proposed rule does not have an impact on any political subdivisions or require their cooperation in enforcing the rules.

G. A determination whether implementation of the proposed rule will have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act: The proposed rule does not have an

adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the Agency has taken to minimize compliance costs and a determination whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule: The proposed rule does not increase compliance costs. There are no less costly, non-regulatory, or less intrusive methods.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk: The proposed rule brings DDS rules into compliance with federal and state law, thereby increasing program effectiveness, and positively impacting the health, safety, and well-being of affected individuals.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented: If the proposed rule is not adopted the state will be in direct conflict with Section 1915(c) of the Social Security Act.

K. The date the rule impact statement was prepared and, if modified, the date modified: Prepared December 17, 2020; modified December 15, 2021.

SUBCHAPTER 1. GENERAL PROVISIONS

340:100-1-2. Definitions

Revised ~~9-15-15~~9-15-22

The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Active treatment" means aggressive and consistent implementation of a program of specialized and generic training, treatment, and health services directed toward the service recipient's acquisition of skills necessary, in order to function as independently as possible.

"Advisory Committee on Services to Persons with Developmental Disabilities" means the committee appointed by the Director of Human Services (Director) to review and make recommendations on Developmental Disabilities Services (DDS) rules and programs ~~of Developmental Disabilities Services (DDS)~~.

"Advocate" means a person who speaks for or on behalf of a service recipient, especially when individual rights or interests are at risk.

"Alternative appropriate setting" means a setting, other than a nursing facility, ~~in which~~ where needed habilitation services are provided, including an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or Home and Community-Based Services (HCBS).

"Assessment" means one or more processes used to obtain information about a service recipient, including his or her condition, personal goals and preferences, functional limitations, health status, or other factors relevant to ~~the~~ service authorization or provision ~~of services~~. Assessment information supports the determination that an individual requires services ~~as well as the development of~~ and is used to develop the Individual Plan (Plan).

"Back-up-plan" means provision for alternative service delivery arrangements for ~~the delivery of services~~ critical to the service recipient's well-being in the event the service provider ~~responsible for furnishing the service~~ fails, is unable to deliver the services, or the home where the person lives is no longer available.

"Capacity to give informed consent" means ~~the~~ an individual's ability to make and express voluntary decisions, given correct and sufficient information about the nature, purpose, risks, and benefits of a proposed service or action, ~~and was~~ when the individual is not adjudicated incapacitated by a court for purposes of the decision.

"Case manager" means an Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) DDS professional who is responsible for assisting a service recipient in gaining access to needed medical, social, educational, or other services per Oklahoma Administrative Code (OAC) 317:30-5-1010.1. Case management activities may include assessment, plan development, plan implementation and monitoring, as well as assistance in accessing services and other resources.

"Challenging behavior" means a behavior that, by its frequency or degree of intensity:

(A) places a service recipient's physical safety, environment, relationships, or participation in the community at risk; or

(B) creates a risk of involvement in civil or criminal processes.

"Client Contact Manager (CCM)" means a computer software system used by DDS case managers to collect and monitor case management data for service recipients.

"Community Integrated Employment (CIE)" means a service program that provides placement, job training, and short-term or long-term supports to assist service recipients in achieving and maintaining employment within the community.

"Confidential information" means:

(A) information related to a service recipient generated by ~~DHS~~ OKDHS or contract providers; and

(B) observations of and discussions concerning service recipients, their families, guardians, or friends.

"Consumer" means a person who is a direct recipient or beneficiary of service planning and delivery and is synonymous with client, service recipient, individual, and member in Oklahoma Health Care Authority (OHCA) policy.

"Contract provider or agency" means an agency rendering services to persons with developmental disabilities under a contractual agreement with ~~DHS~~ OKDHS or OHCA.

"Convalescent care" means nursing facility care:

(A) following a person's release from an acute care hospital that is part of a medically prescribed recovery period ~~of recovery~~; and

(B) not expected to exceed an established number of days.

"DDS" means ~~DHS~~ OKDHS Developmental Disabilities Services.

"Developmental disability" means a person's severe chronic disability ~~of a person~~ that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the person ~~attains~~ is 22 years of age;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more ~~of the~~ major life activity areas ~~of major life activity that are~~:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

"Enabling technology" means equipment, product systems, engineered solutions, devices, or items that support a service recipient's increased independence in the home, employment site, or the community. These items address a service recipient's needs and outcomes identified in his or her Plan.

"Family homes" means residences maintained by persons ~~biologically~~ related by biology, adoption, marriage or common law, to a ~~person receiving services~~ service recipient.

"Family training" means activities designed to equip family members, significant others, and persons with developmental disabilities with knowledge and skills~~,~~ that allow a family member with developmental disabilities to remain in, or return to, his or her home.

"Goals" means long-term categorical statements that describe what the service recipient is expected to achieve in a given time frame and are used synonymously with outcomes.

"Guardian" means a person appointed by a court as general or limited guardian of the person, general or limited guardian of property, special guardian, or temporary guardian as provided by state statutes ~~to ensure~~. A guardian ensures the essential requirements for the ward's health and safety ~~of the ward~~ are met~~, to manage~~ and manages the ward's estate ~~or~~, financial resources ~~of the ward~~, or both.

"Guardian ad litem" means a person appointed by a court to represent the interests of a person in a legal action.

"Habilitation services" means goal-directed services and therapy activities:

(A) designed to assist a service recipient ~~acquire~~ in acquiring a variety of skills, including self-help, socialization, adaptive skills, and prevention of loss of skills; and

(B) based on the service recipient's capacity to increase ~~the~~ his or her own level of physical, mental, and social functioning.

"Human Rights Committee" means the committee charged with the responsibility for external monitoring and advocacy to address protection of individual rights.

"ICF/IID" means an intermediate care facility for individuals with intellectual disabilities (ID) that is:

(A) a residential facility licensed in accordance with Oklahoma law; and

(B) certified by the federal government as a Medicaid services provider ~~of Medicaid services~~ to persons who have ~~intellectual disabilities (~~ID~~)~~ or related conditions.

"Incapacitated" means a court determination ~~made by the court~~ that a person is unable to provide for and make decisions for ~~the person's~~ his or her own needs and safety.

"Individual Plan (Plan)" means a written document developed by the Personal Support Team (Team) based ~~upon~~ on a need assessment ~~of need~~. The Plan:

(A) specifies outcomes pursued on the service recipient's behalf ~~of the service recipient~~, steps taken to achieve outcomes; and

(B) is a single, comprehensive plan that encompasses all relevant components of the service recipient's life. Various aspects of the Plan are assigned to those persons or agencies designated by the Team to provide services.

"Individual provider" means a person rendering services to persons with ID under a contractual agreement with ~~DHS~~ OKDHS or OHCA.

"Intake" means the process ~~by which~~ a person ~~gains~~ goes through to gain access to DDS services. Intake staff:

(A) provides answers to specific service inquiries;

(B) assists in the identification of needs in times of crisis;

(C) supplies information regarding the range and means of accessing available services;

(D) provides assistance as necessary in service application; and

(E) facilitates eligibility determination.

"Intellectual Disability (ID)" means a person, per Section 1408 of Title 10 of the Oklahoma Statutes who:

(A) has significantly sub average functioning, an intelligence quotient (IQ) of less than 70 that manifests before 18 years of age; and

(B) exists concurrently with related limitations in two or more of the applicable adaptive skill areas that are:

(i) communication;
(ii) self-care;
(iii) home living;
(iv) social skills;
(v) use of community resources;
(vi) self-direction;
(vii) health and safety;
(viii) functional academics;
(ix) leisure; and
(x) work.

"Integrated employment site" means a location or activity that provides service recipients with regular interaction ~~for service recipients~~ with persons without disabilities, excluding service providers, to the same extent that a worker without disabilities, in a comparable position, interacts with others.

"Intrusive procedure" means a procedure that impinges upon the service recipient's bodily integrity ~~of the service recipient~~, per OAC 340:100-5-57 and OAC 340:100-5-58. Intrusive procedures include, but are not limited to:

(A) p.r.n. psychotropic medications used for behavioral control;
(B) physical management or physical restraint; and
(C) mechanical restraints for behavioral reasons.

"Job coach" means a person who holds ~~a DHS~~ an OKDHS approved job coach certification and provides ongoing support services to service recipients in supported employment placements. Services directly support the service recipient's work activity, including:

(A) marketing and job development;
(B) job and work site assessment;
(C) training and assessment;
(D) job matching procedures;
(E) developing co-worker supports; and
(F) teaching job skills.

"Least restrictive" means services and supports that maximize the service recipient's independence and freedom and are provided in a manner that is the least restrictive and intrusive possible to meet the service recipient's needs.

"Long-term resident" means a nursing facility resident ~~of a nursing facility~~ with ID or related conditions who has continuously resided in a nursing facility for at least 30- consecutive months prior to the date of the first preadmission screening and resident review (PASRR) disposition.

"Mechanical restraint" means any device used to hinder, forcibly confine, or control an individual's freedom of bodily movement.

"Monitoring" means the ongoing service provision observation and analysis ~~of the provision of services~~ to determine whether the services are furnished per the Plan and effectively meet the service recipient's needs, including whether services adequately protect his or her health and welfare. Monitoring activities may include, but are not limited to, telephone contact, observations, and interviewing the service recipient, family, or service provider.

"Natural supports" means assistance provided by a person, such as a service recipient's family, friend, co-worker, neighbor, or member of a service recipient's club, church, or interest group, or others in the service recipient's community, who:

(A) are not paid specifically to provide assistance to the service recipient; and

(B) provide voluntary assistance.

"Non-prescription medication" means a pharmacological drug sold without a prescription, prepackaged for the service recipient's use ~~by the service recipient~~, and labeled per state and federal statutes and regulations.

"Nursing facility" means an Oklahoma Medicaid-certified institution providing skilled nursing and related services, excluding a facility certified as ICF/IID.

"Personal Support Team (Team)" means the participants in the service recipient's assessment and planning process and includes:

(A) the service recipient; and

(B) service recipient's:

(i) case manager;

(ii) legal guardian; and

(iii) when applicable, advocate, who may be a parent, family member, friend, or other person who knows the service recipient well; and

(C) others, including service providers, whose participation is necessary to achieve the service recipient's~~,~~ desired outcomes.

"Physical management" means an intrusive procedure involving any physical guidance of a service recipient to overcome his or her resistance, or a brief upper body hold to ensure safety per OAC 340:100-5-57.

"Physical restraint" means an intrusive procedure ~~in which~~ where the service recipient is physically held to restrict movement.

"Plan of Care (POC)" means a summary listing of services requested as a result of needs identified within the Plan that indicates the amount, duration, and cost of each service recommended for funding through DDS HCBS Waivers.

"Preadmission screening and resident review (PASRR)" means the process of evaluating, reviewing, and establishing the need for nursing facility services in contrast to other services for persons with ID and related conditions.

"Prescription medication" means any drug ordered by a ~~practitioner of medicine, such as dentistry, osteopathy, optometry, or podiatry~~ health care provider, who is licensed by law to prescribe a drug, intended to be filled, compounded, or dispensed by a pharmacist.

"p.r.n." means to take or administer a medication as needed.

"Program coordinator" means a person employed by a DDS residential or group home contract provider agency ~~responsible for the supervision, coordination, and monitoring of services provided by~~ who supervises, coordinates, and monitors the contract ~~agency~~ agency's service provision to a service recipient.

"Program manager" means a person employed by a DDS employment contract provider agency ~~responsible for the supervision, coordination, and monitoring of services provided by~~ who supervises, coordinates, and monitors the contract ~~agency~~ agency's service provision to a service recipient.

"Psychotropic medication" means a pharmacological drug used to treat a mental disorder, or any drug prescribed to stabilize or improve mood, mental status, or behavior.

"Punishment" means the intentional application of something undesirable or unpleasant, or the removal of something desirable or pleasant, in response to a behavior deemed unacceptable.

"Punitive" means inflicting or involving punishment.

"QIDP" means a qualified ID professional who meets ICF/IID regulations per Section 483.430 of Title 42 of the Code of Federal Regulations (42 C.F.R. § 483.430). A QIDP must have a baccalaureate degree in a human services field, in addition to one year of experience serving persons with ID.

"Related condition" means a severe chronic disability, per 42 C.F.R. § 435.1010 that:

(A) is attributable to:

(i) cerebral palsy;

(ii) epilepsy; or

(iii) other condition except mental illness (MI) that is closely related to ID as it results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID and requires treatment or services similar to those required for persons with ID;

(B) is manifested before the person reaches 22 years of age;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitations in three or more major life activity areas ~~of major life activity~~, including:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) independent living.

"Response cost procedure" means the removal of a reinforcer the individual values as a consequence of a behavior with the intent of reducing the frequency of the behavior.

"Restrictive procedure" or **"restriction"** means a procedure that results in ~~the limitation of~~ limiting the service recipient's rights, per OAC 340:100-5-57 and OAC 340:100-5-58 and includes:

(A) limiting communication or association with others;

(B) any limitation of access to:

(i) leisure activities;

(ii) the service recipient's own money, personal property, or items purchased with the individual's money; and

(iii) food or beverages;

(C) any movement limitation ~~of movement~~ at home or in the community;

(D) visual or electronic supervision during times or places that would otherwise be considered private; or

(E) the use of a response cost procedure ~~that is the removal of a reinforcer valued by the individual as a consequence of a behavior with the intent of reducing the frequency of the behavior~~.

"Sheltered employment" means a service that:

(A) assists service recipients toward achieving their vocational potential through a controlled work environment;

(B) provides worker reimbursement in accordance with individual production and Fair Labor Standards Act (FLSA); and

(C) includes assessment, training, and transitional programming leading to community job placements.

"Sheltered workshop" means a facility that contracts with DDS to provide employment training and sheltered employment services for workers with disabilities.

"Short-term resident" means any resident with ID or related conditions who resided in a nursing facility for less than 30 months prior to the first PASRR disposition date ~~of the first PASRR disposition~~.

"Specialized services" means individualized services specified in PASRR evaluations ~~completed by~~ DDS completes that, combined with services ~~provided by~~ the nursing facility or other service providers provide, results in a treatment regimen leading to ~~the~~ continued and ongoing independence enhancement ~~of independence~~.

"Supplemental Security Income (SSI)" means a federal income subsidy program administered by the Social Security Administration.

"Supported employment" means competitive work in an integrated work setting with ongoing support services for service recipients with severe disabilities for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of severe disabilities.

"Terminal illness" means, as certified by a physician, a person with a medical prognosis of life expectancy of six months or less, when the illness runs its natural course.

"Transition" means ~~the~~ a service recipient's planned movement ~~of a service recipient~~ from one service setting to another, occurring as a result of a Team recommendation and the service recipient's informed consent ~~of the service recipient~~.

"Treatment team for specialized services" means the team whose purpose is to develop a prescribed plan of specialized services for each service recipient. The team:

(A) is composed of the service recipient, guardian or advocate, nursing home representative, and other professionals and paraprofessionals as needed to develop a comprehensive service plan ~~of services~~; and

(B) may include a psychologist, physical therapist, speech pathologist, physician, and nurse's aide among others.

"Vocational assessment" means the employment service evaluation, whether standardized procedures are employed, that:

(A) identifies the service recipient's unique preferences, strengths, and needs ~~of the service recipient~~;

(B) evaluates work skills and work behaviors;

(C) is supplemented by personal interviews and behavioral observations; and

(D) incorporates information that addresses the service recipient's:

(i) medical;
(ii) physical;
(iii) psychological;
(iv) social;
(v) cultural;
(vi) educational goals and objectives; and
(vii) present and future employment options.

"Volunteer guardian" means a person unrelated to the service recipient who:

(A) serves as guardian for the service recipient and is trained and certified by the volunteer guardianship agency; and

(B) is appointed by and responsible to the court to ensure essential requirements for the health and safety of the service recipient are met.

"Ward" means a person ~~for whom~~ who has a court-appointed guardian ~~is appointed by the court~~.

SUBCHAPTER 3. ADMINISTRATION

PART 1. GENERAL ADMINISTRATION

340:100-3-8. Client work [REVOKED]

~~Clients who perform work are compensated according to provisions of the Fair Labor Standards Act (FLSA) as amended.~~

~~(1) No client will be required to perform labor which involves the operation and maintenance of a facility without proper compensation except as it relates to the client's habilitation plan. When appropriate, residential staff shall be responsible for training programs designed to teach residents to clean and maintain their own living areas. Other household duties (chores) may be assigned to the residents on a rotational basis, provided the duties shall be in keeping with normal routines of daily living and not for the convenience of staff or as work for the residence. Regular participation in activities such as meal planning, food purchase, dishwashing, laundry, housekeeping, etc., that leads to the resident's greater functional ability (independence) is not considered work for the residence.~~

~~(2) All client work will be performed as an integral part of or is incorporated within the client's habilitation plan.~~

PART 3. ADMINISTRATION

340:100-3-27. Quality assurance

Revised ~~9-15-17~~9-15-22

(a) **Purpose.** Developmental Disabilities Services (DDS) quality assurance (QA) activities assess and encourage delivery of supports consistent with:

(1) the service recipient's preferences and needs ~~of service recipients~~;

(2) Oklahoma ~~Department of~~ Human Services ~~(DHS)~~ (OKDHS) rules;

(3) applicable Oklahoma Health Care Authority (OHCA) rules;

(4) ~~DHS~~ OKDHS and OHCA contract requirements for Home and Community-Based Services (HCBS);

(5) regulatory standards applicable to services; and
(6) federal and state laws.

(b) **Case manager monitoring.** DDS case managers assess services rendered to each service recipient to ensure service effectiveness ~~of services~~ in meeting the service recipient's needs. The case manager periodically observes service provision to assess implementation of the service recipient's Individual Plan (Plan). The requirements per this Section are minimum expectations for face-to-face visits with service recipients. Case management may require additional visits to ensure the service recipient's health and welfare.

(1) The DDS case manager conducts face-to-face visits to monitor the service recipient's health and welfare and service effectiveness in meeting his or her needs.

(A) Face-to-face visits ~~must~~ include observation of, and talking with, the service recipient regarding ~~the service recipient's~~ his or her health and welfare and satisfaction with services.

(B) The case manager may:

(i) observe service provision and related documentation in any location where services are provided; and

(ii) talk with family members and providers regarding service provision and the service recipient's health and welfare.

(C) For service recipients receiving services through an In-Home Supports Waiver ~~(IHSW)~~:

(i) a face-to-face visit ~~must be~~ is completed at least semi-annually with one visit occurring between January and June and one between July and December; and

(ii) at least one of the two visits ~~must occur~~ occurs at the site where the majority of services are provided.

(D) For service recipients receiving services through ~~a~~ the HCBS Community Waiver:

(i) a face-to-face visit ~~must occur~~ occurs during each calendar month in the ~~person's home who receives~~ residential ~~services~~ service recipient's home, per OAC 340:100-5-22.1, or the group home ~~services~~ service recipient's home, per OAC 317:40-5-152. Case managers ~~must~~ certify home visits on Form 06MP070E, Access to Record and Verification of Monitoring Requirements, located per OAC 340:100-3-40;

(ii) a face-to-face visit ~~must be~~ is completed each calendar-year quarter, coinciding with the quarters established per OAC 340:100-5-52 for a quarterly summary of progress reports, for service recipients who do not receive residential services or group home services, with at least two of these visits occurring at the site where the majority of services are provided; and

(iii) the case manager visits the employment or day services site at least semi-annually, with one visit occurring between January and June, and one between July and December, when services are funded through the HCBS Community Waiver unless the Personal Support Team (Team) requests a DDS area manager or designee approved exception.

(E) For service recipients receiving services through the Homeward Bound Waiver:

(i) a face-to-face visit ~~must occur~~ occurs in the home during each calendar month. Case managers ~~must~~ certify home visits on Form 06MP070E located within the home record per OAC 340:100-3-40; and

(ii) the case manager ~~must visit~~ visits the employment site each calendar-year quarter, coinciding with the quarters established, per OAC 340:100-5-52, for quarterly summary of progress reports, unless the Team requests a DDS area manager or designee approved exception.

(F) For Homeward Bound class members ~~of the Homeward Bound class~~ who reside in an intermediate care facility for individuals with intellectual disabilities ~~(ICF/IID)~~, the case manager visits monthly.

(2) The DDS case manager may also conduct virtual visits in addition to the required minimum face-to-face visits utilizing HIPAA compliant phone calls or video conferencing

~~(2)~~(3) DDS case managers review and ensure Plan implementation. The case manager completes a quarterly review for service recipients receiving services through ~~the Home and Community Based Services (~~HCBS~~)~~ Waivers, documenting the review in Client Contact Manager ~~(CCM)~~.

~~(3)~~(4) When the DDS case manager believes the service recipient is at risk of harm, the case manager takes immediate steps to protect the service recipient and notifies the DDS case management supervisor and other appropriate authorities.

~~(4)~~(5) When the DDS case manager determines ~~the~~ a provider is not effectively addressing a service recipient's needs ~~are not effectively addressed by a provider~~ or meeting contractual responsibilities or policies ~~are not met by the provider~~, steps in (A) through (C) of this paragraph are followed.

(A) The case manager consults with the relevant provider to secure a commitment for necessary service changes within an agreed time frame.

(B) When necessary changes are not accomplished within the specified time frame, the case management supervisor intervenes to secure commitments from the provider.

(C) When the service deficiency is not resolved as a result of the case management supervisor's intervention ~~of the case management supervisor~~, ~~a~~ an administrative inquiry referral ~~for administrative inquiry~~ is initiated, per OAC 340:100-3-27.1.

~~(5)~~(6) If, during a contract survey, administrative inquiry, ~~specialized foster care (~~SFC~~)~~ monitoring, or area survey, DDS QA staff discovers a situation that requires correction by DDS staff, a system administrative inquiry is initiated.

(A) DDS QA staff emails notification to DDS staff to correct the situation, establishing a reasonable time frame for correction.

(B) When the identified staff is unable to correct the situation within the established time frame, DDS QA staff emails notification to the DDS staff supervisor, establishing a reasonable time frame for correction.

(C) When the staff supervisor is unable to correct the situation within the established time frame, DDS QA staff notifies his or her supervisor, who notifies the DDS area manager, establishing a reasonable time frame for correction.

(D) When the area manager is unable to correct the situation within the established time frame, he or she notifies the DDS State Office QA unit, to resolve the situation with the community services unit deputy director.

(c) **SFC monitoring.** DDS QA staff monitors the SFC program in each area for DDS and OHCA policy compliance. Monitoring is based on a proportionate, representative sample of individuals receiving SFC supports identified for the fiscal year for each area. Monitoring includes a visit to the service recipient's SFC home. A home visit can be conducted virtually if the home has electronic equipment that allows for face-to-face communication unless health and safety issues are reported that require on-site review.

(d) **Consumer Service Evaluation.** At least annually, service recipients and families receiving supports are provided the opportunity to complete a service evaluation per ~~DHS~~ OKDHS Publication No. 89-10, Consumer Service Evaluation.

(1) Confidentiality is maintained unless the respondent authorizes ~~DHS~~ OKDHS to reveal his or her name to those responsible for service delivery. ~~DHS~~ OKDHS Publication No. 89-10 may be completed anonymously.

(2) DDS QA staff distributes ~~DHS~~ OKDHS Publication No. 89-10 to service recipients or his or her legal guardians at least annually.

(3) ~~DHS~~ OKDHS Publication No. 89-10, when completed is returned to the DDS State Office QA Unit.

(4) Results are forwarded to the respective DDS area office when authorized by the service recipient or legal guardian for resolution of concerns or staff recognition.

(5) ~~An~~ A response analysis ~~of responses~~ is completed and distributed to DDS area offices, DDS State Office, or ~~DHS~~ OKDHS for action. Data is available upon request.

(e) **Oklahoma - Advocates Involved in Monitoring (OK AIM).** Service recipients and families receiving supports participate in contact providers' formal assessments ~~of contract providers~~ to promote service enhancement, consistent with service recipient expectations.

(1) OK AIM operates under direction of the Oklahomans for Quality Services Committee (OQSC).

(A) OQSC is composed of 15 persons who receive or have a family member receiving DDS services. All areas of Oklahoma are represented.

(i) OQSC members may be nominated by the public at large, current OQSC members, or DDS representatives.

(ii) Appointment of OQSC members occurs as a result of joint consensus by the OQSC chair and DDS director or designee following a determination of the nominee's:

(I) commitment to promote the interests of persons with developmental disabilities; and

(II) capacity to dedicate the necessary time to fulfill his or her responsibilities.

(iii) OQSC members have the authority to elect officers based on a simple majority vote and establish by-laws governing the conduct of business.

(B) OQSC:

(i) develops and refines procedures and the survey instrument used, based ~~upon~~ on feedback ~~received~~ from service recipients and their families, providers, and other key constituents;

(ii) participates in the selection of agencies submitting proposals to conduct OK AIM activities; and

(iii) serves as a resource for education and coordination of agencies conducting OK AIM monitoring activities.

(2) ~~DDS~~ OKDHS issues ~~an invitation to bid (ITB)~~ and awards a Request for Proposal (RFP) in accordance with ~~state law and DHS rules~~ the Oklahoma Central Purchasing Act, Sections 85.1 through 85.44 of Title 74 of the Oklahoma Statutes (74 O.S. §§ 85.1 through 85.44) and the approved OKDHS Internal Purchasing Procedures, and solicits proposals from qualified organizations to participate in the OK AIM initiative. Qualified organizations include agencies that:

(A) are incorporated non-profit agencies dedicated to ~~the representation of~~ representing persons with developmental disabilities and their family members;

(B) are not involved in service delivery funded through DDS or HCBS Waivers; and

(C) meet additional requirements set forth by federal and state laws as indicated in the ~~ITB~~ RFP.

(3) OQSC is consulted regarding bids submitted in response to an ~~ITB~~ RFP. ~~Selection of a qualified organization to conduct OK AIM monitoring and reporting activities occurs per state law and DHS rules.~~

(4) Agencies selected to conduct OK AIM monitoring and reporting activities are responsible for:

(A) soliciting, screening, and training volunteers to conduct OK AIM site visits;

(B) scheduling site visits with all service providers referenced in the ITB within counties for which the agency assumed responsibility;

(C) ensuring consistency of volunteer and staff activities with:

(i) OQSC-approved procedures and protocols;

(ii) federal and state laws; and

(iii) ~~DHS~~ OKDHS and OHCA rules;

(D) accurately recording OK AIM monitoring activities findings;

(E) ensuring provision of findings to provider agencies and DDS; and

(F) immediately notifying the DDS area office of any issue identified during OK AIM monitoring activities that presents risk to the service recipient's health or welfare.

(5) DDS area managers identify ~~DHS~~ OKDHS staff responsible for resolving concerns identified during OK AIM monitoring activities and notify the agencies responsible on how to contact staff during business, evening, and weekend hours.

(6) OQSC with DDS State Office, DDS area offices, and agencies conducting OK AIM activities participation, identifies conditions determined to present significant risks to service recipients.

(A) Conditions determined to present imminent risks to service recipients are reported immediately to the:

(i) statutory investigatory authority;

(ii) DDS area office; and

(iii) provider agency chief executive officer (CEO) or designee.

(B) Issues determined to pose potential risks to service recipients are reported to DDS area office staff, who notify the provider agency CEO or designee, no later than at the close of the first business-day following observation.

(C) OK AIM monitors report any other significant issues to designated DDS area office staff within time frames ~~determined~~ OK AIM determines appropriate ~~by OK AIM~~.

(7) DDS staff immediately identifies DDS area office staff to assume responsibility for verification and correction of problems posing imminent or potential risks.

(A) ~~Time~~ The DDS area manager approves resolution time frames for ~~resolution of~~ validated concerns ~~are approved by the DDS area manager~~ based on the degree of risk.

(B) All identified concerns are resolved within 30-calendar days from initial notification to the DDS area office, unless the DDS area manager authorizes an extension ~~is authorized by the area manager~~ in circumstances that pose no jeopardy to any service recipient.

(C) Concerns presenting immediate and significant risk to service recipients are corrected immediately.

(8) Each DDS area manager designates staff to:

(A) track resolution of each identified concern; and

(B) advise agencies conducting OK AIM monitoring activities of the steps taken to resolve each concern.

(9) OK AIM staff summarizes findings of each home visit ~~conducted by~~ volunteers conduct, ~~noting~~ and staff notes performance in regards to the ~~context of~~ established OQSC expectations ~~established by OQSC, and~~ as published in the OK AIM training manual.

(A) Recommendations for service enhancement are presented to the relevant DDS area office for review within 30-calendar days of a home visit.

(B) DDS area office staff shares this information with the provider and collaborates on recommendations as well as other alternatives to achieve targeted service enhancement. Plans developed as a result are shared with OK AIM staff during the next meeting. Provider comments or action plans are maintained with the OK AIM report in area office files.

(10) ~~The~~ OQSC re-assesses the OK AIM survey process ~~is re-assessed~~ at least annually ~~by OQSC~~ and does so based on feedback solicited from service recipients, DDS area office staff, providers, and other constituencies affected by or involved in the process.

(f) **Independent assessments.** An independent authority annually assesses service outcomes for a sample of service recipients receiving residential services funded or administered through DDS or HCBS Waivers.

(1) Assessments employ standardized measures, facilitating individual as well as congregate data analysis over time.

(2) Assessment protocols provide for identification and resolution of circumstances posing immediate risks to service recipients.

(g) **Failure to cooperate.** Provider agencies failing to cooperate with provisions, or providing false information in response to inquiries per this Section, are subject to identified sanctions including contract termination.

(h) **Findings of non-compliance.** Findings of significant non-compliance with human rights, laws, or rules are immediately reported to the DDS director and other relevant authorities for appropriate action, including disciplinary action of ~~DHS~~ OKDHS employees

or ~~the~~ sanction imposition ~~of sanctions~~, including suspension or contract termination with provider agencies, per OAC 340:100-3-27.2.
(i) **Retaliation.** Provider agencies and ~~DHS~~ OKDHS employees are prohibited from any form of retaliation against any service recipient, employee, or agency for reporting or discussing possible performance deficiencies with any authorized ~~DHS~~ OKDHS agent. Authorized agents are ~~DHS~~ OKDHS staff whose responsibilities include administration, supervision, or oversight of DDS services, including all DDS and Office of Client Advocacy staff.
(j) **QA functions.** Additional DDS QA program components ~~of the DDS QA program~~ are found in OAC 340:100-3-27.1 through OAC 340:100-3-27.5.

340:100-3-40. Community records
Revised ~~9-16-19~~9-15-22
(a) **Purpose.** Oklahoma Administrative Code (OAC) 340:100-3-40 sets forth requirements for:
(1) contract provider records maintenance ~~of records by contract providers~~;
(2) document transfer ~~of documents~~ to a history file for service recipient records ~~maintained by~~ the contract provider maintains; and
(3) information transfer ~~of information~~ when a service recipient changes contract providers.
(b) **General requirements.** Records, electronic or paper, ~~maintained by~~ the contract provider maintains are indexed, orderly, well-maintained, readily accessible, and current. Records ~~must~~ contain adequate documentation of services rendered. Electronic records ~~must~~ meet the requirements~~, in~~ per OAC 317:30-3-4.1.
(1) All service recipient records are available for the service recipient, his or her legal guardian, contract provider staff, and Oklahoma Human Services (OKDHS) authorized agents to review~~,~~ upon request~~, by the service recipient, his or her legal guardian, contract provider staff, and Oklahoma Department of Human Services (DHS) authorized agents~~.
(2) The service recipient record is maintained with:
(A) an index;
(B) the service recipient's name on the record and on each page;
(C) discernable section tabs; and
(D) documents secured in the record.
(3) All entries in the record:
(A) are made per OAC 317:30-3-15;
(B) are in chronological order;
(C) are legible;
(D) include the date and time of each entry, with legible identification of the person making the entry; and
(E) include, when the entry is health-related:
(i) a description of the concern; and
(ii) action taken.
(4) The provider ensures compliance ~~with~~, per OAC 340:2-8-1 through OAC 340:2-8-13 and OAC 340:100-3-2, pertaining to personal information protection, use, and release ~~of personal information~~. The provider holds personal information regarding

service recipients, including names, addresses, photographs, evaluation records ~~of evaluation~~, and all other records confidential. Information is not disclosed, directly or indirectly, unless the adult service recipient or legal guardian consent ~~is obtained~~ in writing ~~from an adult service recipient or the legal guardian~~.

(c) **Home record for service recipients receiving community residential supports, group home services, or non-residential habilitation training specialist (HTS) services.** ~~A~~ The in-home contract provider maintains a current service record ~~of services is maintained by the contract provider in the home~~ for each service recipient receiving community residential supports, per OAC 340:100-5-22.1; group home service, per OAC 340:100-6; or non-residential HTS services, per OAC 340:100-5-35.

(1) Documents contained in each home record are not removed and~~,~~ include:

(A) guardianship documents and other legal documents;

(B) current Individual Plan ~~(Plan)~~ packet and addendum copies; ■ 1

(C) applicable health-related documents including, but not limited to:

(i) ~~Form 06HM039E, Continuous Medical Record, per OAC 340:100-3-40.1;~~

(ii) Form 06HM005E, Referral Form for Examination or Treatment, physician orders, discharge summaries, and emergency room reports;

~~(iii) Form 06HM006E, Health Status and Medication Review;~~

~~(iv)~~ special instructions or the Health Care Plan;

~~(v)~~(iii) individually-identified data forms relevant to the service recipient's current health status;

~~(vi)~~(iv) a Dyskinesia Identification System: Condensed User Scale (DISCUS) or Abnormal Involuntary Movement Scale (AIMS), when required, per OAC 340:100-5-29;

~~(vii)~~(v) current immunization record;

~~(viii)~~(vi) current medication administration records;

~~(ix)~~(vii) the most recent lab, x-ray, and consultation reports, and pharmacological evaluation, when applicable;

~~(x)~~(viii) miscellaneous health-related consultations and correspondence; and

~~(xi)~~(ix) Form 06HM073E, Referral Form for Psychiatric Treatment or Examination;

(D) miscellaneous documents relating to the service recipient including, but not limited to:

(i) observation notes;

(ii) Form 06CB035E, Site Visit Report, completed by all professional contract providers;

(iii) standing medical orders and protocols;

(iv) applicable data collection sheets; and

(v) documentation of program coordination staff home visits;

(E) quarterly residential progress reports ~~on progress~~; and

(F) Form 06MP070E, Access to Home Record and Verification of Monitoring Requirement, certifying that all authorized persons accessing the service recipient information contained within the home record were informed and understand the penalties for misuse of confidential and protected information, per Section 1533.1 of Title 21 of the Oklahoma Statutes.

(2) In unusual circumstances, at the Team's request, and with Developmental Disabilities Services field administrator's written approval, a service recipient's home record or specified document types ~~of documents~~ from the record may be maintained at a location other than the service recipient's home~~, when requested by the Team and approved in writing by the Developmental Disabilities Services field administrator~~.

(d) **Retention.** Each contract provider retains a record for each service recipient receiving services from the provider.

(1) ~~Transfer~~ There is a yearly transfer of all documents more than three months old from the provider agency's records to a history file ~~occurs yearly~~, unless otherwise specified, per OAC 340:10-3-40.

(2) The provider agency retains original records for a six-year period ~~of six years~~ or until any pending litigation involving the service recipient is completed, whichever occurs last.

(e) **Transfers between agencies.** When a service recipient changes provider agencies, within seven-calendar days of the transfer, the agency provides the new agency with a paper or electronic copy of the current home record and any health documents ~~requested by~~ the Team requests ~~within seven-calendar days of the transfer~~.

(f) **Other provider records.** The provider ~~must maintain~~ maintains service records that substantiate ~~the~~ service provision ~~of services~~, service recipient eligibility ~~of service recipients~~, and ~~outcome of services~~ service outcomes.

(1) Records are maintained for a six-year period ~~of six years~~ after ~~DHS~~ OKDHS makes the final payment and all pending matters are closed.

(2) The provider maintains copies of all claims, substantiating documents, and records regarding agency fiscal status within corporate offices in Oklahoma.

INSTRUCTIONS TO STAFF 340:100-3-40
Revised 1-1-20

1. **Individual Plan (Plan) packet. The Developmental Disabilities Services case manager provides to the home record and to the service recipient's Personal Support Team, items (1) through (12). The:**
   (1) Agreement to Implement Individual Plan (Plan);
   (2) annual medical report;
   (3) assessment information from providers used to develop the Plan;
   (4) documentation of Consumer Choice and Consent to Implement the Plan;
   (5) Client Contact Manager Consumer Data Sheets;
   (6) Form 15GR006E, Notice of Grievance Rights - Developmental Disabilities Services (DDS) service recipient, or Form 15GR007E, Notice of Grievance Rights - Hissom class member;
   (7) health summary, when applicable;
   (8) Oklahoma Health Care Authority Form LTC-300, Long Term Care Assessment;
   (9) Plan, including Person-Centered Assessment, and all addenda, including social and developmental histories;
   (10) protective intervention protocol, when applicable;
   (11) psychological evaluation; and

(12) Team Review of Advocate/Guardian Participation for Hissom Class Members only.

340:100-3-40.1. Continuous medical record [REVOKED]

~~Revised 5-15-08~~

~~The continuous medical record provides an overview of the medical history and current medical problems of the service recipient.~~

~~(1) Form 06HM039E, Continuous Medical Record, is:~~

~~(A) initiated by the contract provider;~~

~~(B) maintained in the home record per OAC 340:100-3-40; and~~

~~(C) required for service recipients who receive:~~

~~(i) community residential supports per OAC 340:100-5-22.1; or~~

~~(ii) group home services per OAC 340:100-6.~~

~~(2) Form 06HM039E includes, but is not limited to:~~

~~(A) physician's current diagnosis from Form 06HM005E, Referral Form for Examination and Treatment; and~~

~~(B) information regarding:~~

~~(i) medical allergies;~~

~~(ii) serious diseases and major illnesses;~~

~~(iii) surgeries;~~

~~(iv) fractures;~~

~~(v) sutured lacerations;~~

~~(vi) chronic medical conditions, such as seizures or diabetes; and~~

~~(vii) reasons for emergency room visits or hospitalizations and diagnosis within the past year.~~

~~(3) The health care coordinator:~~

~~(A) or back-up as described in OAC 340:100-5-26, is responsible for making accurate entries on Form 06HM039E within 24 hours of occurrence by recording the information identified in OAC 340:100-3-40.1(2) from Form 06HM005E or other medical records; and~~

~~(B) obtains the relevant historical information.~~

340:100-3-41. Telehealth

Issued 9-15-22

(a) **Applicability and scope.** Telehealth services do not expand services covered through Developmental Disabilities Services (DDS) Home and Community-Based Services (HCBS) waivers. Telehealth services are a delivery option for certain covered services. Telehealth services apply to contract professional services, including speech therapy, physical therapy, occupational therapy, audiology, psychology, nutrition, family training, family counseling, nursing, and dental care.

(1) When there are technological difficulties in performing an objective or a thorough assessment, or there are problems in the service recipient's understanding of telehealth, hands-on-assessment, in-person care, or both is provided for the service recipient.

(2) Any service delivered using telehealth technology is appropriate for telehealth delivery and meets the same quality level and is otherwise on par with the same service delivered in person.

(3) A telehealth encounter maintains the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, Section 1-109 of Title 43A of the Oklahoma Statutes, Part 2 of Title 42 of the Code of Federal Regulations (42 C.F.R., Part 2), and 45 C.F.R., Parts 160 and 164.

(4) For purposes of DDS HCBS waiver reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that occurs in real-time and when the service recipient is actively participating during the transmission.

(b) **Definitions.** The following words and terms when used in this Section shall have the following meaning, unless the context clearly indicates otherwise.

(1) **"Remote patient monitoring"** means using digital technologies to collect medical and other forms of health data, such as vital signs, weight, blood pressure, and blood sugar, from individuals in one location, and electronically transmitting that information securely to health care providers in a different location for assessment and recommendations.

(2) **"Store and forward"** means transmitting a service recipient's medical information from an originating site to the health care provider at a distant site. Photographs provided through a telecommunications system are specific to the service recipient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies do not include:

(A) consultations provided by telephone audio-only communication;

(B) electronic mail;

(C) text message or instant messaging conversation;

(D) website questionnaire;

(E) non-secure video conference; or

(F) facsimile transmission.

(3) **"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information through two-way, real-time interactive communication. This definition does not exclude store and forward technologies. Telehealth occurs between a service recipient and a health care provider with access to the service recipient's relevant clinical information prior to the telemedicine visit. Telehealth does not include website questionnaires, non-secure video conference, or facsimile transmission.

(c) **Requirements.** The following requirements apply to all services rendered via telehealth.

(1) Audio and video telecommunications are compliant with the Interactive Health Insurance Portability and Accountability Act (HIPAA), permitting encryption. The telecommunication service is secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a payment condition, the service recipient is an active participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image is technologically sufficient to support the service billed. Contract providers involved in the telehealth

visit are trained in the use of the telehealth equipment and are competent in its operation.

(3) The medical or behavioral health related service is provided at an appropriate site for telehealth service delivery.

(A) An appropriate telehealth site is one that has the proper security measures in place and appropriate administrative, physical, and technological safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

(B) The room location for the encounter ensures comfort, privacy, and confidentiality on both ends. There is both visual and audio privacy, and the room's placement and selection takes this into consideration.

(C) Appropriate telehealth equipment and networks are used considering factors such as appropriate screen size, resolution, and security.

(D) Providers, service recipients, or both, may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per Oklahoma Administrative Code 317:30-3-89 through 317:30-3-91.

(4) The provider is contracted with DDS and SoonerCare when required, appropriately licensed or certified, and in good standing. Services provided are within the scope of the provider's license or certification. If the provider is outside of Oklahoma, the provider complies with all laws and regulations of the provider's location, including health care and telehealth requirements.

(5) The service recipient retains the right to withdraw from telehealth services at any time.

(6) All telehealth activities comply with Oklahoma Health Care Authority policy, and all other applicable state and federal laws and regulations, including, but not limited to, 59 O.S § 478.1.

(7) The service recipient has access to all transmitted information, with the exception of live interactive video as there is often no stored data in such encounters.

(8) The service recipient's image and personal information is not disseminated to other entities without written consent from the service recipient or legal guardian, or a minor service recipient's parent or legal guardian.

(9) A telehealth service is subject to the same DDS HCBS waiver program restrictions, limitations, and coverage that exist for the service when not provided through telehealth, as only certain telehealth codes are reimbursable through a DDS HCBS waiver.

(e) **Reimbursement.**

(1) Telehealth services are billed with the appropriate modifier.

(f) **Documentation.**

(1) The service provider maintains documentation to substantiate the services rendered.

(2) Documentation indicates the services were rendered via telehealth and the location of the services.

(3) All other DDS documentation guidelines apply to the services rendered via telehealth. Examples include but are not limited to:

(A) chart notes;

(B) start and stop times;
(C) service provider credentials; and
(D) service provider signature.

(g) **Final authority.** DDS has discretion and the final authority to approve or deny any telehealth services based on DDS's or the service recipient's needs.

SUBCHAPTER 5. CLIENT SERVICES

PART 1. ADMISSION AND SAFEGUARDS

340:100-5-2. Service safeguards [REVOKED]

~~(a) **Client transition.** Consumers are assured the delivery of services compatible with need during movements from one service environment to another.~~

~~(1) DDSD staff and contract providers are responsible for assuring that client needs are met in the least restrictive and most normalized setting possible, and evaluate residential status at least annually as part of the Individual Habilitation Plan.~~

~~(2) Client movement to another setting requires the informed consent of the client and/or his/her legal representative. Consumers are advised of the advantages and disadvantages associated with residence in their current and prospective environment(s).~~

~~(3) Staff/providers of the sending and receiving programs, as well as the client/family/guardian, meet as an interdisciplinary team to identify client needs and develop specific action strategies for meeting needs prior to a client's movement.~~

~~(4) Local administrators develop procedures which assure client/family/guardian familiarity with proposed service environments prior to movement.~~

~~(5) Clients are not moved from one service setting to another until the interdisciplinary team confirms that all essential needs will be met in the new service environment.~~

~~(6) The client's Individual Habilitation Plan is reviewed within 30 days of admission/transition to a new service environment.~~

~~(b) **Client discharge.** The Department recognizes that most clients will require services for life, however, DDSD shall plan for each client's discharge from the time of eligibility determination and arrange for discharge when it is determined that the individual no longer requires or desires specialized services.~~

~~(1) Each client's interdisciplinary team considers circumstances resulting in the need for specialized services and incorporates strategies within the IHP aimed at facilitating the eventual discontinuation of services through skill achievement and/or integration into non-specialized services.~~

~~(2) Supervisory staff conduct a review annually to assess client progress toward meeting conditions facilitating discharge.~~

~~(3) Discharge planning is authorized with the informed consent of the consumer and/or legal representative.~~

~~(4) A discharge Individual Habilitation Plan is developed within 30 days of the discharge date which identifies the conditions for discharge, individuals responsible for the delivery of on-going, non-specialized services to the individuals and mechanisms which will allow the client to re-access services in the event of need.~~

~~(5) A signed statement confirming agreement with discharge provisions is secured from the consumer and/or legal representative prior to discharge.~~

PART 3. SERVICE PROVISIONS

340:100-5-22.7. Supplemental room and board funding for persons receiving Home and Community-Based Services (HCBS) Waivers

Issued 2-2-21

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers, per Oklahoma Administrative Code (OAC) 317:35-9-5, and Section 1915(c) of the Social Security Act. Specific Waivers include service recipients who receive:

(1) daily living supports, per OAC 317:40-5-150; or

(2) group home services, per OAC 317:40-5-152.

(b) **General Information.** In an effort to support participation in community life, Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) may supplement room and board costs for service recipients with income insufficient to meet the costs of the items listed in (1) of this subsection. Room and board costs are not a reimbursable Waiver expense, per the HCBS service regulations. Room and board expenses in a residential setting may leave a service recipient with insufficient personal funds. DDS State Fund supplemental payments permit a provider to be reimbursed for room and board costs beyond a service recipient's ability to pay with personal benefits income.

(1) Allowable room and board costs are actual monthly expenses that include:

(A) rent;

(B) food;

(C) housing supplies;

(D) utilities;

(E) basic cable or television;

(F) telephone;

(G) repair and maintenance that are not an obligation of another entity; and

(H) insurance.

(2) Room and board reimbursement is authorized, per OAC 340:100-3-33.1. When the need for a supplemental payment is expected to continue, cost effective community living arrangements are considered and documented in the Individual Plan. The supplemental room and board payment meets all of the requirements in (A) through (E) of this paragraph.

(A) Funding to meet the service recipient's needs is not available through another source.

(B) The service recipient's room and board expenses are consistent with fair market values for properties in the general area.

(C) The supplemental payment is necessary to support community living and is required for reasons other than the preference of the service recipient, family, or provider.

(D) The provider provides detailed expenses, including but not limited to, mortgage detail and status. The mortgage cannot be a loan with business debt that is greater than the property's fair market value or non-routine costs for non-physical plant excluding the normal escrow items such as taxes and insurance.

(E) The provider discloses common ownership interests between the provider and mortgage holder or lessor.

(3) The service recipient's Personal Support Team (Team) ensures the individual has a minimum of $100 of personal spending money each month unless the DDS director or designee approves a lesser amount.

(4) When possible, the Team develops a plan to resolve the room and board deficiency by identifying lower cost housing options or seeking roommates when there are additional bedrooms available.

(c) **Room and board payment.** Each service recipient contributes an amount the provider determines, not to exceed actual expenses. The service recipient contributes employment income to meet his or her room and board costs.

(1) To ensure Waiver funding is not used for room and board costs when the service recipient has exceptionally low income, a room and board supplement is provided. The supplement is provided when he or she: ■ 1

(A) does not have adequate income to meet room and board expenses;

(B) is awaiting a medical decision from the Social Security Administration for Supplemental Security income eligibility; or

(C) is unable to achieve sustained employment resulting in a room and board income deficit.

(2) Each month the provider submits OKDHS Form 06CL001E, Room and Board Supplement Claim Form, for reimbursement within three-months of the last date of service.

(3) Proof of payment for all claim expenditures is included with the initial claim. When the supplement extends beyond six months the provider submits proof of payment in six month intervals. For subsequent claims, DDS may request additional claim expenditures when a significant change occurs.

(d) **Provider requirements.** The provider establishes a written financial agreement with the service recipient or legal guardian that defines the provider and service recipient's responsibilities, per OAC 340:100-5-22.1. When requested, the provider submits a written budget to DDS.

(1) The provider ensures:

(A) service recipient expenses accrue on a monthly basis and are actual expenses;

(B) the Social Security Administration is contacted to review the service recipient's benefits when his or her personal benefits are low; and

(C) the service recipient is employed an average of 30 hours per week. When the service recipient does not participate in 30 hours per week of employment services, the Team develops a plan to address the situation, per OAC 317:40-7-15.

(2) The provider notifies DDS when the service recipient's room and board, income, or expenditures change significantly.

(e) **Service recipient requirements.** DDS may request that the service recipient reimburse OKDHS for the approved room and board expenses when he or she receives a Social Security Disability Benefits back payment. DDS may request reimbursement when:

(1) making the requested reimbursement does not cause the service recipient to be in debt; and

(2) the service recipient or his or her legal guardian completes OKDHS Form 06AD010E, Service Recipient Room and Board Reimbursement.

INSTRUCTIONS TO STAFF 340:100-5-22.7
~~Issued 2-2-21~~Revised 9-15-22

1. (a) When a service recipient has low income, Developmental Disabilities Services (DDS) assists in ~~the development of~~ developing a plan to remedy the cause for reduced personal benefits income.

(1) The Personal Support Team (Team) reviews the service recipient's personal income benefits to ensure he or she is receiving all eligible benefits ~~for which he or she is eligible~~. When it is discovered that he or she is eligible for additional benefits, the Team assists the service recipient in applying for additional benefits.

(2) When a service recipient resides in daily living supports (DLS), with ~~less~~ fewer than two roommates, the DDS field administrator may grant approval for a two-person DLS placement, per Oklahoma Administrative Code ~~(OAC)~~ 317:40-5-150. When the request is submitted, the DDS field administrator ensures the service recipient can afford his or her living arrangement.

(3) When the service recipient is unable to consistently participate in employment, DDS vocational staff is contacted to provide technical assistance to the Team.

PART 5. INDIVIDUAL PLANNING

340:100-5-57.1. Reporting and monitoring use of restrictive or intrusive procedures or emergency interventions [REVOKED]

~~Revised 5-15-08~~

~~(a) The service recipient's Personal Support Team (Team) and Human Rights Committee (HRC) review any use of an intrusive procedure, other than medication previously approved per OAC 340:100-5-26.1, or an emergency intervention to ensure the use was reasonable, necessary, and consistent with the protective intervention plan or in accordance with OAC 340:100-5-57(f).~~

~~(1) Form 06MP046E, Incident Report, is completed by the provider when an intrusive procedure or emergency intervention is used.~~

~~(2) The provider agency program coordination staff:~~

~~(A) reviews Form 06MP046E;~~

~~(B) completes a written evaluation that:~~

~~(i) indicates whether the:~~

~~(I) intrusive procedure was implemented according to the protective intervention plan; or~~

~~(II) emergency intervention complied with requirements per OAC 340:100-5-57(f);~~

~~(ii) indicates whether the use of intrusive procedure or emergency intervention was reasonable and necessary; and~~

~~(iii) includes recommendations and a description of actions taken; and~~

(C) in addition to the requirements of OAC 340:100-3-34, sends the evaluation and copy of Form 06MP046E to the service recipient's HRC, Developmental Disabilities Services Division (DDSD) case manager, and positive support field specialist within 72 hours following the incident.

(b) The DDSD case manager:

(1) reviews each Form 06MP046E and program coordinator evaluation received for service recipients in his or her caseload;

(2) ensures the service recipient's Team meets within five days of receipt of Form 06MP046E documenting use of an intrusive procedure or emergency intervention to ensure the use was reasonable and the least restrictive alternative available;

(3) completes Form 06CB055E, Monthly Summary of Restrictive/Intrusive Procedure Usage, for all restrictive or intrusive procedures or emergency interventions used for service recipients in his or her caseload, that describes systems concerns, recommendations, and planned interventions;

(4) takes necessary action to address identified issues; and

(5) sends Form 06CB055E to the DDSD director of psychological and behavioral supports.

(c) The DDSD director of psychological and behavioral supports and positive support field specialist:

(1) review and maintain copy of Form 06CB055E; and

(2) take further action as needed to ensure requirements per OAC 340:100-5 are followed.

(A) The positive support field specialist may be assigned to provide assistance to the Team.

(B) If problems are noted, an administrative inquiry per OAC 340:100-3-27.1 may be requested.

(C) If it appears use of restrictive or intrusive procedures or emergency intervention has occurred in violation of policy requirements, approval for use of physical management or emergency intervention may be suspended by the DDSD director of psychological and behavioral supports pending review by the Statewide Behavior Review Committee (SBRC) per OAC 340:100-3-14.

(D) If it appears abuse or neglect has occurred, the authorities charged by law with the investigation of alleged abuse are notified.

(E) The DDSD director of psychological and behavioral supports may require additional staff training or supports.

SUBCHAPTER 11. ADMISSION TO ROBERT M. GREER CENTER

340:100-11-1. Purpose [REVOKED]

Issued 5-18-92

The Robert M. Greer Center is an ICF/MR facility developed to provide appropriate programming for a dual diagnosis, Mentally Retarded/Mentally Ill (MR/MI), population. Admissions are generally by transfer from an Oklahoma Mental Health Facility or State School, however, direct admissions from the community may be accepted. All admissions shall be to the Diagnostic and Evaluation (D&E) Unit of the Greer Center. No person shall be denied access to services solely on the basis of a handicapping condition.

340:100-11-2. Intake, Diagnosis and Evaluation Process

~~Issued 5-18-92~~Revised 9-15-22

(a) ~~Eight beds in the East Building will be designated for diagnostic and evaluation purposes. The Greer Diagnostic and Evaluation (D&E) Team will be composed of a Qualified Mental Retardation Professional (QMRP), psychological assistant, physician, psychiatrist, nurse, direct care staff, speech pathologist, recreation therapist, vocational staff, and Independent Living Skills Instructor (ILSI). Additional team members and/or referrals will be added to the team if the initial screening indicates the need.~~ **Legal basis.** Section 1414.1 of Title 10 of the Oklahoma Statutes (10 O.S. § 1414.1) requires Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) to provide care for individuals with a primary intellectual disability diagnosis and a secondary mental illness diagnosis. The Robert M. Greer Center (Greer) was established for this purpose and serves individuals through a contract with OKDHS.

(b) ~~Referral sources are expected to be the Department of Human Services Divisions of Developmental Disabilities Community Services Unit(s), and/or the Department of Mental Health. All referrals should be via the appropriate Community Services Unit to insure continuity and appropriate referral.~~ **Admission criteria.** ■ 1 All admissions are consistent with Part 483.440(b) of Title 42 of the Code of Federal Regulations, regarding intermediate care facility admissions, transfers, and discharges.

(1) Admission criteria for an individual served through Greer includes:

(A) clinical evidence the applicant has challenging behaviors placing his or her physical safety, environment, relationships, and community participation at risk, or creates a risk of involvement in civil or criminal processes; and

(B) clear evidence documenting why the applicant cannot receive appropriate treatment in his or her current environment or through less restrictive community supports. The DDS director or designee approves Greer admissions.

(2) A referral packet is submitted to the DDS director or designee and contains, when available:

(A) a physical examination within one-calendar year of referral;

(B) a list of current prescribed medications;

(C) information regarding hospitalizations in the last two-calendar years, including the reason for admission and prognosis;

(D) physician orders and progress notes up to one-calendar year;

(E) nursing notes up to one-calendar year;

(F) medical records up to one-calendar year;

(G) guardianship or legal papers;

(H) social history and recent social evaluation;

(I) psychological evaluation conducted at 16 years of age or older, by a licensed psychologist, which includes:

(i) intellectual disability diagnosis based on testing that yields a full scale intelligence quotient;

(ii) functional and or adaptive assessment; and

(iii) a statement noting the age of onset of the disability;

(J) dental records;

(K) immunization record;

(L) multi-disciplinary progress notes or assessments up to one-calendar year for:
(i) physical therapy;
(ii) occupational therapy;
(iii) speech therapy and hearing services;
(iv) nutritional services;
(v) vocational; and
(vi) educational records for enrolled students; and
(M) behavioral incident reports;
(N) direct care notes; and
(O) current Individual Plan or treatment plan to include behavioral support plans.

(c) ~~When referral information is received by the Director of the Greer Center, he/she shall meet with the QMRP within 24 hours, or on the first working day if the packet is received on a Friday or the day preceding a holiday, to review the referral packet to determine.~~ **Admission.** Individuals considered for Greer admission are 18 years of age and older. When an applicant is 17 and a half and in need of treatment, the DDS director or designee may grant an exception to the age limit Former Greer residents are eligible for re-admission on the same basis as individuals initially seeking services. Admission is based on a referral packet review that includes:

(1) ~~if adequate information is contained in the packet, and~~ clinical evidence of mental illness, behavioral, or emotional problems, per the current edition of the Diagnostic and Statistical Manual of Mental Disorders, revised and published by the American Psychiatric Association;

(2) ~~if the packet contains any clinical evidence that would clearly contraindicate admission to the D & E Unit~~ documented attempts, and reasons for failure, of techniques and supports applied in the applicant's current environment~~.~~; and

(3) consideration of other available and appropriate community or Wavier services. Placement at Greer constitutes the least restrictive alternative to provide effective treatment to meet the applicant's needs when compared to other available options.

(d) ~~If no clinical evidence contraindicates D & E admission, the Center Director will recommend an admission date at the earliest possible time (within 72 hours). If the situation is critical (i.e., immediate danger exists to the client or others), admission will be recommended within 24 hours if an available bed exists. Admission must be accompanied with guardian/parent approval, or other legally valid form of consent for treatment at Greer (e.g. court or guardian ad litem). All applicable DHS forms will be used. The Superintendent or his/her designee shall be the admitting authority.~~ **Discharge.** ■2 Greer is a short-term treatment facility and residents are transitioned out of the facility when they meet criteria to safely live in a less restrictive placement. When Greer determines a resident is stable and no longer meets criteria to remain, a discharge referral is provided to the DDS director or designee. Discharge planning includes:

(1) a review of pertinent Greer information, including data to support progress made;

(2) discussion with facility staff regarding community supports needed to maintain the resident's stability; and

(3) a referral to the area DDS transition coordinators to initiate the search for potential homes in the community with necessary supports.

(e) ~~If no bed is available, the person may be admitted to a facility designated by the Department of Mental Health with transfer occurring per the Inter-Agency Agreement at~~

~~the earliest possible time.~~ **Post discharge activities.** ■ 3 Greer staff is available after discharge to consult with the individual's community personal support team.

~~(f) During the D & E process, individuals with an existing IHP will have those implemented as appropriate during the periods when formal evaluations are not occurring. When not in structured evaluations or IHP activities, individuals will be involved in a range of activities planned to enhance the evaluation process. Individuals will not attend programming with the Enid State School population unless clinically appropriate. Structured programming shall consist of a minimum of eight hours per day with replication of situational environments which caused problematic behaviors for assessment purposes. Overall active treatment occurs 24 hours daily.~~

~~(g) A preliminary medical assessment must be completed within 24 hours of admission to the D & E Unit. The initial screening for all other areas will be completed within 14 days. Based on the results of this screening, additional in-depth evaluation and further observations may be recommended. All referrals and additional evaluations will be completed within 20 days of admission. The D & E team will convene to make a recommendation within 48 hours after the evaluations are completed, and this recommendation will be forwarded to the Greer Center admission committee within 48 hours. The initial D & E team will gather assessment information including but not limited to the following areas:~~

~~(1) Intellectual and adaptive functioning levels,~~
~~(2) Mental/Emotional disorders and Behavioral Severity Assessment,~~
~~(3) Complete medical assessment; medication history update,~~
~~(4) Communication assessment,~~
~~(5) Social and leisure skills assessment,~~
~~(6) Social history update,~~
~~(7) Vocational assessment,~~
~~(8) Nursing assessment, and~~
~~(9) Psychiatric assessment.~~

INSTRUCTIONS TO STAFF 340:100-11-2
Issued 9-15-22

1. (a) When a service recipient is considered for admission into the Robert M. Greer Center (Greer), the Developmental Disabilities Services (DDS) case manager:

(1) ensures the Personal Support Team (Team) completes an assessment that identifies areas where the service recipient's or community's safety is at risk;

(2) ensures the Team reviews the service recipient's current circumstances, available community supports, incident reports, court orders, guardianship status, Individual Plan (Plan), Protective Intervention Protocol (PIP), prescribed medications, and other relevant circumstances related to the Greer referral;

(3) ensures the Team consults with the DDS positive support field specialist to discuss and document why the service recipient cannot receive appropriate treatment in his or her current environment;

(4) submits referrals for needed services; and

(5) submits a Greer referral to DDS state office when documentation indicates Greer is the least restrictive environment to meet the identified needs.

(b) DDS State Office staff:

(1) reviews existing court limitations or placement issues;

(2) provides service recipient programming recommendations for the current placement; and

(3) notifies the DDS case manager of the admission request's approval or denial.

(c) DDS area staff completes tasks necessary for admission.

2. When the Greer Discharge Committee approves a Greer resident for a community placement, the DDS transition coordinator:

(1) assists in locating community placements;

(2) meets with prospective case management and provider agency staff to discuss expectations and explain the Greer transition process;

(3) reviews the home location when community protection or health and safety concerns are present;

(4) provides the Greer assessments to the community Team;

(5) provides all eligibility documentation to intake and communicates transition dates to establish the plan of care (POC) start date;

(6) submits the Greer PIP to the DDS director of training and behavior support services for review and temporary approval for up to six months from the discharge date;

(7) attends the Greer transition meeting to ensure all services are in place prior to the transition;

(8) ensures a clinical pharmacy review referral is submitted to the DDS director of pharmacy services prior to the community placement;

(9) reviews the Plan prior to POC submission and provides recommendations for revisions as needed;

(10) works with the Team to identify and resolve transition related issues or concerns in the community placement;

(11) monitors progress for up to 18 months and attends the 30-calendar and 90-calendar day meetings and others as required to provide technical assistance;

(12) completes home visits at 15-calendar, 30-calendar, and 90-calendar days, and at six, 12, and 18 months post transition; and

(13) provides home visit summaries to the Team and to Greer.

3. If the service recipient experiences significant behavioral problems in the community placement, the DDS case manager contacts Greer for assistance.

340:100-11-3. Criteria [REVOKED]

~~Issued 5-18-92~~

~~The following criteria will apply for all admissions to the D&E Unit.~~

~~(1) Diagnosis of mental retardation by a psychologist, physician or psychiatrist. The diagnosis must be based on:~~

~~(A) intellectual evaluation;~~

(B) adaptive behavior evaluation;
(C) evidence that retardation occurred within the developmental period;
(D) statutory requirements (AAMR standards); and
(E) preference will be given to individuals whose retardation levels are moderate and above.

(2) Clinical evidence of behavioral/emotional problems, defined in the Diagnostic and Statistical Manual of Mental Disorders, as revised and published by the American Psychiatric Association, current edition, which establish a diagnosis of mental illness/ behavioral or emotional disturbance.

(3) Documented attempts and reasons for failure of treatment techniques applied in the person's current environment.

(4) Persons with pending criminal charges shall not be considered for voluntary admission into the Greer Center unless it can be clinically demonstrated that the behavior of the person does not pose an immediate danger to self or others.

(5) Persons considered for admission must not be considered by a psychologist, psychiatrist, or physician as homicidal or suicidal and have exhibited no suicidal or homicidal tendencies for six months prior to application for admission.

(6) If an applicant has any existing medical or surgical condition that is correctable, it must be remedied by the referring agency (facility) before admission is considered.

(7) If the person is currently a resident of a Department of Mental Health or Department of Human Services facility, a referral packet containing the following must be sent to the Director of the Greer Center for review:

(A) Current physical exam (within one year),
(B) Recent physician orders and progress notes (up to one year, if available),
(C) Recent nursing notes (up to one year, if available),
(D) Face sheet (medical records),
(E) Legal papers (legal status),
(F) Social history and recent social evaluation or update,
(G) Psychological administered or updated within 90 days of referral,
(H) Dental records,
(I) Immunization record,
(J) Multi-disciplinary progress notes (up to one year, if available) for example: P.T., O.T., Speech & Hearing, Vocational and Educational Services, Dietary, Direct Care notes,
(K) Individual Community Assessment Profile, if available, and
(L) Individual Habilitation Plan (if available).

(8) If the referral is for a person who does not currently reside in a Department of Mental Health or Department of Human Services facility, the following procedures must be followed:

(A) Referral must be made through the appropriate Division of Developmental Disabilities Division Community Services Unit,
(B) A determination must be made by the Community Services Unit that all other services are not appropriate and that the Greer Center is the most appropriate service, and
(C) A referral packet containing the documents listed in item 9 of this policy shall be submitted to the Director of the Greer Center.

(9) Persons formerly served by the Greer Center shall be eligible for readmission services on the same basis as an individual initially seeking services.

340:100-11-4. Admission to the Greer Center [REVOKED]

Issued 5-18-92

The D & E team will recommend admission to the Greer Center only if all of the following criteria are met.

(1) The existence of a diagnosis of mental retardation which qualifies the individual for Title XIX funding.

(A) This includes:

(B) A preference will be given to persons whose retardation falls in the mild to moderate range.

(2) Clinical evidence of behavioral or emotional problems defined in the DSM which establish a diagnosis of mental illness/ behavioral or emotional disturbance.

(3) There are documented attempts and reasons for failure of treatment techniques applied in the person's current environment.

(4) The Greer Center must constitute the least restrictive alternative to provide effective treatment to meet the needs of the applicant when compared with other available options.

(5) It is a reasonable expectation that treatment objectives for the individual can be met with Greer Center resources within a maximum of one calendar year. (Since the Greer Center's mission is for short-term treatment of an acute condition, i.e., to return persons to a less restrictive setting as soon as possible, persons requiring chronic, long-term treatment are not appropriate for admission.)

(6) All admissions will be reviewed monthly and the IHP time limited to 90 days with a recommendation for continued placement. The maximum length of stay is one year.

340:100-11-5. Admission and post-admission activities [REVOKED]

Issued 5-18-92

(a) Composition of the Greer Center Admission Committee shall be the Greer Center Director, a representative selected by the Department of Mental Health, and an independent psychologist/psychiatrist on contract to the Department of Human Services.

(b) The admissions committee will receive D & E recommendations no later than the 21st day after D & E admission. They will consider all available information, records and recommendations, and render an admissions decision. The committee will meet or be polled regarding their admissions decisions no later than the 25th day after D & E admission.

(c) The Greer Center Director or designee will serve as the recorder for that meeting and will take all necessary steps to implement the committee decision.

(d) If admission is denied, the individual will be returned to their place of origin within 48 hours. Any referring facility/agency must agree to meet these time requirements for return, in writing, prior to admission to the D & E process. If an applicant is not admitted to the Greer Center after undergoing the diagnostic and evaluation process, the referring agency shall reimburse the Department of Human Services for the number of bed days used at the medicaid rate for that unit.

~~(e) If admission is granted, the Greer Center Interdisciplinary Team will convene the initial IHP meeting no later than the 30th day following D & E admission. The applicant shall be certified for medicaid reimbursement from the initial date of admission.~~

340:100-11-6. Discharge procedures [REVOKED]

~~Issued 5-18-92~~

~~(a) Discharge planning will follow normal Developmental Disabilities Services Division discharge procedures. The DHS/DDSD Transition Plan will be followed and is attached for reference.~~

~~(b) If the individual's mental or physical condition requires treatment unavailable at the Greer Center, he/she will be immediately referred for appropriate intervention.~~

340:100-11-7. Waiting list procedures [REVOKED]

~~Issued 5-18-92~~

~~If a bed is not available when the referral is received, the individual's name will be placed on a waiting list. The order of admission to the D & E unit will be determined by the chronological order of receipt of the complete referral packet. If the referral packet is incomplete, notification of additional information needs will be given. The individual will not be placed on the waiting list until the referral packet is complete.~~

SUBCHAPTER 17. EMPLOYMENT SERVICES

PART 4. COMMUNITY INTEGRATED EMPLOYMENT SERVICES

340:100-17-25. Community integrated employment services

Revised ~~9-15-21~~9-15-22

(a) Community integrated employment (CIE) services promote independence through paid work and training activities. CIE services allow service recipients to engage in gainful integrated employment. CIE services are:

(1) delivered in integrated settings in the community by contract providers;

(2) provided to eligible service recipients 16 years of age and older who are not:

(A) eligible for reimbursement by Oklahoma Health Care Authority through Home and Community-Based Services Waiver employment services; or

(B) residing in a private intermediate care facility for individuals with intellectual disabilities; and

(3) available to service recipients 16 to 21 years of age who have not completed eligibility for services provided through Individuals with Disabilities Education Act. The service recipient may receive CIE services when school is not in session, when he or she is not participating in an Individual Education Program ~~(IEP)~~ that includes extended school year services through his or her school.

(b) Access to CIE services is contingent upon sufficient Oklahoma Human Services (OKDHS) resources and written eligibility determination ~~of eligibility~~, per OAC 340:100-3-1.

(c) The provider agency:

(1) may use, prior to placement, up to 20 hours for assessment and up to 40 hours for job development;

(2) after placement, provides, as needed, job site training, technical assistance to the employer, job adaptation, participation in Personal Support Team meetings, benefits planning, and transportation to and from the work site. These services are reimbursed when the job coach is with the service recipient;

(3) ensures the service recipient is paid per United States Department of Labor (USDOL) wage and hour regulations for work performed;

(4) ensures the service recipient's employment plan includes specific employment outcomes and action steps;

(5) ensures all CIE services are provided by job coaches who complete required training, per OAC 340:100-3-38;

(6) may bill for CIE services rendered prior to eligibility determination ~~of eligibility~~ when CIE services are authorized in an employment plan and the service recipient is ultimately determined eligible; and

(7) receives reimbursement for providing CIE services to only one service recipient at a given time. This does not preclude CIE services from being provided to service recipients in group settings, such as one job coach simultaneously providing CIE services to three service recipients for three hours, in this case, the job coach may only claim three reimbursement units ~~of reimbursement~~, not nine.

(d) CIE services include reimbursement for securing individual gainful employment, individual follow-along, and group placements.

(1) The provider agency ~~must secure~~ secures gainful employment in a job paying at least minimum wage for service recipients, in accordance with the current contract for CIE services.

(2) Follow-along services are available to service recipients who ~~were~~ successfully placed in CIE services or who completed stabilization in Oklahoma Department of Rehabilitation Services supported employment program during the prior contract year. Reimbursement for follow-along services cannot exceed amounts specified in the contract for CIE services.

(3) The provider agency may provide integrated group placements of two or more service recipients in gainful integrated group employment and claim per the contract for CIE services. Group placements:

(A) may pay at or more than minimum wage or commensurate wages per USDOL wage and hour regulations; and

(B) cannot exceed ~~eight~~ five service recipients.

(e) Payment for CIE services is only disbursed following the delivery of authorized CIE service to eligible service recipients.

(1) To receive payment, the provider agency submits ~~to the DDS state office~~ a claim for CIE services rendered ~~and~~, along with any supporting documentation required by OKDHS, to the Developmental Disabilities Services State Office. Claims may be submitted on the provider agency's invoice or on Form 10AD012E, Claim Form, and ~~must~~ include the:

(A) service recipient's:

(i) legal name;

(ii) case number;

(iii) date of birth; and

(iv) Social Security number; and

(B) category, amount, rate, and date of CIE service delivered to the service recipient.

(2) The provider agency maintains documentation available for review that documents the:

(A) service recipient's:

(i) legal name;

(ii) case number or Social Security number;

(iii) date of birth;

(iv) progress toward outcomes;

(v) wages earned; and

(vi) hours worked; and

(B) type and date of CIE service delivered to the service recipient.

(3) Claims for CIE service reimbursement ~~of CIE services must be~~ are submitted within 90-calendar days of service provision. Supporting encumbrances may be cancelled upon a lapse of six months from the actual provision of CIE services.