

## 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:*

<input type="radio"/>	<b>Yes. The State operates a Critical Event or Incident Reporting and Management Process</b> <i>(complete Items b through e)</i>
<input type="radio"/>	<b>No. This Appendix does not apply</b> <i>(do not complete Items b through e).</i> <i>If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.</i>

- 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).

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- 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.

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- 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.

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State:	
Effective Date	

Appendix G: Participant Safeguards  
HCBS Waiver Application Version 3.5



- 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.



State:	
Effective Date	

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions**

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

<input type="radio"/>	<p><b>The State does not permit or prohibits the use of restraints</b> Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
<input type="radio"/>	<p><b>The use of restraints is permitted during the course of the delivery of waiver services.</b> Complete Items G-2-a-i and G-2-a-ii:</p>

- 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).

- 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:

- b. **Use of Restrictive Interventions**

<input type="radio"/>	<p><b>The State does not permit or prohibits the use of restrictive interventions</b> Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
<input type="radio"/>	<p><b>The use of restrictive interventions is permitted during the course of the delivery of waiver services.</b> Complete Items G-2-b-i and G-2-b-ii.</p>

State:	
Effective Date	

Appendix G: Participant Safeguards  
HCBS Waiver Application Version 3.5

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

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

- 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.)*

<input type="radio"/>	<p><b>The State does not permit or prohibits the use of seclusion</b> Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:</p> <div style="border: 1px solid black; height: 40px; background-color: #cccccc;"></div>
<input type="radio"/>	<p><b>The use of seclusion is permitted during the course of the delivery of waiver services.</b> Complete Items G-2-c-i and G-2-c-ii.</p>

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

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

State:	
Effective Date	

## Appendix G-3: Medication Management and Administration

*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:

<input type="radio"/>	<b>No. This Appendix is not applicable</b> <i>(do not complete the remaining items)</i>
<input type="radio"/>	<b>Yes. This Appendix applies</b> <i>(complete the remaining items)</i>

**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.

**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.

**c. Medication Administration by Waiver Providers**

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

<input type="radio"/>	Not applicable <i>(do not complete the remaining items)</i>
<input type="radio"/>	<b>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.</b> <i>(complete the remaining items)</i>

**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).

State:	
Effective Date	

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

<input type="radio"/>	<p><b>Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies). Complete the following three items:</b></p> <p>(a) Specify State agency (or agencies) to which errors are reported:</p> <p>(b) Specify the types of medication errors that providers are required to <i>record</i>:</p> <p>(c) Specify the types of medication errors that providers must <i>report</i> to the State:</p>
<input type="radio"/>	<p><b>Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.</b></p> <p>Specify the types of medication errors that providers are required to record:</p>

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.

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**Quality Improvement: Health and Welfare**

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

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

State:	
Effective Date	

**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 in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**i. Performance Measures**

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

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

<b>Performance Measure:</b>			
<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input 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"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis</b>	<b>Frequency of data aggregation and analysis:</b>

State:	
Effective Date	

<i>(check each that applies)</i>	<i>(check each that applies)</i>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>

**Add another Performance measure (button to prompt another performance measure)**

- 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.**

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

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

<b>Performance Measure:</b>			
<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>

State:	
Effective Date	

	<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"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

**Data Aggregation and Analysis**

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

Add another Performance measure (button to prompt another performance measure)

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

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

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

<b>Performance Measure:</b>	
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State:	
Effective Date	

<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input 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"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

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

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State:	
Effective Date	

- 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.*

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

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

<b>Performance Measure:</b>			
<b>Data Source (Select one) (Several options are listed in the on-line application):</b>			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation (check each that applies)</b>	<b>Frequency of data collection/generation: (check each that applies)</b>	<b>Sampling Approach (check each that applies)</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input 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"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**Add another Data Source for this performance measure**

**Data Aggregation and Analysis**

<b>Responsible Party for data aggregation and analysis (check each that applies)</b>	<b>Frequency of data aggregation and analysis: (check each that applies)</b>

State:	
Effective Date	

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Add another Performance measure (button to prompt another performance measure)**

- 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.

**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.

**ii. Remediation Data Aggregation**

	Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

State:	
Effective Date	

	<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
		<input type="checkbox"/> <b>Continuously and Ongoing</b>
		<input type="checkbox"/> <b>Other</b> Specify:

**c. Timelines**

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

<input type="radio"/>	<b>No</b>
<input type="radio"/>	<b>Yes</b>

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

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State:	
Effective Date	