

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

- 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).

The Division of Developmental Disabilities (DDD) defines incidents as allegations or occurrences of abuse, neglect, and exploitation; events that cause harm to a participant; and events that serve as indicators of risk to participant health and welfare.

The following definitions apply to adults age 18 and older:

Abuse is defined as 1) the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or personal anguish; or 2) any knowing or intentional act which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, or sexual exploitation.

Exploitation means the taking of property of a vulnerable adult by any person by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means.

Neglect is defined as 1) Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior may constitute neglect. Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect; OR 2) Any knowing or intentional act or omission on the part of a caregiver to provide essential services, or the failure of a vulnerable adult, due to physical or mental impairments, to perform self-care or obtain essential services to such an extent that there is actual physical injury to a vulnerable adult or imminent danger of the vulnerable adult suffering physical injury or death.

Physical injury means damage to bodily tissue caused by nontherapeutic conduct, including, but not limited to, fractures, bruises, lacerations, internal injuries, or

dislocations, and shall include, but not be limited to, physical pain, illness, or impairment of physical function.

The following definitions apply to child maltreatment which occurs when a child age birth through age 17 is physically, emotionally, or sexually harmed.

Abuse can be physical, emotional or sexual and is defined as:

Physical: Information indicates the existence of an injury that is unexplained; not consistent with the explanation given or is non-accidental. The information may also only indicate a substantial risk of bodily injury.

Emotional: Information indicates psychopathological or disturbed behavior in a child which is documented by a psychiatrist, psychologist or licensed mental health practitioner to be the result of continual scapegoating, rejection or exposure to violence by the child's parent/caretaker.

Sexual: Information indicates any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Neglect can be emotional or physical and is defined as:

Emotional: Information indicates that the child is suffering or has suffered severe negative emotional effects due to a parent's failure to provide opportunities for normal experience that produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child's ability to form healthy relationships with others.

Physical: Information indicates the failure of the parent to provide basic needs or a safe and sanitary living environment for the child.

*Parent includes guardian, custodian and caretaker.

Medical Neglect of Handicapped Infant: The withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:

- (1) The infant is chronically and irreversibly comatose;
- (2) The provision of this treatment would merely prolong dying or not be effective in ameliorating or correcting all the infant's life-threatening conditions; or
- (3) The provision of this treatment and the treatment itself under these conditions would be inhumane.

Any reason to believe that abuse and/or neglect has occurred is reportable under Nebraska state statutes to the Department of Health and Human Services (DHHS) Protection and Safety unit (housed at the Division of Children and Family Services) or law enforcement. There is no statute of limitations on reporting abuse and/or neglect. Reports can be taken by DHHS at a toll free abuse and neglect hotline that is available 24/7 and posted on the

DHHS website. Reports are also accepted by e-mail, FAX, letter or face-to-face at any DHHS office.

Nebraska Revised Statute 28-372 mandates the following entities to report suspected abuse, neglect, or exploitation of a vulnerable adult: “any physician, psychologist, physician assistant, nurse, nursing assistant, other medical, developmental disability, or mental health professional, law enforcement personnel, caregiver or employee of a caregiver, operator or employee of a sheltered workshop, owner, operator, or employee of any facility licensed by the DHHS Division of Public Health (DPH), or human services professional or paraprofessional not including a member of the clergy.” Nebraska Revised Statute 28-711 requires all persons to report suspected child abuse or neglect.

In addition, under state policies, a provider must document in the Department approved web-based electronic records system any allegation of abuse or neglect as soon as possible but at a minimum within 24 hours of the provider becoming aware of the incident. A DHHS supervisor is notified electronically when an allegation of abuse and/or neglect is entered into the system.

1. Allegation of abuse and/or neglect.
2. Allegation of financial exploitation.
3. Allegation of sexual exploitation.
4. Injuries to participants which require medical attention and treatment by physician.
5. Injuries to participants related to incidents involving physical restraint.
6. Discovery of injury of unknown origin.
7. Injuries or displacement of participant as a result of fire.
8. Medication error resulting in injury, serious illness, or hospitalization.
9. Use of physical restraint
10. Use of prohibited practices such as chemical or mechanical restraint for any reason.
11. Injuries which require medical attention to staff persons and others, resulting from the behavior of a participant.
12. A participant served leaving supervision where the safety of the participant or others is potentially threatened.
13. Use of an emergency room or an urgent care facility for treatment or admission.
14. Possible criminal activity by a participant or by a staff person suspected of engaging in criminal activity towards a participant.
15. Missing person.
16. Property damage caused by participant or staff person.
17. Seizure that last over five minutes or over the timeframe set by the participant’s physician, or which requires treatment at an urgent care center, ER or hospital.
18. Deaths of participants served.
19. Hospitalization.
20. Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of a participant served.

A written summary of the provider's investigation and action taken must be submitted via the electronic records system to the Department within 14 days of the electronic report of the incident.

Should DDD have significant concerns about any provider's performance in managing critical events or incidents, DDD reserves the right to request from any provider an ongoing aggregate report of incidents that may include, but not be limited to, a compilation, analysis, and interpretation of data, and evidentiary examples in order for DDD to evaluate performance and monitor the provider's ability to demonstrate a reduction in the number of incidents over time.

- 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.

Information concerning protections from abuse, neglect, and exploitation is annually provided to each participants and their legal representative by their Service Coordinator, and is also available on the DDD website. There is also a training available to the general public, including participants, family members and providers on the DDD website.

Service Coordination must review and provide a copy of participant rights and the appeal process at the intake meeting and annually thereafter. As applicable, these materials are translated and provided in Spanish. In addition, DDD complies with the LEP Language Assistance Implementation Guidance as per Presidential Executive Order 13166.

- 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.

Upon receipt of a report, the geographically assigned DDD Service Coordinator Supervisor reviews it to determine the appropriate response, which depends upon the type and frequency of the incident. All reports involving health and safety concerns require follow-up actions from the service coordinator. Incidents with law enforcement activity are followed-up to ensure the participant/legal representatives are aware of the natural and logical consequences of the participant's actions if competent. If the participant is not deemed competent then ensuring appropriate supports are in place to ensure safety. When providers report alleged abuse and neglect of adult participants that is not required to be reported by law, Protection and Safety staff shares this information with DDD within 24 hours of receipt. The DDD geographically assigned DDD Service Coordinator Supervisor reviews it with the assigned service coordinator to determine if the participant is safe, and completes an emergency safety plan as needed.

DHHS Protection and Safety staff sends a copy of the intake investigation of reportable allegations of neglect or abuse to DDD.

Timeframes for conducting, completing, and informing the participant of the results of an investigation completed internally by the DD provider are determined by the DD provider agency and are outlined in the DD provider's policies and procedures but are completed in a minimum of 30 calendar days. Timeframes for state staff are established within the program, following statutory and regulatory mandates when required. Timeframes vary depending upon the involvement of law enforcement and the nature of the critical event.

The Division of Children and Family Services Protection and Safety Unit handles all reports of abuse and/or neglect and/or exploitation, which are screened immediately and shared with law enforcement within 24 hours of receipt. Only accepted reports are prioritized for a response.

Reporters are provided with a disposition on whether a report will be accepted and assigned to DCFS for investigation OR there is no indication that the alleged victim is a vulnerable adult or the allegations do not rise to the level of maltreatment and the matter will not be assigned for investigation. At times a hotline worker may have to inform the reporter that further consultation needs to occur with a supervisor and a call back number may be requested so hotline can call the reporter back to inform them of the screening decision. Reports of abuse and neglect are reviewed by a trained Children and Family Services (CFS) Intake Specialist and a CFS Supervisor. CFS Intake Specialists utilize the Structured Decision Making (SDM) Intake Tool, history from database exchange systems and the information provided in the alleged report of abuse and neglect to determine if Adult Protective Services (APS) has the authority to intervene. The SDM Intake tool is a research based instrument that outlines specific criteria that the CFS Intake Specialist must consider in determining if the allegations meet the criteria for APS involvement and subsequently the appropriate response time. There are specific definitions that need to be met in order to determine whether a report will be accepted for investigation. The CFS Intake Specialist must use the definition of a vulnerable adult, and the definitions of abuse, neglect and exploitation that are defined in Nebraska State Statute and APS regulations as part of determining whether APS should intervene.

Adult Protective Services:

Investigations of allegations of abuse and/or neglect and/or exploitation of vulnerable adults are performed by adult protective services (APS) staff in the Division of Children and Family Services and are categorized in three priorities. As outlined in the Adult Protective Services Act, see Nebraska Revised Statutes 28-350 to 28-371.

APS staff conducts screenings of abuse and/or neglect and/or exploitation and if the report is accepted for investigation, the reports are prioritized as follows:

A **Priority 1** report of allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult participant, including death or other vulnerable participants still at risk has a 60-day time frame in which to complete an investigation. Face-to-face contact

must be made with the victim as quickly as possible, but no later than within 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they conduct an investigation and send a written summary of their investigation to the Protection and Safety worker. APS staff may work simultaneously with law enforcement if requested.

A **Priority 2** report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult participant has 60 days in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 5 calendar days of the date of the report was accepted for investigation.

A **Priority 3** reports alleges harm to a vulnerable adult participant which is serious, but not serious enough to be considered Priority 1 or 2 and has 60 days in which to complete an investigation. Face-to-face contact by APS staff or law enforcement must be made with the victim within 10 calendar days of the date of the report was accepted for investigation. APS would not accept an investigation when the information reported to the CFS Intake Specialist at the Adult Abuse and Neglect Hotline and researching collateral information (i.e., criminal data bases; history of APS; previous law enforcement involvement; contacting medical professionals; etc.) does not provide sufficient information to determine that the allegation rises to the level of abuse or neglect.

Child Protective Services:

Investigations of allegations of abuse and/or neglect of children are performed by child protective services (CPS) staff in the Division of Children and Family Services. Since both law enforcement agencies and CPS have statutory obligations pertaining to child abuse/neglect cases, it is necessary to establish which agency will take the primary responsibility for a given case and which kinds of cases will initially be a joint effort. The suggestions below do not preclude joint investigations or an independent assessment by the Department.

Cases appropriate for joint activities may include but not be limited to:

- Sexual assault or abuse of a child by a household member;
- Abuse/neglect in child care homes, child care centers or institutions; and
- Abuse/neglect in foster homes or allegations of abuse/neglect committed by foster parents or foster care providers.
- Cases for law enforcement conducting primary investigation activities depend on established local protocols and may include:
 - Severe physical abuse;
 - Neglect, such as lack of food, unsanitary or dangerous living conditions and lack of essential utilities;
 - Children being left unattended or lack of supervision;
 - Chronic or extreme spouse abuse in the child's presence; and
 - When criminal activity is involved.

At initial assessment, the primary roles of CPS are to gather information to validate maltreatment or allegations on a court petition and to determine what services, if any, are needed and how they can best be provided. When necessary, a plan will be developed and implemented to provide safety for the child. The priority at this phase is securing child safety with attention to working with the family to preserve the family unit whenever possible.

CPS uses an Assessment tool, initial assessment sections, and the case status determination, the worker determines the Department response. Six alternatives are available to the worker and family following case status determination:

1. Worker determines no further intervention service is needed. Case is closed following notification to the family.
2. Worker determines there is a need for further service that can be provided through a community agency or other Department service program. The family is willing to voluntarily engage in the service. The case is closed following engagement of family in the service.
3. Worker determines that ongoing protective services are required to address or control the maltreatment and risk identified in the initial assessment. The family is willing to voluntarily engage in CPS service provision. Case is transferred to the ongoing services for service continuation, further assessment and case planning. (These cases are referred to as "voluntary" cases.)
4. Worker determines that ongoing protective services are required to resolve or control the maltreatment and risk identified in the initial assessment. The family is unwilling to voluntarily engage in services identified as necessary. In these instances, the worker is required to formally request that the county attorney file a petition for court authorization to intervene. (See Court & Legal Issues, 390 NAC 8-000) When court authority is granted, the case is transferred for ongoing services, further assessment and case planning. (These cases are referred to as "involuntary cases".)
5. Worker determines that ongoing services are needed; the family is willing to engage in the services identified as necessary, but court involvement is needed to resolve the identified problem, for example, incest cases.
6. Worker determines a need for ongoing protective services, the parents are unwilling to cooperate, and the county attorney has determined there is inadequate factual information to pursue court action. Case is closed following notification to the family.

The State's regulations identify the relevant parties that may request the results of the investigation and these regulations are on the public website at: http://dhhs.ne.gov/children_family_services/Pages/jus_jusindex.aspx. There is no specified timeframe for release of the information after the completion of an investigation regardless of priority as release of said information is done only upon request. The participant or their representative are informed of the release of information contained in the registry upon request at the time of the investigation by the investigator. There is no mandate nor formal timeline for releasing information to the participant or their representative as this is only done upon their written request. The request can be made at any time, but the response will not occur until the conclusion of the investigation.

- 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.

The Division of Developmental Disabilities within DHHS, the State Medicaid agency, is responsible for overseeing the reporting of, and response to, critical incidents and events.

All critical events are entered into a web-based electronic records system and are subject to DDD analysis at any time but no less frequently than quarterly. This information includes a compilation, analysis, and interpretation of data, and includes evidentiary examples to evaluate performance. The DDD Director reserves the right to request additional review of any incident brought to her attention as a result of the oversight process. However, there may be immediate follow-up of individual events.

Adult and Child Protection and Safety staff are contained within the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services. Protection and Safety staff are also responsible for the oversight of the critical incident management system.

On at least an annual basis, both Adult and Child Protection and Safety staff provide to DDD information about critical incidents that involved waiver participants. Data is obtained and analyzed on waiver participants involved in Protection and Safety reports. The data includes demographical information, types of abuse/neglect reported, and the findings of investigations.

Staff from Protection and Safety and DDD collaborate to identify strategies to reduce the occurrence of critical incidents and to coordinate better on both a system wide and individual participant basis. Examples of these strategies include training of staff from Protection and Safety about this waiver, and cross training to Services Coordinators about Protection and Safety.

Appendix G: Participant Safeguards

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

- a. **Use of Restraints.** (*Select one*):

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).

In Nebraska, restraint means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal function of a portion of the participant's body, or to control the behavior of a participant. Nebraska does not make a distinction between restrictive interventions and restraints, and all policies under G2a apply to restrictive interventions as well.

Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are not to be considered as a restraint such as side rails while transporting a patient to a surgical suite.

Physical restraint can be used in a situation where the participant is in danger of immediate jeopardy or harm. If there are disruptive or challenging behaviors displayed by a participant, then a safety and support plan must be developed utilizing the principles of positive behavioral supports. Restraint may not be used as punishment; for the convenience of staff; or as a substitute for habilitation. Restraint is allowable as an immediate response when it is planned in advance and documented in the behavioral support plan. Restraint cannot be used as a way to deal with under-staffing or as a way to deal with ineffective, inappropriate, or other nonfunctional programs or environments. Corporal punishment, verbal abuse, physical abuse, psychological abuse, denial of an adequate diet, use of a participant to discipline another participant, and placement of a participant in a totally enclosed crib or other barred enclosure are prohibited.

Mandates regarding the use of restraint are detailed in Title 404 of the Nebraska state regulations and must be included in provider policies, procedures, and practices. Specifically, the regulation states that the provider must prohibit the use of restraints except as noted above.

Physical restraint is allowable as an immediate response to an emergency safety situation as a component of a behavioral support plan developed in response to an emergency safety situation. The safety plan is instituted in instances where the participant poses a threat to themselves, others or property and must be kept from harm.

The requirement for behavioral support plans act as a safeguard in the use of restraints because each plan must detail the restraints that may be used for the participant. They also reduce the use of restraints by providing information about common behaviors for the participant. Behavioral support plans must address behaviors that are obstacles to becoming more independent; that interfere with the ability to take part in habilitation; self-injurious behaviors; or behaviors that are a threat to others. The provider's policies and procedures must specify and define approved intervention procedures, and include a description of the mechanism for monitoring the use. The following components must be in place in a behavioral support plan, a safety plan, and in order to develop emergency safety interventions specific to each participant:

1. The functional assessments that defines the communicative function of the behavior for the participant and what purpose the behavior serves in the participant's life as well as a review of the participant's day and residential supports and other relevant data;
2. A safety plan for the participant that emphasizes positive meaningful activities, individualized supports, and options that are incompatible with the behavior targeted for change. The plan must include a description of potential stressors and triggers that may lead to the participant experiencing a crisis, and describe a comprehensive safety program. The participant's safety plan must include the type of physical restraint and separation, the length of time the emergency intervention will be utilized in each instance, and the monitoring procedures that the staff will perform during each instance. There must be meaningful and individualized data collection and data analysis that track progress. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.
3. Prior written consent of the participant or the legal representative must be obtained before implementing the behavioral support plan.

The provider must establish a Review Committee to provide prior review and approval of all behavior support plans, including those that utilize restraints. The effectiveness of the intervention in conjunction with the behavior support plan must be monitored and reviewed. The monitoring of the effectiveness of the intervention is completed on an ongoing basis by designated provider staff that are responsible for quality assurance activities. The Review Committee must have persons qualified to evaluate behavior support plans and a physician, pharmacist, or other allied health professional qualified to evaluate proposals that include the use of medications specifically targeted for behavioral change. The monitoring of the effectiveness of the intervention is completed on an ongoing basis by designated provider staff that are responsible for quality assurance activities.

Direct support and other staff are informed of potential side effects in the event of chemical restraint, in non-technical terms, in DDD's electronic health records system so participants can be monitored for early detection of side effects. The provider must make reports to the physician based on this review.

Medications must be documented in the service plan with the name, dosage, reason for, and the specific behaviors to be affected by the medication; whether the use of the drug was reviewed by the agency's review committee; and whether the drug is reviewed on an ongoing basis by a physician. Medication to manage behavior must be used only in dosages that do not interfere with the participant's ability to take part in habilitation and daily living activities. The use of medication is documented after each drug administration. Medications used solely for the purpose of modifying behavior may be used only with the consent of the participant or legal representative and medications should never be utilized in the absence of other behavioral measures to address the frequency and intensity of these behaviors.

The service plan must include that a less restrictive and less intrusive method had been tried and systematically applied and determined to be ineffective before implementation of psychotropic medications or emergency safety interventions such as physical restraints or separation for the purpose of modifying behavior. The team must evaluate and document that harmful effects of the behavior clearly outweigh any potential harmful effects of the use of restraints or separation.

A participant may receive PRN psychotropic medications as prescribed by a licensed clinical medical practitioner functioning within their scope of practice. The following parameters are in place to ensure the appropriate use of PRN psychotropic medications:

- In general, all *PRN* medicines should only be prescribed based on participant clinical need and not prescribed in advance of anticipated need for controlling behavior not linked to clinical need, or routinely upon admission into a residential provider program.
- Provider staff must be trained in alternative ways of dealing with participant agitation. Those less restrictive methods must be utilized and proven ineffective as determined by the licensed clinical medical practitioner functioning within their scope of practice.
- *PRN medications cannot be utilized* in advance or routinely on admission.
- Antipsychotic *PRN* should only be used for agitation due to psychosis or mania.
- All *PRN* medicines should be prescribed with documentation indicating awareness of regular or standing psychotropic medications/dosages and indicate whether the PRN dosage constitute high dose prescribing outside of standard clinical recommendations.
- Staff administering *PRN* medication should be aware of its potential to raise the total daily dose above the British National Formulary (BNF) maximum licensed dose.
- Intramuscular (IM) and oral doses will be entered into THERAP separately as maximum daily dose for each route is different
- Medication Administration Records (MAR) State frequency, maximum dose and indication clearly.
- If it is clinically appropriate for the dose to be prescribed as a range, the lowest strength should be offered first.
- All *PRN* prescriptions should be reviewed at least once a week by the team.
- Participants prescribed *PRN* high dose antipsychotics must be regularly reviewed (at least once a week) and the high dose antipsychotic only continued for the shortest time necessary.
- **All** *PRN* medication which is administered should be clearly documented by staff in the participants MAR.
- Where *PRN* antipsychotics are added the participants must be monitored for response to treatment, including adverse reactions, side effects and physical health.

- Obtain a current consent to treatment paperwork that addresses whether or not *PRN* usage of psychotropic medication has been ordered for the individual and specifies the clients consent for *PRN* usage when such an order is in place.
- A medication administration record summary (the last 30 days) will be provided to any treating clinician when a medical or psychiatric appointment occurs.

Prior to implementation of restraints or restrictive interventions, employees must complete training and competency standards established by the provider in the following areas:

- Dignity and respectful interactions with participants;
- Abuse, neglect, and exploitation, and state law reporting requirements and prevention;
- Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
- Participants' safety protocols as applicable;
- Positive support techniques; and
- Approved emergency safety intervention techniques.

DD provider staff that administer medication must meet the competency standards defined in Title 172, Chapter 95, Regulations Governing the Provision of Medications by Medication Aides and other Unlicensed Persons. The competency standards are listed in Appendix G-3-C-ii.

- 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:

DHHS DDD is responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed.

The methods for detecting the unauthorized use, over use or inappropriate and/or ineffective use of emergency physical restraints or separation, and behavior modifying drugs, and ensuring that all applicable state requirements are performed by state staff are as follows:

- On-site certification review activities;
- Review of critical incident reports;
- DDD Service Coordination monitoring; and
- Complaint investigations.

On-Site Certification Review. The provider's policies and procedures must be based on state regulations applicable to the use of medications or emergency safety interventions of physical restraint or separation.

Oversight is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-I for additional information.

Information regarding the provider's capacity to support participants with behavioral challenges is gathered during the initial provider enrollment activity. Detection of unauthorized use of restraints may also occur at the time of provider enrollment. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of restraints and separation in emergency safety situations. The provider must have an internal quality review system and a Review Committee. When DDD program staff find policies and procedures that do not comply with regulatory requirements, such as unallowable intervention techniques, an insufficient QI system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD prior to providing services to participants.

Following enrollment, DDD central office analyzes the length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered. When a provider has difficulty developing their policies and procedures related to the use of restraints, DDD works with DPH surveyors to ensure that certification reviews include a focus on those issues and have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by DPH and is reviewed semi-annually by the Quality Improvement Committee. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits, or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

Detection of unauthorized use of restraints may occur through on-site certification review activities, which may be unannounced or scheduled. During a scheduled certification review conducted by DDD, delivery of service is reviewed as well as the agency's systems. At least one participant included in the targeted sample must be taking behavior-modifying medication. At a minimum, 33% of the sample includes participants taking behavior modifying medications. The sample is never of only one participant and always includes at least three. If additional participants included in the sample also take behavior modifying drugs, the reviewer will review

all pertinent documentation for those participants as well. An entire checklist is devoted to review of the development, approval and review of the medication and how it is incorporated into a training program designed to lessen the need for the restrictive procedure.

Review of critical incidents. Reporting of incidents is another method to detect unauthorized use of restraints. Complaint investigations and investigations of allegations of abuse or neglect performed by DDD service coordination and Division of Public Health (DPH) surveyors may also reveal unauthorized, overuse, or inappropriate/ineffective use of restraints. Action that is taken by DDD and/or DPH, if it is determined through an investigation that unauthorized restraints/inappropriate interventions/unknown injuries are discovered, may include an unannounced on-site focused certification review with deficiencies cited, followed by a provider plan of correction and follow-up visits. Action may also include requiring the provider to seek training mandated by the State, placing the provider on probation, limiting admissions, or recoupment of payments made to the provider. Please refer to Section G-1 for an extensive description of DDD's management of critical incidents.

Incident reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The QIC reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents, including illegal use of restraints by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

Service Coordination monitoring. DDD Service Coordination monitoring may detect unauthorized use of restraints. Monitoring of 100 percent of all participants is designed to review the implementation of each participant's service plan after both the annual and semi-annual team meetings. In addition, the SC conducts ongoing unannounced monitoring, which allows for focused monitoring if issues have been raised or are noted during the time of a full monitoring. Observations are documented on a checklist and entered into the electronic health records system. If aggressive behaviors, rights restrictions, or injuries are observed, for example, the service coordinator will question provider staff and review participant files, which may reveal unauthorized interventions, inappropriate interventions, or injuries of an unknown nature.

To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the SC Administrator, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local

service coordination level with reports being provided to the DDD central office staff on a quarterly basis.

Complaint investigations. A report of complaint investigations, which would include illegal use of restraints, is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint.

The DDD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee, which would include deaths caused by improper use of restraints.

Data analysis. The frequency of the oversight activities varies by activity. The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data. Data from these activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Data from the above activities are gathered and analyzed to identify state-wide trends and patterns and support improvement strategies. A summary of certification activities is completed by DPH staff and is reviewed semi-annually by the DDD QI Committee (QIC). The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

Quarterly, the DDD Quality Improvement Committee reviews an aggregated report compiled from the statewide database of critical incidents and events, including restraint utilization. This also includes aggregated DDD Service Coordination monitoring reports.

Appendix G: Participant Safeguards

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

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

☒ **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.

Permitted restrictive interventions (referred to in Nebraska as “restraints”) include an action or procedure that limits a participant’s movement; a participant’s access to other participants, locations or activities; or restricts participant rights. The use of restraints are not allowable habilitation techniques unless incorporated into an approved behavior support plan when the participant must be kept from harm (e.g., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the participant).

Protocols for the use of restraints are written into state regulations and must be included in provider policies, procedures, and practices. In emergency instances where the participant must be kept from imminent harm to self or other, the provider must use their reasonable and best judgment to intervene to keep the participant from injuring themselves or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the participants and others from immediate jeopardy or physical harm. A participant could be physically guided away from an area and staff may block the exit. The participant would always have line-of-sight supervision, and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The participant could not be put in a room with the door closed and no one watching them. Separation from harmful circumstances or from participants at risk can only be used as an emergency safety intervention when the participant must be kept from imminent danger to self or others (e.g., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the participant) and must be reported immediately on the DDD electronic records system.

The following documentation is required when restraints are used:

- Written agency provider policies and procedures;
- Written positive support plan to be used in conjunction with the restraint, the criterion for the elimination of the restraint, and method to collect data;
- Written discussion and prior approval by the service plan team and documentation the service plan team’s determination of the participant’s ability to acquire, retain, or understand the information proposed in the restraint;
- Written informed consent;

- Incident reports related to the use of restraints; and
- Orientation, training, and/or competency standards for staff prior to implementation of restraints.

Every time a provider utilizes a restraint they are required per the General Event Report (GER) guide to complete a High GER into DDD's electronic records system.

The provider must develop a policy specifying whether they allow for the use of restraints. If the provider allows the use of restraints, the written policies and procedures must include the following:

- The restraint determined necessary for one participant must not affect other participants who receive services in that setting;
- The restraint must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as an effective positive behavior support plan;
- The restraint must be the least restrictive and intrusive possible;
- All restraints must be temporary;
- Prior to proposing a restraint, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed;
- The restraint must be safe for the participant; and
- Provider-approved restraints must be specified and defined.

Restraints can only be used as an integral part of a written habilitation strategy that is designed to lead to a less restrictive way of addressing the unacceptable behavior and ultimately to the elimination of the behavior for which the restrictive measure is used.

The provider must ensure that the written habilitative strategies stress positive approaches in addressing behaviors. The provider must have written policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each participant.

The safeguards for detecting the unauthorized use of restraints include provider enrollment, on-site certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints, practices, protocols, and documentation for the use of restraints, including medication to modify behaviors, and the use of restraint or separation. See G-2-a-i and G-2-a-ii for additional information.

Prior to implementation of a restraint, the provider must ensure review and written approval by the service plan team and rights review committee and written informed consent.

The provider must participate in the service plan team process to discuss and review the proposed restraint prior to implementation. The service plan must document the service plan team's determination of the participant's ability to acquire, retain, or understand the information proposed in the restraint. The discussion and approval of the use of the restraint including the following must be recorded in the participant's service plan:

- The proposed restraint(s);
- Methods previously tried and shown to be ineffective;
- Risks involved with the restraint and risk involved if no restraint is used;
- Rationale for the proposed restraint;
- Other possible alternative methods;
- Strategies to lead to elimination of the restrictive measure and the criterion for the elimination of the restraint; and
- Frequency that the participant's service plan team will review the effectiveness of the plan, but not less than every six months. The service plan team review must address: the original reason for restraint, current circumstances, success or failure of the positive behavior support plan, and the rationale based on evidence for continued use of the restraint; and decrease in the use or elimination of the restraint as soon as circumstances justify, based on established and approved criterion in the service plan.

The provider must obtain written informed consent from each participant, or guardian or legal representative as applicable, for authorization to use a restraint. The written informed consent or emergency verbal consent must be obtained prior to implementation of the restrictive restraint.

In addressing maladaptive behavior, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each participant. The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations:

The provider must assure that the following components of positive behavioral supports are in place:

- The assessment must define the communicative function of the behavior for the participant;
- The assessment must focus on what purpose the identified behavior serves in the participant's life;
- A review of the participant's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
- A behavior support plan for the participant must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
- There must be a combination of a planned meaningful day and individualized supports for the participant;

- The plan must include a description of potential stressors and triggers that may lead to the participant experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
- There must be meaningful and individualized data collection and data analysis that track the progress of the participant. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

If restraint is utilized, prior written consent of the participant or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of restraint must be documented and reported. Please refer to Section G-1 for a description of DDD's critical incident reporting system.

The provider must ensure that employees responsible for providing supports and services to participants are educated and trained on the minimum requirements necessary to address the participant's needs prior to working with participants in services.

Staff responsible for providing direct services must demonstrate the competence to support participants as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with participants.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated via competency-based testing. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with participants. Employees must complete the following training requirements: Participant's choice;

- Participant's rights in accordance with state and federal laws;
- Confidentiality;
- Dignity and respectful interactions with participants; and
- Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with a participant. The following training areas must be addressed:

- Emergency procedures;
- Cardiopulmonary resuscitation;
- Basic first aid;

- Infection control;
- Participants' medical protocols as applicable; and
- Participants' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to participants. This training must include:

- Implementation and development of the service plan and interdisciplinary process;
- Positive behavior support techniques;
- Approved restraint techniques;
- Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the participant;
- Use of adaptive and augmentative devices used to support participants, as necessary;
- Other training required by the provider; and
- Other training as required by the specific service options.

- 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:

DHHS Division of Public Health (DPH) staff and surveyors are responsible for monitoring and overseeing the use of restraints.

The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restraints and ensuring that all applicable state requirements are followed. The State-wide oversight responsibilities that are employed are the same as methods described in Appendix G-2-a-i, G-2-a-ii, and G-2-b-i.

DDD has recently become a National Core Indicators state and trend analysis data will also be gleaned from this source during the lifespan of the waiver.

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:

Seclusion means the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving. The State does not permit the use of seclusion by any provider of any waiver service. Services include supervision components which assure that participants receive individualized oversight from qualified providers to maintain their safety and dignity.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing DDD day and residential habilitation service providers. Regulations in Nebraska Administrative Code Title 175 for these licensed providers state that seclusion is not allowed. Surveyors from the Public Health Division may conduct on site compliance inspections on a random basis of state licensed health care facilities and services. In addition, the Public Health Division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act.

The DHHS Division of Public Health provides compliance survey inspection findings to DDD which are then forwarded to the local service coordination staff for follow up action.

Local DDD services coordination offices are responsible for participant monitoring which includes satisfaction interviewing and observation of service delivery. They are positioned to identify potential use of seclusion and would report such a finding to the State as a Complaint Report or an Incident Report.

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:

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.

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96). Medication Administration Records (MARs) are housed in DDD's electronic health record system, which all providers have access to; providers are mandated to update MARs in this system effective January 1, 2017. Prior to January 1, 2017 providers utilize other electronic information or paper systems to monitor medication administration. Compliance reviews of the provider are completed by the Division of Public Health within DHHS.

First line responsibility for monitoring participant medication regimens resides with the medical professionals that prescribe the medications, every time that the professional prescribes the medications. The medical professional that prescribes the medications determines the frequency of the monitoring, based on the participant's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

Medications used solely for the purpose of modifying behavior may be used only with the consent of the participant or legal representative.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the medical professionals who prescribe them and the pharmacist who fills the prescriptions.

First line monitoring methods are carried out by the DD provider, and consist of documenting and reporting the following to the physician at every appointment, legal representative when requested, and the delegating licensed health care professional: Unsafe conditions of medications; adverse reactions to medications; medication errors; and staff observations regarding the behavior which the medication has been prescribed to reduce.

The second line monitors are licensed health care professionals whose scope of practice allows delegation of medication administration. The health care professionals, usually Registered Nurses, delegate the administration of medication to medication aides. The licensed health care professionals are employees of the DD provider agency or who have entered into a contract with the DD provider.

Second line monitoring activities and frequency of monitoring is determined by the health care professional and the DD provider. The medical professional that prescribes the medications determines the frequency of the health professional's monitoring which may be monthly, quarterly, semi-annually, or annually and is based on the participant's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues. The DD provider's monitoring activities may include observation of the administration of medications or treatment; review of records relating to medication

provision or treatment; review of incident reports related to medication or treatment errors; retraining; and continued observations.

Staff observations regarding the behavior which the medication has been prescribed to reduce are also reported to the provider's review committee when the positive behavioral supports plan for that participant is scheduled for review. Each DD provider must have policies and procedures that identify the frequency of monitoring.

In addition to meeting statutory and regulatory requirements, the DD provider agencies must have policies and procedures addressing the provision of medications, per applicable state regulations.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement that includes frequency of QA/QI monitoring activities. The provider QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action. The provider's reports of QA/QI activities are reviewed on-site when DPH completes a certification review, annually or every two years, based on the certification status of the provider.

- 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.

DHHS Division of Public Health (DPH) is responsible for the oversight of compliance with the Neb. Rev. § 71-6718 - 71-6743, known as the Medication Aide Act. The administration of medication is a regulated activity as a method to ensure that participant medications are managed appropriately. The purpose of the Medication Aide Act is to ensure the health, safety and welfare of participants through accurate, cost-effective, and safe utilization of medication aides for the administration of medications. Medication aides and other unlicensed persons may help with the physical act and documentation of provision of medication; and, under specific conditions such persons may also assist with monitoring therapeutic effects. Medication aides must be recertified every two years.

The administration of medication by licensed health care professionals is regulated by their respective practice acts. Under these regulations, administration of medication in the home is regulated only if provided through a licensed home health agency or through certified home and community-based providers. These regulations do not govern self-administration of medication. These regulations do not govern the provision of medication in an emergency situation. Licensed home

health agencies do not administer medications to waiver participants that receive provider operated waiver services. This section only applies to medications administered by certified DD agency providers.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:

1. Review of each DD provider's policies and procedures during the provider initial certification process;
2. On-site certification review activities; and
3. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDD staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled, are oversight activities completed by DPH. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of participants served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including participants prescribed behavior modifying medication. The sample size ranges based on the number of participants served at the site; however, it is never of only one participant and always includes at least three. From this certification review, it would be determined whether or not participants receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DPH, and the provider is advised of changes that may be necessary to the POI.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH-approved Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:

1. Maintaining confidentiality;

2. Compliance with a participant's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five Rights (Provides the right medication, to the right participant, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Compliance with every participant's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. On an ongoing basis, when a complaint involving the performance of a Medication Aide is received by the DPH by phone, FAX or on-line, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry. The risk of continued harmful practices is eliminated by removing the medication aide from the registry.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

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:***
 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).

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96).

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of participants through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

Medication aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of: 1) a licensed health care professional whose scope of practice allows medication administration; 2) a participant with capability and capacity to make informed decision about medications for their medication (i.e. self-administration); or 3) a caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for a participant. A caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

A caretaker has current first-hand knowledge of the participant's health status and the medications being provided, and has consistent frequent interaction with the participant. A staff member of a facility, school, or other entity is not a caretaker.

The ability to self-administer medication means that the participant is physically capable of:

- The act of taking or applying a dose of a medication;
- Taking or applying the medication according to a specific prescription or recommended protocol;
- Observing and monitoring themselves for desired effect, side effects, interactions, and contraindications of the medication, and taking appropriate actions based upon those observations;
- Receiving no assistance in any way from another person for any activity related to medication administration.

The inability to self-administer medications means the participant:

- Is not at least 19 years of age. Minor children may take their own medication(s) with appropriate caretaker monitoring;
- Does not have cognitive capacity to make informed decision about taking medications;
- Is not physically able to take or apply a dose of a medication;
- Does not have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for nonprescription medication; and
- Does not have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The DD provider agency must evaluate a participant's medication administration abilities, and determine the level of assistance needed for medication administration.

For participants who do not have the capability and capacity to make informed decision about medications and for whom there are not caretakers, acceptance of responsibility for direction and monitoring must be provided by a licensed health care professional.

Documentation may be accomplished by any of the following methods:

- (1) When licensed health care professionals are employees, entities may identify on an individual basis or by title and job description/role delineation the licensed health care professional or the classification(s) of licensed health care professionals who are responsible to provide direction and monitoring. Written acceptance of responsibility is not required to be

participant-specific and can be through acceptance of title and job description/role delineation.

(2) When licensed health care professionals are not employees, entities must identify the licensed health care professional by name, profession, and license number who is designated to provide direction and monitoring. Written acceptance of responsibility needs to be participant-specific.

(3) A licensed health care professional who provides services directly to a participant for direction and monitoring, rather than indirectly through facility employment, needs to have a written contract with the participant or other responsible party on behalf of the participant which identifies acceptance of said responsibility.

The minimum competency standards are defined in regulations. Medication aides and other unlicensed persons who provide medication must:

(1) Recognize the participant's right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of a similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

(2) Recognize and honor the right of those participants, with capability and capacity to make an informed decision about medications, to refuse medications and at no time to be forced to take medications. In the case of a participant who does not have the capability and capacity to make informed decision about medications, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the participant.

(3) Follow currently acceptable standards in hygiene and infection control including hand washing.

(4) Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to participants.

(5) Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s)

should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(6) Accurately document medication name, dose, route, and time administered, or refusal.

(7) Provide the right medication, to the right participant, at the right time, in the right dose, and by the right route.

(8) Provide medications according to the specialty needs of participant's based upon such things as age, swallowing ability, and ability to cooperate.

(9) Recognize general conditions, which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in participant condition, which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(10) Safely provide medications for all ages of participants according to the following routes: oral, topical, inhalation and instillation as referenced in section 005.

(11) Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

(12) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. 28-372.

(13) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. 28-711.

(14) Recognize the participant's property rights and physical boundaries.

The regulations relating to medication aides specify that direction and monitoring of the medication administration completed by medication aides will be completed on an ongoing basis. The DD provider agency must have policies and procedures in place for monitoring medication administration by medication aides.

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act.

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

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:

Medication errors are any violation of the "Five Rights" - providing the right medication, to the right participant, at the right time, in the right dose, and by the right route, or inaccurate documentation of medication name, dose, route, and/or time administered.

Medication errors must be reported to the person responsible for providing directions and monitoring. This person could be a prescriber, a caretaker, or a licensed health care professional.

Medication errors suspected to be abuse or neglect must be reported to DHHS Protection and Safety Services and/or Children and Family Services and/or law enforcement.

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.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement. The provider's QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:

- a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
- b. On-site certification review activities; and

c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DPH. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of participants served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including participants prescribed behavior modifying medication. The sample size ranges based on the number of participants served at the site; however, it is never of only one participant and always includes at least three. From this certification review, it would be determined whether or not participants receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. Upon request by DPH, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. See G-3b.ii for a description of these competencies.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and their status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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.

i. Sub-Assurances:

- a. Sub-assurance:** The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measures

Percent of participants reviewed who received information/education about how to report abuse, neglect exploitation and other critical incidents as specified in the approved waiver. Numerator = number of participants reviewed who received information/education; Denominator = number of participants reviewed.

Data Source:

Electronic Health records system

Information/Education

Responsible Party of data collection/generation (check each that applies)	Frequency of data collection/generation (check each that applies)	Sampling Approach(check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample: Confidence Interval= 95% confidence interval with +/- 5% margin of error
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (specify) 8% Proportionate random sample
	<input type="checkbox"/> Other (specify)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that apply)	Frequency of data aggregation and analysis (check each that apply)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (specify)

Percent of participants' death reviews conducted which did not require additional follow up/remediation. Numerator = number of participants' death reviews conducted which did not require additional follow up/remediation; Denominator = number of participants' death reviews conducted.

Data Source:

Electronic Health records system

Death Reviews

Responsible Party of data collection/generation (check each that applies)	Frequency of data collection/generation	Sampling Approach(check each that applies)
--	---	--

	(check each that applies)	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample: Confidence Interval=
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Other (specify)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that apply)	Frequency of data aggregation and analysis (check each that apply)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other (specify)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (specify)

- b. **Sub-assurance:** The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measures

Percent of Incident reports completed with appropriate resolution activity.
 Numerator = number of Incident reports completed with appropriate resolution activity; Denominator = number of Incident reports.

Data Source:

- Electronic Health records system

Incident Reports

Responsible Party of data collection/generation (check each that applies)	Frequency of data collection/generation	Sampling Approach(check each that applies)

	(check each that applies)	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample: Confidence Interval=
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Other (specify)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that apply)	Frequency of data aggregation and analysis (check each that apply)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other (specify)	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (specify)

Number and percent of initial incidents reports that were filed appropriately (timely and according to policies and procedures) Numerator- Number of incident reports completed appropriately (timely and according to policies and procedures) Denominator- Total number of initial incident reports

Data Source:

- Electronic Health records system

Incident Reports

Responsible Party of data collection/generation (check each that applies)	Frequency of data collection/generation (check each that applies)	Sampling Approach(check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample: Confidence Interval=
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (<i>specify</i>) 8% Proportionate random sample
	<input type="checkbox"/> Other (<i>specify</i>)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that apply</i>)	Frequency of data aggregation and analysis (<i>check each that apply</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other (<i>specify</i>)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (<i>specify</i>)

- c. **Sub-assurance:** The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with 175 Nebraska Administrative Code 19-002.23. Numerator- Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred. Denominator- Total number of allegations of wrongful restraint and involuntary seclusion

Data Source:

- Electronic Health records system

Allegations – Restraint/Seclusion

Responsible Party of data collection/generation (<i>check each that applies</i>)	Frequency of data collection/generation (<i>check each that applies</i>)	Sampling Approach(<i>check each that applies</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample: Confidence Interval= 95% confidence interval with +/- 5% margin of error.
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (<i>specify</i>) 8% Proportionate random sample
	<input type="checkbox"/> Other (<i>specify</i>)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that apply</i>)	Frequency of data aggregation and analysis (<i>check each that apply</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (<i>specify</i>)

- d. **Sub-assurance:** The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures:

Number and percent of waiver participants reviewed with a serious risk(s) identified on the DDD medical and behavioral risk screens where there is evidence of follow up. Numerator- Number of waiver participants reviewed with a serious risk(s) identified on the assessment where there is evidence of follow up. Denominator- Total number of waiver participants reviewed with a serious risk(s) identified on the assessment.

Data Source:

- Electronic Health records system

Risk Screens

Responsible Party of data collection/generation (<i>check each that applies</i>)	Frequency of data collection/generation (<i>check each that applies</i>)	Sampling Approach(<i>check each that applies</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample: Confidence Interval= 95%

		confidence interval with +/- 5% margin of error.
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other (<i>specify</i>) 8% Proportionate random sample
	<input type="checkbox"/> Other (<i>specify</i>)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that apply</i>)	Frequency of data aggregation and analysis (<i>check each that apply</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other: (<i>specify</i>)

- 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.

Nebraska Revised Statute 83-1202 states that it is the intent of the Legislature that the first priority of the state in responding to the needs of persons with developmental disabilities should be to ensure that all such persons have sufficient food, housing, clothing, medical care, protections from abuse or neglect, and protection from harm. Inherent throughout the State regulations, providers of waiver services and supports must ensure that participants are free from abuse, neglect, mistreatment, and exploitation; health, safety, and well-being of the participant is a priority; and participants are treated with consideration, respect, and dignity. Nebraska Revised Statute 83-1216 and state regulations also require that all DD providers who will provide direct contact services undergo background checks. DHHS also adhere to state statute by completing background and criminal history checks prior to hiring DDD service coordinators.

Information concerning protections from abuse, neglect, mistreatment, and exploitation is provided to participants and his/her legal representative prior to the initiation of services and annually thereafter. Participants may contact DHHS Protective Services or law enforcement. Participants may also tell their DDD SC, a trusted friend, or family member who will report the suspected abuse or neglect on the participant's behalf. DHHS has a statewide toll-free number for reporting allegations which is available 24/7.

Incidents are required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved web-based service system used for incident reporting and case management, within 24 hours of the verbal report. A written summary must be submitted via the web-based incident reporting system to the Department of the provider's investigation and action taken within 14 days. DDD staff triages/reviews the information daily and makes a determination whether to do a complaint investigation or handle it in another manner.

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.

The State has set up processes to address individual problems as they are discovered.

DHHS staff conduct reviews of each service plan and additional evidence of the process to ensure the service plan reflects the participant's directions, preferences, and personal and career goals. Staff ensure that the service plan is based on adequate assessments of their abilities and that health and safety issues are addressed. When variances are noted, the SC and their Supervisor are notified and take action to correct the service plan. If issues are discovered that will affect the waiver status of the participant, the SC is notified and given a date to respond. The date of response is determined by the SC Supervisor and varies between five and ten working days, based on the nature of the issue.

DDD Service Coordination monitors the implementation of the service plan to ensure the timely and efficacious delivery of all services specified in the service plan for the participant. Full reviews are conducted within 60 days of the annual and semi-annual service plans. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the participant, their family or others. The full reviews consist of checking on items grouped into six groupings: rights, habilitation, financial, service needs, health and safety, and home/work environment.

When issues or problems are discovered during a SC monitoring, the participant's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the participant, manager of services, and/or providers, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

A review of the service plan and the on-site monitoring are documented and entered into a database. This allows individual SCs to track issues that aren't resolved and for DSSs and SC Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators, and provide aggregate information for SC Supervisors, the Service Coordination Administrator, and the DDD central office. This information is reviewed and acted on, as appropriate, at the local service coordination office level.

This information is summarized and reviewed by the DDD QIC quarterly. The summarized data for the service plan review are also shared with service coordination staff at the local service coordination level and the DSSs. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of participants that is not required to be reported by law, the Protection and Safety staff share this information with DDD within 24 hours of receipt. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

The database for incidents is a web-based service system used for incident reporting and case management and the database allows DDD to review and aggregate data in various formats. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on a participant and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the QIC. The QIC determines the need for systemic follow-up and additional areas requiring probing and/or DDD management intervention.

ii. **Remediation Data Aggregation:**

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

Responsible Party for data aggregation and analysis (<i>check each that apply</i>)	Frequency of data aggregation and analysis (<i>check each that apply</i>)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Agency	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other: (<i>specify</i>) Semi-Annually or more often as determined by the DDD Director

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 Health and Welfare that are currently non-operational.

No

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