Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The setting assessments have not been completed. The timelines and plans for the settings assessment has been added to Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DRAFT Document 1.

• Following selection of and linkage to a Support Coordinator agency, the assigned Support Soordinator explains all available services in the waiver during the initial contact so that the participant and his/her family/legal representatives can make informed choices. The participant is also informed of any procedural safeguards, their rights and responsibilities, how to request a change of Support Coordination agencies or Direct Service Providers, and the grievance and/or complaint procedures. Printed information is given to the participant at this visit. The Support Coordinator provides assistance in gaining access to the full range of needed services including medical, social, educational, and/or other supports as identified by the participant.

• The initial planning meetings are conducted in a face-to-face visit in the participant's place of residence. During the initial visit, the participant chooses who will be part of his/her planning process. The Support Coordinator assists the participant/family in contacting the team members with the date(s) and time(s) of meeting(s). The Support Coordinator facilitates the planning meeting with the participant/family driving the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

• An Inventory for Client and Agency Planning (ICAP) is completed initially and as needed and is required prior to developing the Plan of Care.

• The Plan of Care is developed through a collaborative process which includes the Support Coordinator, participant and his/her family and friends, legal representatives, appropriate professionals/service providers, and others whom the participant chooses to be involved. This group is hereafter referred to as the support team.

• Initial Support Coordinator contact with the participant occurs within 3 business days of being linked to the Support Coordination agency of choice.

• For initial participants, the Plan of Care development process must begin within seven (7) calendar days following linkage to the Support Coordination agency of the participant's choice.

• The Support Coordinator contacts the participant and/or his/her family/authorized representative to schedule the initial, annual, and any subsequent support planning meeting at a time and place that is convenient to the participant and/or his/her family/authorized representative.

• The Support Coordinator is required to submit the complete initial Plan of Care to the appropriate LGE within thirty-five (35) days following linkage and then annually prior to the expiration of the annual Plan of Care.

• The LGE staff has ten (10) business days to review the information, complete the precertification home visit and approve the Plan of Care prior to waiver services beginning.

• At least quarterly, the Support Coordinator and the participant/family, and others the participant/family chooses to be present, review the Plan of Care to determine if the goals identified in the Plan of Care are being achieved, if the participant's/family's needs including health and welfare are being addressed, and to make any adjustments or changes to the Plan of Care as necessary.

• The entire support team meets annually to review and revise the participant's Plan of Care for the new Plan of Care year. The annual date of the Plan of Care does not change, even if there has been a more recent meeting to revise the services within the Plan of Care.

B. ASSESSMENTS

The Developmental Disabilities Support Needs Assessment Profile (DD SNAP) and the Inventory for Client and Agency Planning (ICAP) are completed for all applicants to the Louisiana developmental disability system. As appropriate other standardized assessments ((i.e., test of intellectual functioning (Wechsler Series of Intelligence Test and Stanford-Binet Intelligence Scales) and test of adaptive functioning (Vineland Adaptive Behavior Scales)) are used during the systems entry process to determine if an applicant has an intellectual or developmental disability. Information from the above assessments, as appropriate, is used in the development of the Plan of Care.

The needs-based assessments described below are completed within the discovery process for all applicants to identify the individual's service needs. Discovery activities include:

- An ICAP which is completed initially and as needed and is required prior to developing the Plan of Care.
- A review of the participant's records relevant to service planning (i.e. school, vocational, medical, psychological records, etc.)
- A personal outcomes assessment, which assists the planning team in determining personal goals and desired personal outcomes
- A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapy, physical therapy, speech therapy, nutritional, etc.)

In addition, the needs-based assessments described below may be completed within the discovery process for all applicants to provide additional information to assist in identifying the individual's service needs. Discovery activities may include the completion and review of the Supports Intensity Scale (SIS) and Louisiana PLUS (LA PLUS) assessments.

- The Supports Intensity Scale (SIS) is a standardized assessment tool designed to evaluate the practical support requirements of people with developmental disabilities. The SIS measures support needs for 85 different activities in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The SIS then rates each activity according to frequency, amount, and type of supports needed.

- The Louisiana PLUS (LA PLUS) is a complimentary assessment tool designed to identify support needs and related information not addressed by the SIS. The LA PLUS is used to evaluate a person's support needs based on information and data collected from four areas of the person's life, including:
  - Other support needs – material supports; hearing-related supports; supports for communicating needs; and stress and risks factors.
  - Living arrangements
  - Medical and diagnostic information
  - Personal satisfaction reports – supports at home; work/day programs; living environment; family relationships; and social relationships.

Information obtained through the discovery process is shared with the support team in preparation for the Plan of Care meeting and result in an individualized Plan of Care.
Based on the findings of the discovery activities described above a Plan of Care is developed.

A reassessment may be conducted at any time, particularly with a significant life change, but must be completed at least annually. The assessment process is intended to be ongoing and designed to reflect changes in the participant's life, needs, and personal outcomes, inclusive of his/her preferences.

If the participant disagrees with the proposed services in the Plan of Care the participant or his/her family/authorized representative may request additional services and present supporting documentation. If the participant or his/her family/authorized representative is not satisfied with the decision related to the request for additional services, then he/she may appeal any limit or denial of services through the Department of Health and Hospitals, Bureau of Appeals' process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing.

C. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

The Support Coordinator informs the participant and his/her family/authorized representative of all available waiver services during the initial contact with the Support Coordination agency, in quarterly meetings as needed, on an annual basis during the Plan of Care development process, and as requested.

D. INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN THE PLAN OF CARE

The following components are designed to incorporate the participant's goals, needs, and preferences in the Plan of Care:

- Discovery, which involves gathering information about the participant's interests, goals, preferences, and support needs through assessments and interviews. The discovery process ends with the formulation of the participant's vision and goals.
- Planning. This involves using the information from the discovery process to develop the Plan of Care. During the planning process, the support team works with the participant to develop strategies to assist him/her in achieving his/her goals and support needs. Strategies should identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs and an appropriate action plan. For each personal outcome/goal identified, the support team will identify the following: the participant's strengths, skills, abilities that can be used to achieve his/her goals; challenges, barriers, health issues, or risk factors that can be deterrents to meeting his/her goals; strategies, treatments, or trainings which can be implemented to overcome barriers; any opportunities available for increasing the participant's independence in achieving his/her goals.
- Implementation, which involves the completion of noted strategies and provision of needed supports according to the participant's Plan of Care.

E. COORDINATION OF SERVICES

The planning process requires the identification and utilization of all appropriate supports available to the participant prior to the support team considering waiver services.
Services are coordinated through the participant's Support Coordinator. The Support Coordinator leads the support team in developing a Plan of Care with and for the participant. The Plan of Care must include the following required components:

- The participant's prioritized personal goals and specific strategies to achieve or maintain his/her desired personal goals. These strategies will focus first on the natural and community supports available to the participant and, if needed, paid services will be accessed

as a supplement to natural and community supports.

- An action plan which will lead to the implementation of strategies to achieve the participant's personal goals, including action steps, review dates, and the names of the persons who are responsible for specific steps.
- Identified barriers, including health and safety risks, and specific strategies with timelines and the persons assigned to specific responsibilities, to address each issue.
- All the services and supports the participant receives, regardless of the funding source which may include natural support networks, generic community services, and state plan services.
- Identification of the frequency and location of services through a daily and alternate schedule.
- Identification of providers and specification of the service arrangement.
- Identification of the support team members who will assist the support coordinator in the planning process, as well as building and implementing supports for the participant.
- Signature of all support team members present in the planning meeting to indicate their agreement with the Plan of Care.

F. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN OF CARE

Each participant's Plan of Care includes multiple strategies and actions to achieve his/her life vision and goals, while addressing key support needs. The support team is responsible for:

- Identifying any necessary training the participant's family or staff need in order to implement the actions and strategies described in the Plan of Care and determining who will provide the necessary training.

- Identifying any resources needed by the participant's family or staff to implement the actions and strategies described in the Plan of Care and determining who will provide or acquire the needed resources.

In addition, the Support Coordinator is required to make a monthly contact with participant and visit the participant in his/her home once per quarter to monitor the implementation of the Plan of Care, the participant's satisfaction with services, and to determine if the participant has any new interests, goals, or needs.

The Support Coordinator is responsible for reviewing the information on the Plan of Care, tracking progress on identified goals and timelines, and obtaining updated information on the participant's natural supports. This includes monitoring how individual providers (e.g. vocational, supported living) implement their portion of the participant's Plan of Care so that all relative goals and objectives are achieved.

During the quarterly monitoring reviews, the support team will review various data sources related to the participant's goals and objectives in order to determine if progress has been made.

G. HOW AND WHEN PLAN IS UPDATED

At least quarterly, the support team meets to review the Plan of Care to determine if the participant's goals have been achieved, if the participant's needs are being met, and to make any adjustments to the Plan of Care.

The Plan of Care must be updated at least annually or as necessary to meet the participant's needs. The completed, updated, annual Plan of Care must be submitted to the appropriate LGE no later than thirty five (35) days prior to expiration of the previous Plan of Care.

At any time that the Support Coordinator or any other support team member identifies a condition related to the participant's health status, behavioral change, or any other type of change which is not satisfactorily addressed or which requires updated discussion or planning, the support coordinator will immediately reconvene the support team to revise the Plan of Care to reflect the participant's revised needs and desired outcomes. This change in the participant's condition or health status, behavior or other change may or may not have been identified through re-assessment of the ICAP but may have recently surfaced, been identified through the participant's primary care physician, or been identified through periodic monitoring.

Emergency revisions must be submitted by the support coordinator to the LGE within twenty-four (24) hours or by the next working day. Revisions that include routine changes, such as planned vacations, must be submitted by the Support Coordinator at least seven (7) days prior to the change.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Information from various assessments conducted during the planning process is used to identify any potential risks, which are then addressed through mitigation strategies that are included in the Plan of Care.

In addition, information gained during interviews with the participant and his/her legal representatives and support team members, as well as information from the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District pre-certification visit is also used during the initial planning process to identify potential risks to the participant.

• The participant and all support team members are given informed choice regarding the inclusion of any strategies recommended to be included in an initial or revised Plan of Care. The initial or revised Plan of Care with the included strategies must be signed and dated by all support team members.

• Recommendations from support team members on strategies to mitigate specific risk are incorporated into the Plan of Care. The LGE reviews recommendations, makes additional recommendations, and/or refers the issue to the OCDD State Office for input prior to approval of an initial or revised Plan of care.

The direct service provider is responsible for completing an emergency evacuation plan and back- up plan for each participant. Both are submitted to the Support Coordinator during the Plan of Care development process. The Support Coordinator is responsible for submitting the back-up plan and emergency evacuation plan to the LGE along with the participant's Plan of Care. The LGE ensures that the back- up plan and emergency evacuation plan are in place and will not approve the Plan of Care without these documents.

BACK-UP STAFFING PLANS

• Support Coordinators are to ensure that back-up and emergency evacuation plans are in place.

• All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety as outlined in the Plan of Care, and are required to have functional Individualized Back-Up Plans consistent with the participant's Plan of Care. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the participant.

• The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the agency's individualized back-up plan, and/or emergency evacuation response plan requirements unless agreed to by the participant/family because the family prefers to make other arrangements.

• The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and support coordinators.

• It is the identified enrolled provider of waiver services' responsibility to develop the back-up plan and provide it to the Support Coordinator in a time frame that will allow it to be submitted for review/approval as a part of the Plan of Care.

• The Support Coordinator is responsible for working with the participant, his/her family, friends, and providers during initial and subsequent Plan of Care meetings to establish plans to address these situations.

• The Support Coordinator assists the participant and the support team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's Plan of Care.

• All back-up plans must include detailed strategies and person-specific information that addresses the specialized care and supports needed by the participant as identified in the Plan of Care. Back-up plans must be updated no less than annually to assure information is kept current and applicable to the participant's needs at all times.

EMERGENCY EVACUATION PLANS

An Emergency Evacuation Response Plan must be developed in addition to the individual back-up plan, be included in or attached to the participant's Plan of Care, and reviewed a minimum of once each Plan of Care year.

The Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts.

The Emergency Evacuation Response Plan must include at a minimum the following components:

• Individualized risk assessment of potential health emergencies;

• Geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

• A detailed plan to address participant's individualized evacuation needs

Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security;

Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post-emergency protocols.

Training for direct support staff must occur prior to any worker being solely responsible for the support of the participant, and participants must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

On acceptance of the waiver offer, the data management contractor offers Freedom of Choice of Support Coordination agencies.

The participant and his/her legal representatives are informed of the services available under the waiver during the initial contact that occurs no later than three (3) business days after the participant's linkage to the Support Coordination agency of his/her choice.

At initial contact and annually with the participant, the Support Coordinator discusses the Provider Freedom of Choice form and the availability of all services. The Support Coordinator is responsible for offering Freedom of Choice of providers.

Part of this contact involves a discussion of Freedom of Choice of enrolled waiver providers, the availability of all services, as well as what the participant and his/her legal representatives require from Support Coordination. The Freedom of Choice list includes all providers in the participant's region that are enrolled to provide specific waiver services. The Support Coordinator is responsible for maintaining a current listing of qualified providers.

The Support Coordinator is responsible for advising the participant that changes in providers can be requested at any time, but only by the participant or personal representative. The Support Coordinator will facilitate any request for a change of all providers.

The participant and his/her legal representative are encouraged by the Support Coordinator to interview or visit each provider agency they are interested in, in order to make informed choices.

The Support Coordinator can assist the participant/family members in setting up appointments to interview the different provider agencies, they can assist the participant/family members on what questions they should ask the potential providers, and they can refer them to Families Helping Families or other advocacy groups. The Support Coordinator will assist with any other needs the participant/family members may have in selecting a qualified provider.

The Support Coordinator is not allowed to make recommendations and does not coerce the participant/family in making his/her decision.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Through a Memorandum of Understanding (MOU) with the Operating Agency (OCDD), the Medicaid agency (BHSF) has delegated approval of Plans of Care to the operating agency. This is done to assure that the operating agency is complying with all HCBS regulations related to service planning, is following the Residential Options Waiver Application requirements and is identifying areas of deficiency on the plans of care and implementing appropriate corrective actions. OCDD and BHSF will collaborate on any corrective actions as needed.

The Medicaid agency receives reports specific to the Residential Options Waiver which facilitate Medicaid's oversight of the service plan approval processes.

The following Operations Reports are generated quarterly from the Medicaid data contractor database: Program enrollment, LOC redeterminations, service plan timeliness, service utilization and made available directly to the Medicaid agency.

Participant Health & Welfare reports are generated from the MDS-HC Data Base & Medicaid Administrative Data Base annually and are submitted by OCDD to the Medicaid agency.

Mortality Reports are generated from the Medicaid Eligibility Data Base annually and are submitted by OCDD to the Medicaid agency.

Critical Incident Trend Report are generated quarterly from the Waiver OTIS Data Base and submitted by OCDD to the Medicaid agency.

Support Coordination Agency Monitoring Report: Support Coordination Agency Monitoring Data Base is generated annually and submitted by OCDD to the Medicaid agency.

HCBS Waiver Management Report: Trend and comparative abstract of data included in program operations report, critical incident trend report, and support coordination agency monitoring report. Frequency: annually.

These reports are reviewed and acted upon by the Cross-Waiver Quality Team which meets every other month and is composed of representatives from the Program Offices, Medicaid and DHH IT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ● **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Support Coordinator is responsible for monitoring the implementation of the Plan of Care, the participant's health and welfare and the effectiveness of the Plan of Care in meeting the participant's needs and preferences.

The Support Coordinator contacts the participant and his/her legal representative within 10 working days after the initial Plan of Care is approved to assure the appropriateness and adequacy of services delivery.

Support Coordinators make monthly contacts with each participant and/or his/her legal representatives. One contact per quarter must be a face-to-face visit in the participant's place of residence.

During these contacts the Support Coordinator checks to make sure that:

- There is access to waiver and non-waiver services identified in the Plan of Care, including access to health services;
- The strategies to meet the participant's personal goals are being implemented and the effectiveness of the strategies;
- The services outlined in the Plan of Care are meeting the needs of the participant;
- The participant is satisfied with the service providers he/she has chosen;
- Services are being furnished in accordance with the Plan of Care;
- The participant's health and welfare needs are being met; and
- Back-up plans, if utilized, are effective and persons identified as responsible for back-up plans are still active in the participant's life.

Information from Support Coordinator's monitoring is maintained at the Support Coordination Agency's physical office. Support Coordinators must refer any findings during contacts or visits that appear to be out of compliance with federal or state regulations, and OCDD policies to the LGE for review and recommendations. If the finding cannot be resolved at the local level, LGE will refer it to the OCDD State Office to be resolved.

Revisions to the Plan of Care reflect the results of the monitoring. During the monitoring of the Plan of Care implementation, if changes are needed, a revision to the Plan of Care will be completed. All revisions must be reviewed and prior approved by the LGE. Emergency revisions to the Plan of Care must be submitted to LGE within 24 hours or next business day. Routine revisions must be submitted to LGE within at least seven (7) days prior to the change.

If a participant receives a denial, reduction or termination of services, appeal information is provided to them as outlined in Appendix F, section F-1.

b. Monitoring Safeguards. *Select one:*

- ● **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.a.1. Number and percentage of plans of care in which services and supports align with the participants' assessed needs. Percentage = Number of plans of care that meet the assessed needs of waiver participants / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
✓ **State Medicaid Agency**	☐ **Weekly**
✓ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	✓ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.i.a.2. Number and percentage of plans of care in which services and supports align with the participant's assessed risk. Percentage = Number of plans of care that meet the assessed risks of waiver participants / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
✓ **Operating Agency**	☐ **Monthly**	✓ **Less than 100% Review**
☐ **Sub-State Entity**	✓ **Quarterly**	✓ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ State Medicaid Agency	Weekly
✓ Operating Agency	Monthly
Sub-State Entity	✓ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
D.a.i.a.3. Number and percentage of plans of care that address participants' personal goals. Percentage = Number of plans of care that address participants' personal goals / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
State Medicaid Agency	Weekly	100% Review
✓ Operating Agency	Monthly	✓ Less than 100% Review
Sub-State Entity	✓ Quarterly	✓ Representative Sample Confidence Interval = 95% +/- 5%
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ State Medicaid Agency	Weekly
✓ Operating Agency	Monthly
Sub-State Entity	✓ Quarterly

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.b.1. Number and percentage of plans of care that are developed in accordance with state requirements. Percentage = Number of plans of care that meet state requirements / Total number of plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ State Medicaid Agency	Weekly
✓ Operating Agency	Monthly
Sub-State Entity	✓ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.c.1. Number and percentage of annual plans of care received prior to the expiration date of the approved plan of care. Percentage = Number of annual plans of care received by due date / Total number of plans of care due during reporting period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
State Medicaid Agency	Weekly	100% Review
✓ Operating Agency	Monthly	✓ Less than 100% Review
Sub-State Entity	✓ Quarterly	✓ Representative Sample Confidence Interval = 95% +/- 5%
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ State Medicaid Agency	Weekly
✓ Operating Agency	Monthly
Sub-State Entity	✓ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.d.1. Number and percentage of participants who received services in the amount, frequency and duration specified in their plan of care. Percentage = Number of participants who received services in the amount, frequency and duration specified in their plan of care / Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Data Contractor

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	Weekly	✓ 100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	✓ Quarterly	Representative Sample Confidence Interval =
✓ Other Specify: Medicaid Data Contractor	Annually	Stratified Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
✓ **State Medicaid Agency**	☐ **Weekly**
✓ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	✓ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.e.1. Number and percentage of initial applicants who received a choice between waiver and institutional services as documented by an appropriately completed freedom of choice form. Percentage = The number of initial applicants who received a choice between waiver and institutional services / Total number of initial applicants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
✓ **Operating Agency**	☐ **Monthly**	✓ **Less than 100% Review**
☐ **Sub-State Entity**	✓ **Quarterly**	✓ **Representative Sample**

		Confidence Interval = 95% +/- 5%
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
✓ State Medicaid Agency	Weekly
✓ Operating Agency	Monthly
Sub-State Entity	✓ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
D.a.i.c.2. Number and percentage of waiver participants who received a choice of available waiver services providers, as documented by a signed and dated freedom of choice listing. Percentage = Number of participants offered choice of available waiver service providers / Total number of records reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
State Medicaid Agency	Weekly	100% Review
✓ Operating Agency	Monthly	✓ Less than 100% Review
Sub-State Entity	✓ Quarterly	✓ Representative Sample Confidence Interval = 95% +/- 5%
Other Specify:	Annually	Stratified Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Performance Measures D.a.i.a.1, D.a.i.a.2, D.a.i.a.3, D.a.i.b.1, D.a.i.c.1, D.a.i.e.1, and D.a.i.e.2: A random sample of participants whose plans were approved during the preceding quarter will be generated by OCDD. For each participant included, OCDD Regional Waiver Supports and Services Office or Human Services Authoritiy or District quality or supervisory staff will review participants records to obtain the information necessary for reporting these performance measures.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures D.a.i.a.1, D.a.i.a.2, D.a.i.a.3, D.a.i.b.1, D.a.i.e.1, and D.a.i.e.2:

During the Level of Care/Plan of Care (LOC/POC) Quality Review:
- Items needing remediation are flagged by the data system;
- Specific information related to the flagged item is entered into the data system;
- Remediation is tracked by verification of actions taken ; and
- Once remediation is completed, the case is closed.

On a quarterly basis at the State Office level, remediation data is aggregated and reviewed by the Performance Review Committee to assure that all cases needing remediation are addressed. Trends and patterns are identified in order to improve performance.

All aggregated discovery and remediation data is submitted by the operating agency to MPSW on a quarterly basis for analysis. MPSW also reviews the performance measure reports and monitors remediation activity on a quarterly basis to ensure all instances of non-compliance are remediated within 30 days of notification. MPSW then monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
✓ **State Medicaid Agency**	☐ **Weekly**
✓ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	✓ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Direction is a service delivery option which allows participants (or their authorized representative) to exercise Employer Authority in the delivery of their authorized self-directed services(Community Living Supports).

Participants are informed of all available services and service delivery options, including Self-Direction, at the time of the initial assessment, annually, or as requested by participants or their authorized representative. Participants, who are interested in Self-Direction, need only notify their Support Coordinator who will facilitate the enrollment process.

A contracted fiscal/employer agent is responsible for processing the participant's employer-related payroll, withholding and depositing the required employment-related taxes, and sending payroll reports to the participant or his/her authorized representative.

Support Coordinators assist participants by providing the following activities:

- The development of the participant's Plan of Care;
- Organizing the unique resources the participant needs;
- Training participants on their employer responsibilities;
- Completing required forms for participation in Self-Direction;
- Back-up service planning;
- Budget planning;
- Verifying that potential employees meet program qualifications; and
- Ensuring participants' needs are being met through services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [✓] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

To be eligible, the participant must:

- Be able to participate in the Self-Direction option without a lapse in or decline in quality of care or an increased risk to health and welfare. Health and welfare safeguards are articulated in Appendix G of this document and include the application of a comprehensive monitoring strategy and risk assessment and management system.

- Complete the training programs (e.g. initial enrollment training) designated by OCDD.

- Understand the rights, risks, and responsibilities of managing his/her own care, effectively managing his/her Plan of Care; or if unable to make decisions independently have a willing decision maker (authorized representative as listed on the participant's Plan of Care) who understands the rights, risks, and responsibilities of managing the care and supports of the participant within their Plan of Care.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants are informed of the Self-Direction option at the time of the initial assessment, annually, or as requested by participants or their authorized representative. If the participant is interested, the Support Coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, and the benefits and risks of each service option, and the process for enrolling in Self-Direction.

Prior to enrolling in Self-Direction, the participant or his/her authorized representative is trained by the support coordinator on the material contained in the Self-Direction Employer Handbook. This includes training the participant (or his/her authorized representative) on the process for completing the following duties:

- Best practices in recruiting, hiring, training, and supervising staff;
- Determining and verifying staff qualifications;
- The process for obtaining criminal background checks on staff;
- Determining the duties of staff based on the service specifications;
- Determining the wages for staff within the limits set by the state;
- Scheduling staff and determining the number of staff needed.
- Orienting and instructing staff in duties;
- Best practices for evaluating staff performance;
- Verifying time worked by staff and approving timesheets;
- Terminating staff, as necessary;
- Emergency Preparedness planning; and
- Back-up planning.

This training also includes a discussion on the differences between Self-Direction and other service delivery options (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

Participants who choose Self-Direction are provided with a copy of the Self-Direction Employer Handbook by the Support Coordinator or OCDD. Participants verify that they have received the required training from their support coordinator and a copy of the Self-Direction Employer Handbook by signing the "Service Agreement" form.

The Self-Direction Employer Handbook was developed through contribution and feedback from participants and families to ensure that the information is easy-to-understand and addresses participants' perspective.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Living Supports	✓	

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- ● **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - ☐ **Governmental entities**
  - ✓ **Private entities**

- ○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- ○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

  The waiver service entitled:

- ● **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal management services are provided by a contracted fiscal/employer agency, procured through the Department's Request for Proposal (RFP) process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The charges for fiscal management services will be paid through a monthly fee per participant by the Bureau of Health Services Financing (BHSF).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ✓ **Assist participant in verifying support worker citizenship status**
- ✓ **Collect and process timesheets of support workers**
- ✓ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☑ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Bureau of Health Services Financing (BHSF) is responsible for the monitoring of the performance and financial integrity of FMS and the terms of the contract. BHSF performs monitoring of the fiscal/employer agent's claims payment activities, billing history, and adherence to the terms of the contract on an on-going basis. OCDD provides BHSF with any data or other relevant information regarding the fiscal/employer agent's performance. If any problems are identified (regardless of the origination of issue), BHSF will require a corrective action plan from the fiscal/employer agent and will monitor its implementation.

Semi-monthly statements of participants' employer related payroll activities are sent to the participant, BHSF, and OCDD for review to monitor the utilization of Plan of Care units and payments.

In addition, BHSF requires that the fiscal/employer agent submit an annual independent audit by a Certified Public Accountant (CPA) to verify that expenditures are accounted for and disbursed according to generally accepted accounting principles.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Support Coordinators will inform participants of the Self-Direction option at the time of initial assessment, annually, and as requested by participants or their authorized representative. If participants or their authorized representative are interested, the Support Coordinator shall provide detailed information regarding the differences between service delivery options, roles and responsibilities in Self-Direction, and benefits and risks associated with Self-Direction. The Support Coordinator is responsible for providing the participant or their authorized representative with the Self-Direction Employer Handbook.

If the participant decides that he/she would like to participate in this option, the support coordinator shall notify the OCDD LGE and the Self-Direction Program Manager. Once notified by OCDD that the participant is eligible to participate in Self-Direction, the Support Coordinator facilitates the scheduling of the initial Self-Direction planning meeting.

The Support Coordinator will assist participants and their authorized representative with determining the number of direct care workers needed, preparing and completing of required forms as needed, determining what resources the participant will need to participate in Self-Direction, and arranging for other needed supports and services. The Support Coordinator will be responsible for training the participant (or his/her authorized representative) on the material contained in the Self-Direction Employer Handbook, which includes information on recruiting, hiring, and managing staff, with the participant.

The Support Coordinator will then facilitate planning and preparation of the Plan of Care/revision, which will be submitted to the OCDD LGE for approval. Support Coordinator is responsible for monitoring service delivery and implementation dates, and updating the participant's Plan of Care annually or as changes in service needs occur. The OCDD LGE will approve changes as needed.

Support Coordinators also act as a resource and advocate for the participant in identifying and obtaining formal and informal supports, assist the participant in working with the fiscal/employer agent, and provide employment support to participants inclusive of the duties specified in Appendix E-2-a-ii.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Dental	☐
Respite Services - Out of Home	☐
One-Time Transitional Services	☐
Assistive Technology/Specialized Medical Equipment and Supplies	☐
Companion Care	☐
Environmental Accessibility Adaptations	☐
Housing Stabilization Service	☐
Host Home	☐
Nursing	☐
Prevocational Services	☐
Transportation - Community Access	☐
Supported Employment	☐
Personal Emergency Response System	☐
Adult Day Health Care	☐
Shared Living Services	☐
Professional Services	☐
Day Habilitation	☐
Support Coordination	☑
Housing Stabilization Transition Service	☐
Community Living Supports	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

All waiver participants have access to independent advocacy through the Advocacy Center in Louisiana.

The Advocacy Center has a multi-disciplinary staff of lawyers, paralegals, client advocates and support staff who provide the

following services: Legal Representation, Advocacy Assistance, Information and Referral, Systems Advocacy, Education and Training, Self-Advocacy, Publications, and Outreach.

The Advocacy Center is Louisiana's protection and advocacy system. Federal law requires that a protection and advocacy system operate in every state to protect the rights of persons with mental or physical disabilities. The Advocacy Center is also funded by the state to provide legal assistance to people residing in nursing homes in Louisiana and to advocate for the rights of group home and nursing home residents. Among the diverse services offered are legal representation, information and referral, outreach and training. The Advocacy Center also provides limited legal services as well as outreach and education to senior citizens of Orleans, Plaquemines and St. Tammany under contract with the Councils on Aging in those parishes.

The Advocacy Center helps to give clients the skills and knowledge to act on their own behalf. The Advocacy Center provides a variety of booklets, reports, flyers, and other resources pertaining to persons 60 years or older and persons with disabilities. The Advocacy Center does not provide other direct services or perform waiver functions that have a direct impact on a participant.

Support Coordinators are responsible for informing participants of the availability of independent advocacy.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Selection of the Self-Direction option is strictly voluntary and the participant may choose at any time to withdraw and return to traditional payment option. Withdrawal requires a revision of the Plan of Care, eliminating the FMS and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

Should the request for voluntary withdrawal occur, the participant will receive counseling and assistance from his/her Support Coordinator immediately upon identification of issues or concerns in any of the above situations

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination requires a revision of the Plan of Care, eliminating the fiscal/employer agency and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual.

Involuntary termination may occur for the following reasons:

- If the participant does not receive self-directed services for ninety days or more.

- If at any time OCDD determines that the health, safety, and welfare of the participant is compromised by continued participation in the Self-Direction option, the participant will be required to return to the traditional payment option.

- If there is evidence that the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care and the Support Coordinator agrees, then the participant will be required to return to the traditional payment option.

- If the participant or the authorized representative/co-signer consistently:

  o Permits employees to work over the hours approved in the participant's Plan of Care or allowed by the participant's program

  o Places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff, as documented by the fiscal/employer agent.

  o Fails to provide required documentation of expenditures and related items, or fails to cooperate with the fiscal/employer agent or support coordinator in preparing any additional documentation of expenditures, as documented by the fiscal/employer agent and/or the Support Coordinator.

  o Violates Medicaid program rules or guidelines of the of the Self-Direction option.

- If the participant becomes ineligible for Medicaid and/or home and community-based waiver services, the applicable rule for case closure/discharge will be applied.

- If there is proof of misuse of public funds.

When action is taken to terminate a participant from Self-Direction involuntarily, the Support Coordinator immediately assists the participant in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the participant is eligible. There is no denial of services, only the transition to a different payment option. The participant and Support Coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	5	
Year 2	10	
Year 3	15	
Year 4	30	
Year 5	60	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

It is included in the FMS contract.

The cost of criminal background checks are paid for by DHH.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Louisiana Medicaid Eligibility Manual states, "Every applicant for and participant of Louisiana Medicaid benefits has the right to appeal any agency action or decision and has the right to a fair hearing of the appeal in the presence of an impartial hearing officer". (Medicaid Eligibility Manual, T-100/Fair Hearings/General Information).

Both applicants and recipients are afforded the right to request a fair hearing for services which have been denied, not acted upon with reasonable promptness, suspended, terminated, reduced or discontinued, La. R.S. 46:107. A person may file an administrative appeal to the Division of Administrative Law in the Louisiana Department of Health and Hospitals regarding the following determinations:

1) A finding by the office that the person does not qualify for system entry;
2) Denial of entrance into a home and community-based service waiver;

3) Involuntary reduction or termination of a support or service;
4) Discharge from the system; and/or
5) Other cases as stated in office policy or as promulgated in regulation.

During the initial assessment process, which must begin within 7 calendar days of referral/linkage of the participant to the Support Coordination agency, the Support Coordinator will give a participant and his/her legal representatives an OCDD information sheet entitled "Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver" which includes information on how to file a complaint, grievance, or appeal with the Louisiana Department of Health and Hospitals. A copy of this information sheet is kept in the participant's record at the Support Coordination agency's physical location of business. In addition, the Plan of Care contains a section that addresses the right to a fair hearing within ten days, and how to request a fair hearing, if the participant and his/her legal representatives disagree with any decision rendered regarding approval of the plan. Dated signatures of the participant, his/her legal representatives, and a witness are required on this section. Copies of the service plan, including this section are kept in the appropriate OCDD LGE and the Support Coordination agency's physical location of business.

If an individual does not receive the Louisiana Medicaid Long Term Care Choice of Service form offering the choice of home and community based services as an alternative to institutional care, and/or the Freedom of Choice form for case management and/or direct service providers, he/she or his/her legal representatives may request a fair hearing with the Division of Administrative Law in the Louisiana Department of Health and Hospitals in writing, by phone or e-mail. The OCDD Regional LGE is responsible for giving information to the individual and his/her legal representatives of how to contact the Louisiana Department of Health and Hospitals Division of Administrative Law by writing, phone or e-mail, and how to contact The Advocacy Center by phone or mail. This is done at the time of enrollment and at any other time the participant and his/her legal representative requests the number(s).

BHSF utilizes the Adequate Notice of Home and Community Based Services (Waiver) Decision Form 18-W to notify individuals by mail if they have not been approved for Home and Community Based Waiver services due to financial ineligibility. A separate page is attached to this form entitled "Your Fair Hearing Rights". This page contains information on how to request a fair hearing, how to obtain free legal assistance, and a section to complete if the individual is requesting a fair hearing. If the participant does not return this form, it does not prohibit his right to appeal and receive a fair hearing.

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate OCDD LGE providing 10 days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten days of receipt of a proposed adverse action by the OCDD LGE in order for current waiver services remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the OCDD Local Governing Entity (LGE). Once a request for an appeal is received, the OCDD LGE must submit the request to the Division of Administrative Law no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate OCDD LGE.

During an appeal request and/or fair hearing the Support Coordinator provides:
Assistance as requested by the participant and his/her legal representatives;
Documentation in progress notes of the status of the appeal; and
Information the participant and his/her legal representatives need to complete the appeal or prepare for a fair hearing.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law directly, or may request withdrawal through the OCDD Local Governing Entity (LGE). Requests for withdrawal are kept in the participant's record at the appropriate OCDD LGE.

Enrolled providers of waiver services provide participants and their legal representatives notice in writing at least fifteen days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services' physical location of business.

All Administrative Hearings are conducted in accordance with the Louisiana Administrative Procedure Act, La. R.S. 49:950 et seq. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.

The operating agency will provide MPSW with quarterly reports of those persons who have been notified of appeal rights when waiver services have been denied, terminated or reduced. Included will be dates of notification and reasons prompting notification.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Bureau of HealthServices Financing, Health Standards Section (HSS) is responsible for the operation of the grievance/complaint system.

The OCDD is responsible for receiving, reporting, and responding to customer complaints received for participants supported through their office, including those supported through the waiver.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OCDD is responsible for receiving, reporting and responding to customer complaints received for people supported through their office including those supported through the ROW. A complaint is a written or verbal statement expressing concern or dissatisfaction, which calls for action/resolution. Each OCDD entity including OCDD Regional Local Governing Entity (LGE) and State Office are responsible for receiving, reporting, and responding to customer complaints. Each OCDD entity is responsible for training their staff, participants, their families, and providers regarding OCDD's policy on Customer Complaints. A complaint may be made in person or by phone, fax, e-mail or mail to an OCDD entity. When a complaint is received by OCDD the complaint is triaged to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Health Services Finance, Program Integrity, Protective Services etc.) for action/resolution. The initiation of the complaint review and follow-up occurs within two business days of receipt of the complaint. Actions to resolve the complaint will be completed within thirty calendar days of receipt of the complaint. A written response describing the actions in response to the complaint, is mailed to the complainant within five (5) business days of the complaint resolution/action. OCDD will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a data base for tracking of complaints and quality management purposes.

The Bureau of Health Services Financing, Health Standards Section (HSS) is responsible for the operation of the Home and Community Based Waiver Complaint Line that involves complaints against licensed providers.

• The HSS State Office complaint line is the central point of entry for all complaints regarding the waiver. The HSS maintains an established complaint line with a toll free number for participants and their legal representatives.

• The nature and scope of the complaint is at the discretion of the individual registering the complaint.

• The complaint line number is printed on business cards, brochures, and fact sheets. It is given to participants and their legal representative(s) at intake by their Support Coordinator. During the pre-certification visit the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff checks to make sure that the information has been given to them. The Support Coordinator reviews the information during quarterly face to face visits, and each year at the annual service plan team meeting, or whenever it is requested by the participant and his/her legal representative(s).

• HSS and OCDD LGE, as well as support agencies such as Families Helping Families distribute the HSS complaint line information when assisting participants and their legal representative(s). Direct service providers are also required to give the complaint line number to all participants.

• Support Coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair

Hearing. OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff checks to make sure that this information has been relayed to them during the pre-certification visit.

• If the OCDD LGE or State Office staff is contacted by a participant/legal representative(s), other state agency, support coordinator or provider wishing to file a complaint, the OCDD LGE staff will refer the complaint by fax to the HSS complaint line within 24 hours for tracking and distribution.

• HSS triages all complaints in the following manner:

o. Provider non-compliance licensing issues are resolved by HSS.

o. Complaints identified as abuse, neglect, exploitation or extortion are referred immediately to the appropriate bureau of protective services (Child Protective Services, Adult Protective Services, or Elderly Protective Servcies).

o. All other types of complaints are referred to OCDD State Office for incident resolution. Complaints identified as critical events or incidents are investigated by the appropriate office within thirty days of receipt of such report.

• Pursuant to Louisiana Revised Statutes 40:2009.14 if the complaint involves provider non-compliance, HSS will investigate by telephone, provider report, or at the time of the next scheduled visit to the provider's facility and send a written report to the complainant within 45 days of receipt of the completed investigation, if a response to the complaint is requested by the complainant.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events or incidents that are required to be reported for review and follow-up action by the appropriate authority are:

• Abuse (adult/elderly): The infliction of physical or mental injury on a participant by other parties. (Louisiana Revised Statutes 15:1503).

• Abuse (child): Any acts which seriously endanger the physical, mental, or emotional health and safety of a child (Louisiana Children's Code, Article 1003).

• Exploitation: The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property (Louisiana Revised Statutes 15:1503).

• Extortion: The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 15:1503).

• Neglect (adult/elderly): The failure, by a caregiver responsible for an adult's care or by other parties, or by the adult participant's action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being (Louisiana Revised Statutes 15:1503).

• Neglect (child): The refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for an injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired (Children's Code Article 1003).

• Fall: A participant is either found on the floor or ground (un-witnessed event), or the participant comes to rest on the floor or ground unintentionally, assisted or unassisted (witnessed).

• Involvement with Law Enforcement: Occurs when a participant, his/her staff, or others responsible for the participant's care, are

involved directly or indirectly in an alleged criminal manner, resulting in law enforcement actions.

- Loss or Destruction of Home: Damage to or loss of the participant's home that causes harm or the risk of harm to the participant.

- Major Behavioral Incident: an incident engaged in by a participant that is alleged, suspected, or witnessed by the reporter that can reasonably be expected to result in harm, or that may affect the safety and well-being of the participant (e.g., attempted suicide, suicidal threats, self-endangerment, elopement/missing, self-injury, property destruction, offensive sexual behavior, sexual aggression, physical aggression).

- Major Illness: Any substantial change in health status, illness, or sickness (suspected or confirmed) which requires unscheduled treatment, or other medical intervention by a physician, nurse, dentist, or other licensed health care providers. Major illnesses include but are not limited to bowel obstruction, decubitis, pneumonia, or seizures.

- Major Injury: Any suspected or confirmed wound or injury to a participant of known or unknown origin requiring medical attention by a physician, nurse, dentist, or any licensed heal care provider.

- Major Medication Incident: The administration or self-administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer or self-administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist, or any licensed health care provider. Major medication incidents include staff error, pharmacy error, person error, medication non-adherence, and family error.

- Healthcare Admission: The admission of a participant to a hospital or other health care facility for the purpose of receiving medical care or other treatments, etc. Reportable healthcare admissions include acute care facility, emergency room, nursing home, psychiatric hospital, rehabilitation facility, respite center/supports and services center.

- Restraint Use: Any personal, physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts movement or function of a participant or a portion of a participant's body (OCDD Policy # 701 Restraints and Seclusion).

- Self-neglect: The failure by the participant's action or inaction to provide the proper or necessary supports or other medical, surgical, or any other care necessary for his/her own well-being. (Louisiana Revised Statutes 15:1503).

- Death: This is determined by the physician or coroner who issues the death certificate for a participant.

Individuals and entities who must report critical incidents and the reporting method(s) employed are:

- Participant and/or family member(s):
  - o Report as soon as possible to the direct service provider and/or support coordination agency.

- Direct Service Provider (DSP) staff:
  - o Must immediately take the necessary action required to assure the participant is protected from further harm and respond to any emergency needs of the participant.
  - o Must verbally report all critical incidents immediately upon discovery or within 2 hours of the incident to the Support Coordinator/Agency after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant.
  - o Must fax or hand deliver a copy of the completed Critical Incident Report (hard copy) to the Support Coordinator/Agency as soon as possible, but no later than 24 hours of the incident occurrence or discovery.
  - o Submit a follow-up report regarding the Critical Incident to the Support Coordinator/Agency by the close of the third business day following the initial report.

- Support Coordinator:
  - o When Support Coordinator discovers an incident, the Support Coordinator must contact the direct service provider within 2 hours of discovery and inform the provider of the incident. Must collaborate to assure that the participant is protected from further harm and assure that emergency actions are taken.
  - o Enters the critical incident information into the web-based Online Tracking System (OTIS) by close of the next business day.
  - o Enters follow-up case notes within 6 business days after the initial critical incident is received from the direct service provider or discovery by the support coordinator.

- OCDD LGE CSRA, or designee:
  - o Review all critical incident reports on a daily basis
  - o Immediately or within 24 hours notify verbally and in writing (via e-mail) the State Office Quality Management Designee, if the incident involves the death or the arrest of a participant or when the critical incident involves the abuse/neglect of a participant and results in the involvement of Law Enforcement.

- OCDD LGE Staff:
  - o When staff suspect or become aware that a Critical Incident meets the definition of abuse, neglect, exploitation, or extortion, immediately report the case to the appropriate protective agency (e.g., CPS, APS/EPS).
  - o Assure that activities occur within required timelines, including closure of the critical incident within thirty days, unless an extension has been granted

- OCDD Quality Management Section:
  - o Upon receipt of e-mail or verbal notification involving the death of a participant, the arrest of a participant, or of the abuse or neglect of a participant involving law enforcement, immediately, but no later than twenty-four hours, notify in writing, sending via e-mail to all the following:

DHH Deputy Chief of Staff;
DHH Bureau of Media and Communication;
OCDD Assistant Secretary or Designee;
OCDD Deputy Assistant Secretary;
Executive Director of Waiver Supports and Services;
Executive Director of Community Services;
OCDD Quality Management Staff;
Other OCDD State and LGE Staff as deemed appropriate

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

- A Rights and HIPAA form are completed during the initial Single Point of Entry Determination Process for System Entry intake interview with the individual and his/her legal representatives. A Support Profile is completed during the intake interview that addresses issues concerning the individual's well-being, health, safety, and security.

- During the initial assessment and Plan of Care development process, the Support Coordinator explains the participant's right to be free from abuse and neglect and gives the number for the HSS complaint line to the participant and his/her legal representatives, reviews the participant's rights and responsibilities and gives them a copy of the OCDD Rights and Responsibilities for Applicants/Recipients of a Home and Community Based Waiver. The Support Coordinator also checks that the participant and his/her legal representative(s) have the HSS complaint line number at the quarterly face-to-face visits, or whenever it is requested.

- The participant/family member has a responsibility for reporting critical incidents.

- During the Pre-Certification Visit (after the assessment process and Plan of Care have been completed, but prior to services being initiated) the OCDD Local Governing Entity (LGE)staff will review all information, including information about abuse and neglect, with the participant and his/her legal representatives; make sure that they have phone numbers for the HSS complaint line, the OCDD LGE, and the Support Coordination agency for reporting purposes; and that they understand their rights and responsibilities and have been given a copy of the OCDD Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver.

When there is a change in the participant's services, choice of self-direction, POC, etc., the participant's Support Coordinator reviews and explains the information with the participant/family. The Support Coordinator is available at any point in time to train/education the participant/family regarding issues/needs that may arise.

- Each direct service provider is required by licensing regulations to have a written orientation program for participants being admitted to their programs that include participant rights and responsibilities, and grievance and appeal procedures that contain information on abuse and neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports/Evaluation of Reports/Investigations/Timeframes:

- Direct Support Provider:
  - o Once notification of a Critical Incident is received by the provider agency, within two (2) hours of discovery, they must inform the support coordinator of the incident. The provider must assure that the participant is protected from further harm and respond to any emergency needs of the participant.
  - o If abuse/neglect/exploitation/extortion is suspected, provider must immediately contact the appropriate protective service agency (CPS, APS/EPS). The provider must cooperate with the appropriate protective service agency once the agency has been notified and an investigation commences. The provider is required to provide relevant information, records, and access to members of the agency conducting the investigation.
  - o The provider participates in planning meetings to resolve the Critical Incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.
  - o The provider tracks Critical Incidents in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

- Support Coordinator:
  - o Receives Critical Incident Report from provider within 24 hours of the incident. Enter the critical incident information into the web-based Online Tracking System (OTIS) by close of the next business day. Enter follow-up case notes within 6 business days after the initial critical incident is received from the direct service provider or discovery by the support coordinator. The support coordinator must collaborate with the provider to assure that the participant is protected from further harm and respond to any emergency needs of the participant.

o If abuse/neglect/exploitation/extortion is suspected, support coordinator must immediately contact the appropriate protective service agency (CPS, APS/EPS).

o Convene planning meetings that may be required to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents from occurring in the future.

o Obtain the participant summary from the web-based Online Tracking System (OTIS) after closure by the OCDD Regional Office or Human Service Authority/District and forward to the provider and participant within 15 days.

o Track critical incidents to identify required remediation actions and quality improvement goals, and to determine the effectiveness of strategies employed.

- OCDD LGE CSRA, or designee:

o On a daily basis, the CSRA, or designee, will review all new incoming critical incident reports, determine the report priority level (i.e., urgent or non-urgent), and assign the report to regional staff immediately or within 1 business day.

o Close cases after all needed follow-up has occurred and all necessary data has been entered into OTIS (supervisor review and closure).

o Tracks Critical Incidents by report to identify remediation needs and quality improvement goals and to determine the effectiveness of the strategies employed to assure resolution to the Critical Incident Report.

o The CSRA will sample Critical Incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve Critical Incidents.

- OCDD LGE Staff:

o Upon receipt of the notification of the Critical Incident from the CSRA, staff will continue case follow-up which includes providing technical assistance to the support coordinator, requesting any additional information from the support coordinator as needed, review to assure that all necessary information has been entered by the support coordinator into the web-based Online Tracking System (OTIS).

o If staff suspect or become aware that a Critical Incident meets the definition of abuse, neglect, exploitation or extortion, staff must immediately report the incident to the appropriate protective service agency.

o Make timely referrals to other agencies as necessary.

o Staff will complete the participant summary and assure closure of the Critical Incident within 30 days.

- CPS (ages 0 to 17):

o Upon receipt of an allegation or report of abuse, neglect or exploitation involving a child by a family member or legal guardian, CPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 90 days.

o If the perpetrator/accused is a direct service provider staff person, a report is made to Health Standards Section for the investigation.

- APS/EPS(ages 18 and above):

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion involving an adult/elderly participant by a family member or legal guardian, APS/EPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 90 days.

o If the perpetrator/accused is a direct service provider staff person, APS/EPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 30 days.

- Health Standards Section:

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion by a direct service provider staff, Health Standards Section investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 30 days.

- Law Enforcement:

o Upon receipt of an allegation or report of abuse, neglect, or exploitation of a child that involves a direct service provider staff, law enforcement will investigate within their timeframe for closure of the case.

- OCDD State Office (Quality Section):

o Within 24 hours or immediately upon discovery, OCDD LGE will notify both verbally and in writing (via e-mail) the OCDD State Office Quality Management Designee when critical incidents involve the death or arrest of a participant, or when critical incidents of abuse/neglect of a participant results in the involvement of Law Enforcement.

o Provides technical assistance to the OCDD Local Governing Entity (LGE)as needed. OCDD State Office (Quality Section) identifies necessary remediation to be taken by the direct service provider, support coordinator/agency, and OCDD LGE staff.

o Identifies and reviews trends and patterns to identify potential quality enhancement goals and utilizes the critical incident data to determine the effectiveness of OCDD Quality Enhancement strategies.

Process and timeframes for informing the participant/family/legal representative and other relevant parties of the investigation results:

- The OCDD LGE staff completes the participant summary for all Critical Incidents within 30 days of the Critical Incident.

- The support coordinator obtains the participant summary and forwards a copy to the participant and direct service provider within 15 days of closure by the OCDD LGE.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OCDD is the State entity responsible for overseeing the operation of the incident management system.

A multi-agency Memorandum of Understanding delineates the responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants. Agencies include Medicaid, OCDD, and Local Governing Entities.

The process for the oversight agency to communicate information and findings to the Medicaid agency:

• OCDD provides the State Medicaid Agency quarterly reports which include all Critical Incidents.
Methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

• Periodically, the OCDD LGE shall select a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents.

• A sample of critical incidents to review for adherence to policy, including a review to determine if all necessary actions were taken to address/resolve critical incidents is selected.

• OCDD aggregates critical incident data and analyze the data to identify trends and patterns;

• OCDD reviews reports of the trends and patterns to identify potential quality enhancement goals;

• OCDD utilizes critical incident data to determine the effectiveness of quality enhancement strategies.

• OCDD utilizes the information and data collected on critical incidents for quality management purposes, including but not limited to the following:
o Development and review of reports to assure that follow-up and case closure of critical incidents occur according to this policy on an on-going basis for individual cases and quality review of aggregate data
o Quarterly analysis of data to identify trends and patterns for effective program management that ensures the safety and well-being of people receiving OCDD supports and services and ensures that people receive quality supports and services from OCDD
o Annual analysis of data to determine the effectiveness of quality enhancement goals and activities; and
o Identification of participants who experience frequent critical incidents and will need strategies to mitigate risk included in their Plan of Care on an on-going basis by support coordination agencies as they perform their quarterly Plan of Care reviews.

Frequency of oversight activities:
MPSW reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine if there are any trends and patterns that indicate further action is needed. MPSW also monitors the data reports to see if remediation activities implemented in the previous quarter were effective in improving data results for the current period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

MPSW also conducts a look-behind review of critical incidents to ensure remediation activities occurred correctly and timely; if necessary steps were taken in response to reported incidents; and if appropriate referrals to HSS and protective services/law enforcement were made.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

● **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraint: any physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts movement or function of the person or a portion of the person's body, must be reported as a critical incident. Categories of

restraint use:

•Behavioral: restraints used to suppress a person's behavior and do not include restraints utilized when conducting a medical treatment. May be planned or unplanned. May involve personal, mechanical, or chemical restraints. Includes a protective hold.

•Medical: restraints applied as a health related protection that are prescribed by a licensed physician, licensed dentist, or licensed podiatrist. Used when absolutely necessary during the conduct of a specified medical or surgical procedure or when absolutely necessary for the protection of the person during the time that a medical condition exists. May be planned or unplanned. May involve personal, mechanical, or chemical restraints. The appropriate use of "light sedation" is not considered a medical restraint.

The operating agency provides Bureau of Health Services Financing (Medicaid agency) with aggregate data and reports which are inclusive of any reported restraint use.

Seclusion is not permitted.

•Enrolled providers of waiver services are prohibited by licensing regulations to inflict corporal punishment, use chemical restraints, psychological abuse, verbal abuse, seclusion, forced exercise, mechanical restraints, any procedure which denies food, drink, or use of rest room facilities and any cruel, severe, unusual or unnecessary punishment.

•The only restraint that may be used in an emergency is a protective hold (falls under the definition of a behavioral restraint).

•Protective holds are only to be used in an emergency to prevent a person from causing harm to self or others and after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff and of short duration. [Louisiana Revised Statutes 40.2006(E)(2) & 40.2120.11-40:2120.16 which cover the broad range of agencies, programs, and facilities who are subject to the Statutes.]

•Pursuant to DHH Policy #0028-04, the Office for Citizens with Developmental Disabilities has a Policy on Restraint and Seclusion (#701). This policy covers:

o Individual right to be free from restraints imposed for the purpose of coercion, discipline or convenience of or retaliation by staff;

o When restraints are necessary in an emergency situation where the behavior of the individual represents an imminent risk of injury to the individual or others;

o Staff training and competence in methods for minimizing the use of restraint and safely applying restraint and in policies concerning the use of restraint.

•Enrolled providers of waiver services are required by licensing regulations to ensure that non-intrusive, positive approaches to address the meaning/origin of behaviors that could potentially cause harm to self or others.

•Direct care staff are required to have initial and annual training in the management of aggressive behavior, this includes acceptable and prohibited responses, crisis de-escalation, and safe methods for protecting the person and staff, including techniques for physically holding a person if necessary. When a participant becomes angry, verbally aggressive or highly excitable, staff will utilize this training.

•If a protective hold must be utilized, direct care staff will notify the Support Coordinator verbally immediately or within two hours of discovery and report in writing via Critical Incident Report within 24 hours, following appropriate reporting procedures.

•The Support Coordinator will contact the participant and his/her legal representatives within 24 hours of receiving the incident report involving a physical hold. Changes to the service plan or living situation will be considered to support the person"s safety and well-being. Follow-up visits with the participant and his/her legal representatives are conducted and include questions about any actions taken by a service provider that may qualify as unauthorized use or misapplication of physical restraints.

•Unauthorized use of restraints is detected through the licensing and surveying process that HSS conducts, as a result of the Support Coordinator's monthly contacts with participants and their legal representative(s), or as a result of receipt of a critical incident report or complaint.

OCDD does not support the use of restraint (which will be referred to as protective supports and procedures) as a true behavioral intervention with application contingent on exhibition of a specific problem behavior on a routine basis. Rather, it is only to be used in situations where there is immediate, imminent risk of harm to self or others if physical intervention does not occur. Protective supports and procedures are incorporate in the Plan of Care if use is anticipated based on the participant's behavioral trends and patterns. Behavioral challenges are addressed in an ongoing plan that utilize other appropriate and less restrictive techniques to prevent the problems, de-escalate them when they occur, and teach appropriate options/coping skills/replacement behaviors.

The direct service provider is responsible for reviewing incidents and trends while OCDD is responsible for reviewing direct service provider practices and use of protective supports and procedures. Incidents reaching a specified threshold will be reviewed by the OCDD Clinical Review Committee.

Almost any other technique is considered less restrictive than restraint use besides medication for the purposes of sedating the participant or use of aversive conditioning techniques which OCDD does not allow. Plans are written by private psychological service providers and as a result, the techniques will vary, but may include:

Preventive strategy examples:

1. Identification of triggers for the challenging behavior and avoidance of triggers (i.e., noise may be a trigger so efforts are made to avoid loud/crowded spaces); and
2. Identification of things the participant enjoys and times/activities during which the challenging behavior is least likely to occur and providing increased opportunities for accessing meaningful/enjoyable things (i.e., finding someone a job that they enjoy; spending more time with family if this is important, etc).

Teaching examples:

1. Teaching the participant problem solving, anger management, or relaxation skills to avoid escalation of the challenging behavior and then teaching staff to recognize the early signs of agitation and how to prompt use of the new coping skills; and
2. Reinforcing exhibition of appropriate behavior (identified in the plan) and not reinforcing the challenging behavior so it

is more likely that appropriate behavior alternatives will be chosen Intervention examples:

1. Blocking the participant from reaching an object he/she may throw or a person he/she may hit but not actually holding or restraining the participant; and
2. Removing objects that may be used aggressively.

Again, it should be noted that these are only examples in each category of possible strategies. There are many other alternatives that may be used. Each plan is tailored to meet the participant's needs and is developed by different professionals.

The use of restraints requires prior permission. Informed consent is obtained from the participant or his/her legal guardian relevant to the participant's consent for implementation of the plan. At a minimum, informed consent includes the essential components necessary for understanding the potential risks and benefits of the plan. Also, the participant or legal guardian shall be informed of the right to withhold or withdraw consent at any time. If a restraint is unplanned, as in emergency situations, prior permission is not obtained. However, unplanned restraints are based on the fact that the restraint is a response to an emergent situation in which imminent risk of harm exists to person and/or others.

Strategies considered prior to restraint use include Positive Support Procedures (based on the individual support need), Desensitization, assessment by allied health professionals for alternate communication strategies, and identification of possible medical antecedents, etc.

When restraint is used for behavior support procedures, a licensed psychologist authorizes the use. When restraints are used for medical protective supports and procedures (as those applied as a health-related protection) a licensed physician, licensed dentist, or licensed podiatrist, authorizes the use.

The following practices are employed to ensure the health and safety of individuals when restraints are used:

• Staff training and competence: Staff must be competent in the use of restraint methods to avoid/prevent use of restraints and methods for implementing emergency restraints when necessary as a last resort. Required competencies include demonstration of knowledge of OCDD's philosophy and policy re: use of restraints and knowledge concerning the conditions necessary for implementation of emergency restraints; competency in use of procedures taught in standard state approved programs for managing aggressive behaviors or an alternate crisis intervention system that does not use prone personal restraints; demonstration of competency in outlined support plan strategies relative to avoiding/preventing use of restraints and any methods for guiding the person more effectively, as well as the use of specific types of emergency restraints before applying them (inclusive of application, release, documentation, monitoring, and other information relative to safety of administering these procedures); staff responsible for visually and continually monitoring the person in behavioral restraints shall demonstrate competency in knowledge/implementation of agency protective support policies, application of protective supports, recognizing signs of distress, recognizing when to contact physician or emergency medical service so as to evaluate/treat the person's physical status, and documentation; demonstration of knowledge/competency in, and procedures for accessing emergency medical services rapidly; competency/training in all aspects of applying medical restraints as prescribed by the person's physician (inclusive of training on strategies for reducing time in which medical restraints are required as outlined in support plan and documentation of training on essential steps for applying mechanical restraints and for implementing support plan strategies).

• Implementation: Each agency must have a policy that defines minimum components include defining limitations on use of restraints within the agency in a manner that is consistent with OCDD policy/philosophy on protective supports; a system to identify who is qualified to implement restraints within the agency (with agency maintaining tracking of which staff are trained and when annual re-training is to occur); each agency must have a system for tracking the use of emergency restraints and mechanical restraints, if used; and each agency where emergency restraints are implemented must have safety procedures in place to protect the participant and staff (inclusive of provision of back up staff in the event of an emergency; procedures to check health of the person prior to, during and following implementation of emergent restraints, as well as safety actions to maximize safety of participant/others; procedures for addressing incidents that led to the use of emergency restraints (including development of a Positive Behavior Support Plan that include strategies to prevent/avoid future incidents and is integrated into the support plan); and procures to review incidents within 24 hours so as to prevent, to act quickly, or avoid future incidents).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

• The Health Standards Section of Bureau of Health Services Financing (BHSF), the Medicaid Agency, is responsible for monitoring that client rights are observed and that there are no negative outcomes related to the use of physical or chemical restraints.

• Oversight is conducted through ongoing monitoring of Critical Incident/Incident Reports via the Online Tracking Incident System (OTIS) and Health Standards Section will investigate incidents involving complaints involving immediate jeopardy, serious injuries, and other serious critical incidents.

• The OCDD LGE staff may refer reports of use of restraint to the State Office Review Committee for guidance and recommendations.

• Any participant who has had a protective hold used is placed on the high risk monitoring list.

• Unauthorized, over use or inappropriate use of restraints is detected through the annual monitoring HSS conducts or as a result of support coordinator's monthly contacts with participants and their legal representative(s), or as a result of receipt of a Critical Incident report.

• The OCDD Critical Incident Program Manager and HSS ensure that all applicable state requirements have been

followed regarding restraint as part of the Critical Incident report review process.

• OCDD has developed the Online Tracking Incident System (OTIS) to identify trends and patterns and support improvement strategies regarding Critical Incidents. This system allows the Health Standards Section of BHSF and OCDD to work together to collect and compile data and use it to prevent reoccurrence of incidents.

The operating agency provides the Bureau of Health Services Financing with aggregate data and reports which are inclusive of any reported restraint use, etc. Aggregate data is provided to the Medicaid Agency on a quarterly basis and every fiscal year.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

● **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State prohibits the use of restrictive interventions. The state strategies for detecting unauthorized use of restraints is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families. See G-2 d. Critical incidents – Responsibility for Review of and Response to Critical Events or Incidents

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

● **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion. The state strategies for detecting unauthorized use of seclusion is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families.See G-2 d. Critical incidents – Responsibility for Review of and Response to Critical Events or Incidents

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ● **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Support Coordinator is responsible for including medications, entity responsible for medication administration, and oversight into the participant's Plan of Care.

If the participant's direct service worker(s) is listed as being the responsible party for medication administration, authority is documented through the State Certified Medication Attendant Program.

The Support Coordination agencies contracted by the state who serve the participants are required to have a Registered Nurse Consultant on their staff. These RN Consultants are responsible for ongoing monitoring of participant medication regimens.

The Support Coordination agency's RN Consultant reviews all medication regimens initially and annually at the time of the Plan of Care for all participants and enters the date of review into CMIS. After the review is completed, the RN notifies the Support Coordinator if the participant has:

a. an especially complex medication regimen or:
b. is prescribed behavior modifying medications as part of their treatment program.

The RN enters the date of the medication review into CMIS.

When a Support Coordinator is notified of the above, the Support Coordinator will contact the RN Consultant after each quarterly face-to-face participant visit in order to give the RN Consultant an update and answer any questions the RN may have relevant to the participant's regimen. The Support Coordinator enters the date of contact with the RN into CMIS. At any time that a Support Coordinator has non-emergency health -related concerns they notify the RN Consultant.

During quarterly face-to-face contact with the participant the Support Coordinator obtains an update on medical and health related information, including physician visits, treatments, hospitalizations, medication updates and ensures that physician delegation, if applicable, is current.

If either the RN consultant or the Support Coordinator detects any potential harmful practices, the RN Consultant makes a face-to-face visit with the participant and when necessary follows up with the participant's medical practitioner. If a medication management issue also meets the OCDD criteria for a critical incident it is reported according to OCDD Critical Incident Policy.

The Local Governing Entity (LGE) approves initial and annual Plans of Care to ensure that:

- Information is included regarding whether or not the participant self-administers medication;

Medications listed have been properly recorded and match those listed on the Form 90-L; and

- If the participant does not self-administer, a register nurse shall authorize and monitor medication administration and noncomplex task performed by the DSW in accordance with LAC 48:I. Chapter 92 published in the Louisiana Register, Vol. 38, No. 12, December 20, 2012.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

OCDD/LGE is responsible for the oversight of medication management and follow up.

OCDD and OCDD/LGE (Local Governing Entity) staff review and approve Plans of Care that include the participant's medication and medication administration. Health Standards is responsible for surveys that monitor waiver participants which includes assessing medication administration for those included in the monitoring sample.

The Health Standards Section conducts a State Survey and Complaint investigations for Residential Options Waiver Home and Community Based Service Providers serving waiver participants in a sample review. This survey includes an assessment of services provided and their outcomes. Types of services reviewed include medications and treatments ordered by physicians. HSS ensures that corrective action occurs if findings warrant. Follow up will be conducted in those cases. HSS will share its findings with OCDD.

In accordance with OCDD policy, critical incidents regarding medication errors must be reported to the LGE. They are responsible for investigating critical incidents regarding medication management and following up with the Support Coordinator and direct service provider to ensure that any unsafe practices are remedied. OCDD will share discovery of possible deficient provider practices with HSS and Medicaid Program Support and Waivers (MPSW). Reports will be sent quarterly.

The OCDD State Office Quality Enhancement Section has the responsibility to:

• Analyze and trend data received from the HSS and medication critical incidents in order to identify potentially harmful practices and implement training, technical assistance, and policy and procedural changes to improve quality.
• Develop reports for LGE staff, committees, and external stakeholders, as appropriate.

The Online Tracking Information System (OTIS), an on-line, web-based reporting system for all critical incident reporting, including major medication incidents and staff , pharmacy, family, or participant medication errors expands and clarifies reporting categories and definitions for medication critical incidents.

OTIS allows the Support Coordination Agency and the LGE staff to directly input critical incident reports, follow-up information and resolution into the system and generate individual and aggregate reports. The system also allows real-time access and viewing of information for OCDD, HSS-BHSF, Adult Protective Services and Support Coordination Agencies.

Medication management monitoring is included in the critical incident data reports submitted to the State Medicaid Agency (SMA) quarterly. MPSW reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by MPSW.

MPSW monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness. MPSW also conducts look-behind reviews on data submitted by the operating agency.

MPSW reviews reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine if there are any trends and patterns that indicate further action is needed. MPSW also monitors the data reports to see if remediation activities implemented in the previous quarter were effective in improving data results for the current period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

MPSW also conducts a look-behind review of critical incidents to ensure remediation activities occurred correctly and timely, if necessary steps were taken in response to reported incidents.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ● **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unlicensed direct care staff that performs administration of medications or procedures may currently do so under Registered Nurse (RN) delegation. The RN signs a written document which indicates the participant's procedures, medications, dosages, site of administration and instructions. This document verifies that the delegating RN has provided specific training and instructions

to the direct care staff concerning the listed medications and/or procedures, and verifies that they are acting under the RN's authority. Each provider agency's administration has the responsibility for conducting on-site visits and assessments of all employees delegated by the RN to give medications. They must also provide oversight when a person self-medicates.

In addition, the DHH-OCDD administers the Certified Medication Attendant Program which provides for the training and certification of unlicensed direct care staff through certified nurse instructors who are also trained by DHH-OCDD. These persons are trained to administer medications to persons with developmental disabilities. The state statute provides for the qualifications of the drug administration course and course applicants/participants and specifies authorized and prohibited functions for such certified provider personnel. This program is available to both waiver and institutional providers of developmental disabilities services.
Waiver provider personnel are mandated to have a minimum of 16 hours of training prior to working with a participant and up to 16 hours per year of continued education per licensing regulations including Nurse Delegation training.

iii. Medication Error Reporting. *Select one of the following:*

● **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported by waiver providers through the OTIS Critical Incident Reporting system, which is accessed by the Health Standards Section and OCDD with follow-up for conducting corrective actions via the LGE staff and contracted Support Coordinators.

(b) Specify the types of medication errors that providers are required to *record:*

The administration of medication:
- In an incorrect form;
- Administered to wrong person;
- Administered but not as prescribed (dose & route);
- Ordered to the wrong person; or
- The failure to administer a prescribed medication.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication administration incident reporting:

- Major medication incident - the administration of medication in an incorrect form, not as prescribed or ordered to the wrong person or the failure to administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist or any licensed health care provider.

- Staff's error - the staff failure to administer or administered the wrong medication or dosage to a person. The staff's failure to fill a new prescription order within 24 hours or a medication refill prior to the next ordered dosage.

- Pharmacy error - The pharmacy incorrectly dispenses the meds etc.

- Participant's error - The participant unintentionally fails to take medication as prescribed

- Medication Non-Adherence - The participant refuses medication for three consecutive days

- Family error - A family member intentionally or unintentionally fails to administer a prescribed medication refill to the participant prior to the next ordered dosage

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

HSS is the State agency responsible for monitoring waiver providers which includes the administration of medications for those clients included in the monitoring sample and to assure that there is no negative outcomes.

HSS identifies problems in provider performance through their licensing and survey reviews of all Medicaid enrolled direct service providers. This includes a review of medication administration records, policy, and reporting policy.

The Online Tracking Information System (OTIS) a web-based reporting system for all critical incident reporting, including major medication incidents and staff or pharmacy medication errors. The system expands and clarifies reporting categories and definitions for medication critical incidents. OTIS allows real-time access to information for OCDD, MPSW, LGE, Health Standards Sections, Adult Protective Services and Support Coordination Agencies.

OCDD will share discovery of possible deficient provider practices with HSS. The OCDD State Office Quality Enhancement Section will aggregate, track and trend data from the HSS and medication critical incidents and disseminate reports to LGE staff and committees, as appropriate. These reports will be used to identify potentially harmful practices and implement training, technical assistance, and policy/procedural changes to improve quality statewide. The OCDD Quality Enhancement Section reports findings to the Medicaid agency (BHSF).

OCDD's discovery of medication errors and related concerns may surface at any time and result from the LGE's ongoing, real-time reviews of OTIS critical incident reports (which include medication errors), from support coordinators quarterly on-site reviews and monthly contacts with participants and from direct complaints from participants, families or other stakeholders which may be phoned into OCDD State Office and the LGE. As these medication-related concerns surface, the LGE staff follow up to assure that appropriate corrective actions have been implemented by waiver providers. The LGE staff follow up to critical incidents involving medication is entered into the OTIS data base which is automatically accessible to the State Medicaid Agency and Health Standards Section.

When discovery of medication-related critical incidents involve abuse/neglect, immediate jeopardy to participants, fraudulent claims or other serious licensing deficiencies, they are immediately reported to the respective DHH Bureau, Section or Program Office with legal authority to investigate, sanction, recoup or take other actions to protect waiver participants (i.e., OAAS/Adult Protective Services; Health Standards Section; BHSF/Program Integrity Section).

MPSW reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by MPSW. MPSW also monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.a.1. The number of reported critical incidents and rate per thousand participants in the ROW. Percentage = Number of critical incidents times one thousand / Total number of ROW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
G.a.i.a.2. Number and percentage of critical incidents reported alleging abuse, neglect, exploitation, or extortion that were substantiated by Protective Services/law enforcement. Percentage = Number of substantiated allegations of abuse, neglect, exploitation or extortion / Total number of reported allegations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review