Guidelines for Support Planning

Applicable to the New Opportunities Waiver

Office for Citizens with Developmental Disabilities

Louisiana Department of Health and Hospitals

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Guidelines for Support Planning

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ACRONYMS, TERMS, AND DEFINITIONS

CPOC	**Comprehensive Plan of Care** is the support plan format currently used in the NOW. The CPOC format is included as an attachment in Section 4.
Day Hab **Day Habilitation** **Day Program**	**Day Habilitation** services provide participants, age 18 years or older, with assistance in developing social and adaptive skills necessary to enable them to participate as independently as possible in the community. It allows for peer interaction, meaningful and age-appropriate activities, community and social integration, which provide enrichment and promote wellness. It includes the assistance and/or training in the performance of tasks related to acquiring, maintaining, or improving skills including but not limited to: personal grooming; housekeeping; laundry; cooking; shopping; and money management. Day Habilitation services are provided in a community-based setting focused on enabling the participant to attain or maintain his or her maximum functional level. Day Habilitation services shall be coordinated with any physical, occupational, or speech therapies or employment listed in the participant's approved Plan of Care. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

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ERT	**Employment Related Training** services consists of paid employment for participants, 18 years of age old or older, for whom competitive employment at or above the minimum wage is unlikely and who because of their disabilities need intensive ongoing support to perform in a work setting. Employment Related Training services also include training designed to improve and/or maintain the participant's capacity to perform productive work and function adaptively in the work environment. **Description of Services** Employment Related Training Services include, but are not limited to: A participant receives assistance and prompting in the development of employment-related skills. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, and behavioral support needs and any medical task, which can be delegated. • A participant is employed at a commensurate wage at a provider facility for a set or variable number of hours. • A participant observes an employee of an area business to obtain information to make an informed choice regarding vocational interest. • A participant is taught to use work related equipment. • A participant is taught to observe work-related personal safety skills. • A participant is assisted in planning appropriate meals for lunch while at work. • A participant learns basic personal finance skills. • A participant and his/her family, as appropriate, receive information and counseling on benefits planning and assistance in the process.
GPSORC	**Guidelines for Planning State Office Review Committee** OCDD developed the Guidelines for Planning State Office Review Committee and process to perform oversight functions required for implementation of the "Guidelines for Support Planning." Details of the committee function and makeup are covered in Section 7.3.

HIPAA	The **Health Insurance Portability and Accountability Act** of 1996 includes privacy rules that protect the privacy of individually identifiable health information. The Privacy Rule provides federal protections for personal health information held by covered entities, such as Medicaid, and gives people an array of rights with respect to their private information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. Following HIPAA is important in the team process and also must be taken into account when planning for shared supports.
ICF/DD	**Intermediate Care Facility for Persons with Developmental Disabilities** In 1971, an amendment to the Social Security Act allowed the financing of special facilities with federal dollars. These facilities were called Intermediate Care Facilities for the Mentally Retarded or ICFs/MR. As of 2007 Louisiana defined ICFs/MR as Intermediate Care Facilities for People with Developmental Disabilities or ICFs/DD. The purpose of the ICF/DD is that of diagnosis, treatment, or rehabilitation of people with developmental disabilities. The ICF/DD provides a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services that are individualized according to each participant's needs. ICF/DD services are provided in a broad range of residential services such as community homes (up to 7 people), group homes (8-15 people), small (16-32 people) or large (33+) institutions, including state-operated supports and services centers (previously developmental centers) and privately-operated agencies.
IFS	**Individual and Family Support** services are defined as direct support and assistance, which may take place in the participant's residence or community, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning; provide relief of the caregiver; and promote inclusion in the community. IFS services may not supplant primary care available to the participant through natural and community supports. **Description of Services** • Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal

	care and behavioral support needs, and any medical task which can be delegated. • Assistance and/or training in the performance of tasks related to maintaining a safe, healthy, and stable home, such as: housekeeping; bed making; dusting; vacuuming; laundry; cooking; evacuating the home in emergency situations; shopping; and money management (including bill paying). The IFS rate does not include the cost of the supplies needed or the cost of the meals themselves. • Personal support and assistance in participating in community, health, and leisure activities. This may include accompanying the participant to these activities. • Support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal, social networks, and natural supports. • Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences (e.g., volunteer work, community awareness activities).
ISR	The **Individual Supports Review** Protocol defines requirements and review criteria for assessments needed for CPOC planning and each section of the CPOC. The Protocol is used by the support coordinator supervisor, OCDD Regional Waiver Office, and state office for review of individual CPOCs to assure compliance with OCDD "Guidelines for Support Planning" prior to plan approval and implementation. The ISR utilization is discussed in Section 7.
LA PLUS	**Louisiana Plus** includes complimentary assessment items in a number of areas: material supports (e.g., powered wheelchair, walker, vehicle modification, etc.), vision related supports, hearing related supports, supports for communicating needs, positive behavior supports, physician supports, professional supports (e.g., registered nurse, psychologists, occupational therapists, physical therapists, speech therapists, etc.), stress and risk factors, protective supervision, summoning help, and sharing supports. The information on the SIS/LA PLUS is used both in determining the Resource Allocation Level System and in developing support plans for each participant based upon his/her unique support needs.

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NOW	**New Opportunities Waiver** is a Home and Community-Based Services Waiver program. Waiver programs are based on federal criteria which allow services to be provided in a home or community-based setting for the participant who would otherwise require institutional care. Due to the demand for these services, there is a Developmental Disability (DD) Request for Services Registry (RFSR) that lists participants who meet the Louisiana definition of developmental disability and their request date. This waiver is offered on a first-come, first-served basis. Persons interested in being added to the RFSR for this waiver should contact their local Regional Office/ Human Services District/Authority. The application process does not begin until an opening (slot) is available. At that time, medical and financial determinations are completed simultaneously to validate that the participant has a developmental disability and meets the financial and medical/psychological requirements for institutional care in an ICF/DD. Through freedom of choice, requestors choose their support coordinator and direct service provider(s). NOW is only appropriate for those participants whose health and welfare can be assured through the Comprehensive Plan of Care and for whom home and community-based waiver services represent a least restrictive treatment alternative. NOW is intended to provide specific, activity-focused services rather than continuous custodial care. The following are the services provided under the NOW: Individualized and Family Support (IFS) Service-Day-Night; Center-Based Respite; Community Integration and Development; Environmental Accessibilities Adaptations; Specialized Medical Equipment and Supplies as an Extended State Plan Service; Supported Living; Substitute Family Care; Day Habilitation and Transportation for Day Habilitation; Supported Employment and Transportation for Supported Employment; Employment Related Training; Professional Services; Personal Emergency Response System; Skilled Nursing Services; and One-Time Transitional Services.

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SE/Mobile Crew	**Supported Employment** is work in an integrated work setting or employment in an integrated work setting in which participants, age 18 and older, are working toward competitive work that is consistent with their strengths, resources, priorities, and interests and for whom competitive employment has not traditionally occurred. Supported Employment includes activities needed to sustain paid work by participants receiving waiver services, including supervision and training. Supported Employment services also includes assistance and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated. **Types of Supported Employment Services** 1. Individual Placement or One-To-One Model: A One-To-One Model of Supported Employment is a placement strategy in which an employment specialist (job coach) places a participant into competitive employment, provides training and support, and then gradually reduces time and assistance at the work site once a certain percentage of the job is mastered by the participant. Once the participant has mastered the job task, he or she may be transitioned to the Follow Along status of Supported Employment, if needed. 2. Follow Along: Follow Along services are supports to maintain the participant in his/her job and are provided by an entity other than the Louisiana Rehabilitation Services (LRS). Follow along services are designed for persons only requiring minimum oversight at the job site and are limited to 24 days per Plan of Care year. Ongoing support services can be provided from more than one source. 3. Mobile Work Crew/Enclave: An employment situation in which a group of two or more workers, but fewer than eight workers, with disabilities are working at a particular work setting under the supervision of a permanent employment specialist (job coach/supervisor). The workers with disabilities may be disbursed throughout the company and among workers without disabilities, or congregated as a group in one part of the business.

SFC	**Substitute Family Care** provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided to participants residing in a Medicaid enrolled Substitute Family Care home. Substitute Family Care is a stand-alone family living arrangement for participants, age 18 years of age or older, in which SFC parents assume the direct responsibility for the participant's physical, social, and emotional well being and growth, including family ties.
SIS	**Supports Intensity Scale** assesses six life activities based on 49 items: (Home Living, Community Living, Lifelong Learning, Employment, Health and Safety, Social Activities); Advocacy; Medical Support; Behavior Support. The information on the SIS/LA PLUS is used both in determining the Resource Allocation Level System and in developing support plans for each participant based upon his/her unique support needs.
SL	**Supported Living** (SL)services assist participants, age 18 years of age or older, to acquire, improve, or maintain social and adaptive skills necessary to enable participants to reside in the community and to participate as independently as possible. SL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping, and money management (including bill paying). These services will also assist the participant in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff, and assisting the participant in accessing other programs for which he/she qualifies. Services must be coordinated with any other services listed in the CPOC and may serve to reinforce skills or lessons taught in school, therapy, or other settings.
SRI	**Statistical Resources, Inc.** is a data management contractor. SRI maintains the Request for Service Registry and mails out the NOW offer packet. The NOW offer packet form (Waiver Acceptance/Denial/Inactive Status Form) is returned to SRI. SRI is also contacted by the GPSORC regarding approvals of IFS hours. SRI manages prior and post authorization for the NOW services.
SSC	**Supports and Services Center** is a public (state-operated) Intermediate

	Care Facility for people with developmental disabilities (ICF/DD).
90-L	**Request for Medical Eligibility Determination - BHSF Form 90-L** is a form completed by a physician and is used to establish ICF/DD level of care. Proper completion of the 90-L verifies that the participant requires one or more waiver services at least monthly in order to avoid institutionalization for his/her mental retardation or developmental disability. The form is required for entrance into the waiver. For more information see Section 2.2.

1

OCDD'S SUPPORT PLANNING PROCESS OVERVIEW

1.1 Planning Values

1.2 Planning Assumptions

1.3 Support Planning and the Louisiana Resource Allocation System

1.4 Use of the Guidelines

OCDD'S SUPPORT PLANNING PROCESS OVERVIEW

The Office for Citizens with Developmental Disabilities (OCDD) has developed the "Guidelines for Support Planning" as a framework for all activities related to planning for individualized supports and services within the New Opportunities Waiver (NOW). The "Guidelines for Support Planning" involve four main components:

1. **Discovery** involves gathering information about the participant's interests, goals, and support needs.
    - A Support Needs Assessment is conducted using the Supports Intensity Scale (SIS) and Louisiana Plus (LA PLUS).
    - A Personal Outcomes Interview/Discovery Meeting is completed with each participant and/or guardian.
    - Other needed information/assessments are completed as indicated for each participant.

2. **Planning** involves using the information from Discovery to develop a support plan.
    - A support team is established to work with the participant to develop strategies to assist in achieving the participant's goals and address his/her support needs.
    - The plan strategies identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs.

3. **Implementation** involves completion of the noted strategies and provision of needed supports according to the participant's plan.
    - Training is provided for the participant's family and support staff.
    - Resources needed are identified and secured.

4. **Review** involves assessing if implementation occurred as planned and if positive changes occurred as a result of the plan.

- The team assesses the effectiveness of strategies following implementation.
- Changes are made as needed.

1.1 PLANNING VALUES

A. OCDD's person-centered support planning process is founded on five values:

1. Each person defines his/her own outcomes.

    a. The process of assisting a participant to identify his/her own outcomes is developmental.

2. The planning process begins with the discovery of who the person is.

    a. The focus is on the participant receiving supports, his/her desires/goals/support needs, and strategies to move toward achieving goals and meeting support needs.

3. The planning process builds on the important, meaningful life experiences of the person rather than with the limitation of services actually available.

    a. Depending upon each participant's past experiences and opportunities, there will be a difference in ability to identify things that are important to the participant, possible goals, or changes the person would like to have in his/her life.

4. There is a partnership with the person and all the important people in his/her life.

    a. The support team led by the support coordinator assists the participant in this process including planning and developing opportunities for greater experiences when appropriate.

b. Throughout the planning process, the support team listens, responds, and provides assistance to the participant.

5. Individualized supports and services are provided to assist a person to achieve his/her vision and goals.

a. Each participant's plan is unique and focused on the things that are most important to him/her and the barriers that must be addressed.

b. Each participant's plan will identify and provide opportunities to learn new skills and increase independence in ways that move the person toward his or her life vision and goals.

B. Planning is a process and is not an event that occurs once a year. This process occurs continuously throughout each day, week, month, and year with subsequent needed changes in support plans occurring as interests and needs change.

C. The annual planning meeting and quarterly reviews represent only the minimum required planning activities.

D. Meetings, plan changes or other needed support activities occur as needed based upon each participant's unique situation(s).

1.2 PLANNING ASSUMPTIONS

A. The "Guidelines for Support Planning" are consistent with the values discussed in the previous section and assume the following:

1. People will have full lives with an array of activities and interests consistent with each person's interests, goals, and life vision.

2. People will have meaningful work, school or other appropriate daytime activities, including retirement activities if a person is of retirement age.

3. People will use a variety of supports (natural, community, educational, paid, etc.) with all supports being coordinated to bring each person the best support and assistance possible.

4. When people live independently and need significantly more supports than those recommended for their level, they will share supports unless contraindicated.

5. Plans will foster independence for each person.

6. People living with family and people living independently will have different needs, and the needs of each will be addressed.

1.3 SUPPORT PLANNING AND THE LOUISIANA RESOURCE ALLOCATION SYSTEM

A. The Louisiana Resource Allocation System, which is included as a part of the OCDD "Guidelines for Support Planning," is completed as part of a person-centered planning process.

B. As a part of the planning process, the support team assists the participant in determining needed supports and services including recommended Individual and Family Supports (IFS) under the NOW to achieve the person's life vision and goals. The support team completes this process using the framework in the "Guidelines for Support Planning."

C. IFS may also be referred to as attendant care services (ACS).

D. These guidelines provide for the allocation of IFS supports based on the assessment of participant needs. OCDD has selected the Support Intensity Scale (SIS), complemented by the Louisiana Plus (LA PLUS), for assessing persons' support needs. For participants younger than age 16, by agreement with AAIDD, a modified SIS assessment which removes SIS items not relevant for youths (e.g., employment items), complemented by the LA PLUS, is used.

E. IFS support hours are offered to participants based on the Louisiana Resource Allocation System. This system provides for the allocation of IFS hours to participants based on one of seven levels of need. (The levels are described in more detail in Section 14.) The system distinguishes participants living with family and those living independently.

F. Other services under the NOW are accessed in the planning process based on the participant's identified needs within the current NOW service guidelines.

1.4 USE OF THE GUIDELINES

A. The "Guidelines for Support Planning" publication describes the operations and application of the procedures involved in making a waiver offer, discovery, planning, plan approvals, implementation of plans, review of plans, and training requirements for persons involved in the process. In addition, the publication provides information on the Resource Allocation Level System in the New Opportunities Waiver Individual and Family Support (IFS) service.

B. Appropriate elements of the "Guidelines for Support Planning" are intended to be used by support coordinators, participants and families, and service providers.

C. The "Guidelines for Support Planning" does not replace the Louisiana Medicaid New Opportunities Waiver Service Manual. The Medicaid manual covers details of the waiver as a Medicaid service and contains important information for service providers regarding service delivery, licensing, and billing.

D. The Office for Citizens with Developmental Disabilities will maintain the "Guidelines for Support Planning" as an online publication. An electronic version of the publication will be posted and available on the official OCDD web site: http://www.dhh.louisiana.gov/offices/?ID=77.

1. The posted electronic version will be updated monthly, or more frequently as necessary.

2. The posted electronic version will be considered the most current version of the document.

3. Providers, support coordinators, OCDD staff, and other responsible parties must visit the online posting to acquire recent updates.

4. The OCDD will maintain and post a "Guidelines for Support Planning" Document Revisions Summary to assist users to locate corrections, additions, and deletions.

5. The publication is designed to facilitate frequent updates. If a section is revised, then the entire section should be removed and replaced with the most recent information. For example, if Section 1.4 is updated, then the user should remove the old Section 1.4 and replace the page with the updated Section 1.4. Updated pages will include an initial version issue date in parenthesis followed by a revision effective date (EF) noted in the bottom right footer.

6. Emergency updates are effective immediately, unless otherwise specified. Emergency updates notification will be made using the OCDD communications system of memorandum email and fax. The change will be posted online as a part of the manual and reflected in the Document Revision Summary.

2

NEW OPPORTUNITIES WAIVER OFFER ACTIVITIES

2.1 Letters to Participants on the Request for Services Registry or those Receiving an Emergency Option or Transition from Supports and Services Center

2.2 Completion of the 90-L Request for Medical Eligibility Determination

2.3 Follow-Up of NOW Offer Letter Mailings

2.4 Selection of a Support Coordination Agency

2.5 Linkage to Support Coordination

2.6 Scheduling the Supports Intensity Scale (SIS) and the Louisiana Plus (LA PLUS)

2.7 Establishing the Person's Acuity Level

2.8 Attachments

- 2.8.1 New Opportunities Waiver Offer - Request for Information
- 2.8.2 Waiver Acceptance/Inactive/Declination Status Form
- 2.8.3 Request for Medical Eligibility Determination - BHSF Form 90-L
- 2.8.4 Support Coordination Choice and Release of Information Form
- 2.8.5 BHSF Form 90-L Physicians Letter and Instructions
- 2.8.6 Request for Removal from Inactive Status

NEW OPPORTUNITIES WAIVER OFFER ACTIVITIES

Before the support planning process begins for the New Opportunities Waiver (NOW), certain activities must be completed.

Participants on the Request for Services Registry or those receiving an emergency waiver option are contacted by OCDD by letter and must follow the letter's instructions.

The support team at an OCDD Supports and Services Center (SSC) assists in notification and completion of activities for participants transitioning from an SSC.

This Section describes the NOW offer activities that must be completed before support planning is completed and NOW services are initiated. Section 2.3 describes OCDD Central Office and OCDD Regional Office/ Human Services District/Authority follow-up of NOW offer letter mailings.

2.1 LETTERS TO PARTICIPANTS ON THE REQUEST FOR SERVICES REGISTRY OR THOSE RECEIVING AN EMERGENCY WAIVER OPTION OR TRANSITION FROM SUPPORTS AND SERVICES CENTER

A. Participants on the Request for Services Registry who are offered an opening in the NOW and participants who qualify for the emergency waiver option will receive a NOW offer letter and a series of attachments from OCDD describing the steps that need to be completed to begin the process for receiving NOW services. The attachments to this Section appear in 2.8 and include a sample of the letter *(Attachment 2.8.1)* along with the three attachments:

1. Waiver Acceptance/Inactive/Declination Status Form *(Attachment 2.8.2)*

2. Request for Medical Eligibility Determination Form - BHSF Form 90-L *(Attachment 2.8.3)*

3. Support Coordination Choice and Release of Information Form (*Attachment 2.8.4* - Example is provided for Region 1.)

B. All three forms are required to begin the NOW waiver process and are described in this Section.

C. The Waiver Acceptance/Inactive/Declination Status Form *(Attachment 2.8.2)* is used to determine if the participant wants to use NOW services at this time, at a later time or not at all. The form provides three choices:

- ❑ I want to use NOW services as soon as I can qualify to get them.
- ❑ I want to use NOW services later on. I have the supports I need right now.
- ❑ I do not want to use NOW services.

D. Participants/families are instructed to return the Waiver Acceptance/Inactive/ Declination Status Form immediately to:

OCDD

c/o Statistical Resources Inc.

11505 Perkins Road, Suite H

Baton Rouge, Louisiana 70810

E. For participants transitioning from a Supports and Services Center (SSC), the Waiver Acceptance/Inactive/Declination Status Form is completed with assistance from the SSC support team and forwarded to OCDD at the address noted above.

F. Participants and families are also instructed to initiate completion of the BHSF Form 90-L *(Attachment 2.8.3)* and the Support Coordination Choice and Release of Information Form *(Attachment 2.8.4)* consistent with the process described that follows in Sections 2.2 and 2.4.

2.2 COMPLETION OF THE BHSF FORM 90-L REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

A. In order to receive NOW services, participants must meet the definition of developmental disability and require the level of care available in an Intermediate Care Facility for Persons with Developmental Disabilities (formerly Intermediate Care Facility for the Mentally Retarded) which requires active treatment of mental retardation or developmental disability. Entrance to the waiver is contingent on the participant requiring one or more waiver services at least monthly in order to avoid institutionalization for mental retardation or developmental disability. Louisiana defines developmental disability in LRS 28:451.2 as:

"Developmental Disability" means either:

(a) A severe chronic disability of a person that:

(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

(ii) Is manifested before the person reaches age twenty-two.

(iii) Is likely to continue indefinitely.

(iv) Results in substantial functional limitations in three or more of the following areas of major life activity:

(aa) Self-care.

(bb) Receptive and expressive language.

(cc) Learning.

(dd) Mobility.

(ee) Self-direction.

(ff) Capacity for independent living.

(gg) Economic Self-sufficiency.

(v) Is not attributable solely to mental illness.

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

(b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a

high probability of resulting in those criteria in Subparagraph (a) of this Paragraph later in life that may be considered to be a developmental disability.

B. Medical Eligibility Determination is completed by a physician on the BHSF Form 90-L - Request for Medical Eligibility Determination *(Attachment 2.8.3)* to establish that the participant meets the ICF/DD level of care requirement for waiver supports and services.

1. For those on the Request for Services Registry receiving a NOW offer letter or those receiving an emergency waiver option, participants/families are instructed to complete Section I of the 90-L and have their physician complete Sections II and III of the form.

2. A letter to the physician which includes a fact sheet and 90-L completion instructions is also provided. (See *Attachment 2.8.5*.)

3. For participants transitioning from a Supports and Services Center (SSC), the 90-L is completed by their physician at the SSC.

2.3 FOLLOW-UP OF NOW OFFER LETTER MAILINGS

A. Statistical Resources, Inc. (SRI) provides notification to OCDD regarding NOW offer mailings. OCDD attempts to contact by phone each participant/guardian who has been mailed a NOW offer letter.

1. The phone contact is focused on several issues:

a. Assuring that the participant/guardian receives the mailed information,

b. Providing clarification regarding the next steps be taken by participant to complete the 90-L,

c. Updating all contact information, and

d. Facilitating completion and return of the offer forms to SRI.

2. Multiple attempts with documentation are made to contact the participant/guardian by phone. These attempts are made after hours and on weekends as necessary.

3. If a participant is not reached by using the contact information on the DD Request for Services Registry, the OCDD will make attempts to locate a more current address using available state databases (e.g. MEDS, LAMI, LDET, BENDEX, ITS).

   a. If new contact information is found, the OCDD resumes phone contact as described in A.1.

4. If all attempts at phone contact have failed, the participant/guardian's information is then forwarded to the OCDD Regional Office/Human Services District/Authority of the last known location for further investigation and follow-up.

B. If the participant does not respond, SRI sends a second and final NOW offer letter mailing.

C. OCDD Regional Offices/ Human Services Districts/Authorities are responsible for making follow-up contact with:

1. Persons who are un-locatable following the efforts described in item A,

2. Persons supported in ICFs/DD who have not responded to the NOW offer letter mailing, and

3. Persons supported in nursing facilities who have not responded to the NOW offer letter mailing.

D. OCDD Regional Office/ Human Services District/Authority follow-up contacts require in-person discussion with the participant or legally authorized representative/guardian. OCDD Regional Offices/ Human Services Districts/Authorities may work in collaboration with applicable local ombudsmen programs to complete these contacts.

1. The purpose of the follow-up contact is:

a. Assuring that the participant/guardian receives the mailed information,

b. Providing clarification regarding the next steps be taken by participant to complete the 90-L,

c. Updating all contact information, and

d. Facilitating completion and return of the offer forms to SRI.

E. If concerns arise about freedom of choice or rights violations, OCDD Regional Offices/ Human Services Districts/Authorities should refer the concern to the appropriate ombudsman for assistance.

F. OCDD Regional Offices/ Human Services Districts/Authorities are responsible for completing required follow-up forms for documentation and tracking purposes and for submitting these forms to the appropriate OCDD Central Office representative.

G. If after all efforts to reach the participant there is still no response to the second offer letter mailing, SRI will close the participant's request on the Request for Services Registry due to his/her failure to respond.

H. The participant/guardian may elect to be placed on inactive status, which preserves his/her Request for Services Registry date.

1. Participants are removed from inactive status at the request of the participant/guardian. The regional waiver office must be contacted to complete the inactive status documentation *(Attachment 2.8.6).*

2.4 SELECTION OF A SUPPORT COORDINATION AGENCY

A. The next step in securing New Opportunities Waiver services is completion of the Support Coordination Choice and Release of Information Form *(Attachment 2.8.4)*. Completion of this form accomplishes three requirements for receipt of waiver services:

1. Documents that the participant was offered both institutional and waiver services (This is a federal Medicaid requirement.),

2. Allows the participant to select among support coordination agencies available in the region and documents their freedom of choice, and

3. Documents the participant's agreement to release information relevant to the application.

B. The Support Coordination Choice and Release of Information Form is completed by the participant/family. It should be returned to the address below:

OCDD

c/o Statistical Resources Inc.

11505 Perkins Road, Suite H

Baton Rouge, Louisiana 70810

2.5 LINKAGE TO SUPPORT COORDINATION

A. Once the activities described in Section 2.1 are completed and the three forms identified in Section 2.1 are returned to OCDD c/o SRI, the participant is linked to his/her chosen support coordination agency.

B. Following linkage:

1. The support coordination agency administration assigns a support coordinator.

2. A referral is sent by SRI to the parish Medicaid office to complete the financial determination.

C. The assigned support coordinator will contact the participant by phone within three (3) days of receipt of linkage notification. Within ten (10) calendar days following linkage, the support coordinator meets with the participant face-to-face.

1. At this time the support coordinator determines any "need for immediate case management intervention" and takes appropriate steps to address any identified needs.

2. Required OCDD forms are completed, and the participant/guardian is provided with information about rights and responsibilities, specific policies and procedures, and helpful toll-free numbers.

D. Upon linkage and completion of financial determination, the planning process is initiated as described in the next Section. (See *Attachment 4.4.1* for Timelines for Initial Support Planning.)

2.6 SCHEDULING THE SUPPORTS INTENSITY SCALE (SIS) AND THE LA PLUS

A. For participants on the Request for Services Registry receiving a NOW offer letter or those receiving an emergency waiver offer, the support coordination agency receives notification of completion of freedom of choice documentation [made by means of the Support Coordination Choice and Release of Information Form *(Attachment 2.8.4)*]. Once the support coordination agency is notified, the support coordination agency contacts the participant/guardian to schedule the SIS/LA PLUS.

B. The SIS/LA PLUS assessment is expected to be completed, submitted for review to the SIS Project Office, and accepted by the SIS Project Office within thirty (30) days of linkage to a support coordination agency.

   1. This SIS/ LA PLUS are part of the Discovery process discussed in Sections 3.1 and 3.2.

   2. The SIS/LA PLUS must be completed before the Planning Meeting. (Section 3.5, Section 4 introduction and 4.1)

   3. OCDD recommends that the support coordination agency schedule the SIS/LA PLUS assessment to occur within two weeks of the linkage date, allowing an additional two weeks for revisions. (Process is discussed in Section 2.7.)

C. For participants transitioning from a Supports and Services Center, the support coordination agency contacts the agency Transition Services Officer to schedule completion of the assessment.

D. It is important that SIS/LA PLUS forms are completed and submitted promptly according to schedule so that planning and services are not delayed.

2.7 ESTABLISHING THE PERSON'S ACUITY LEVEL

A. Once the SIS/LA PLUS is completed and submitted, the assessment is examined for accuracy.

B. The process for submission, review, and acuity level determination is completed as follows:

1. The assigned support coordinator submits the completed assessment to the OCDD SIS/LA PLUS Project Office within three business days of completion of the assessment.

2. The SIS/LA PLUS Project Office reviews the assessment for accuracy within five business days of submission.

3. If revisions are needed, the assigned support coordinator completes the needed revisions within three business days of notification by the SIS/LA PLUS Project Office.

4. Once a SIS/LA PLUS assessment is accepted by the SIS/LA PLUS Project Office, it is scored, and an acuity level is determined.

5. The assigned support coordinator receives notification of the acuity level once determined by the SIS/LA PLUS Project Office.

C. One of seven acuity levels in the Louisiana Resource Allocation System is assigned based on the needs of the participant as reflected on the SIS/LA PLUS and pre-established criteria. Development and validation of the Resource Allocation System is described in the Appendix, Section 14.

2.8 ATTACHMENTS

Attachment 2.8.1 New Opportunities Waiver Offer- Request for Information

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

New Opportunities Waiver Offer - Request for Information

DATE

Name
Address Line 1
Address Line 2

Dear Name:

You are currently on the Developmental Disabilities (DD) Request for Services Registry (RFSR) for the New Opportunities Waiver (NOW). You may have heard of this waiver in the past; it used to be called the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver. The NOW is a service of the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD).

We are contacting you because it is time for you to be evaluated for eligibility for NOW services. This process requires that you follow the instructions in this letter and review the information included in this packet carefully. You may want to ask your family or a close friend to help you to go through the packet and to stay organized.

If at any point, you have questions or need assistance, call **1-866-517-7687**. An OCDD representative will respond to your request.

Do you want New Opportunities Waiver (NOW) services?

The NOW may be a great opportunity for you. Think about whether or not you want to use NOW services. You have three choices:

1. I want to use NOW services **as soon as I can qualify** to get them.
2. I want to use NOW services **later on**. I have the supports I need right now.
3. I **do not** want to use NOW services.

Information about NOW is included in this packet. The Fact Sheet on **blue pages** tells you what services are available in NOW. Please review this information carefully to see if you are interested in getting NOW services. There is also a brochure that has great information on sharing supports. Please review this information and learn about sharing supports if you elect to use NOW services.

Bienville Building • 628 N. 4th Street • P.O. Box 3117 • Baton Rouge, Louisiana 70821-3117
Phone: 1-866-517-7687• *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Revised July 1, 2009
Replaces March 23, 2009 Issuance

OCDD-006-2
Page 1 of 4

Attachment 2.8.1 New Opportunities Waiver Offer- Request for Information

After you have made your choice, follow the instructions in the section that matches your choice.

I want to use NOW services as soon as I can qualify to get them.

In order to start NOW services, you must complete and return some paperwork. This paperwork helps OCDD to determine your eligibility and to process your entry to NOW as quickly as possible.

Step 1: Return Immediately

Complete the **yellow pages** and return ***immediately*** in the enclosed self-addressed, stamped envelope.

The yellow pages are the:

- Waiver Acceptance/Inactive Status/Declination Form-- This form tells OCDD whether or not you are interested in using NOW services.
- Freedom of Choice Form-- You will select a Support Coordination Agency and show your choice of agency on this form. There are brochures included to help you decide which agency you would like to select.

Mailing the yellow pages immediately will keep you on track to start your waiver services as soon as possible.

These pages must be signed by you, your parent/guardian, or authorized representative.

Step 2: Return as soon as possible

The **green pages** need to be filled out by two separate people:

- **You, your parent/guardian, or authorized representative** will need to **fill out Section I** (Recipient Information) of the 90-L form. The top of this form says "Request for Medical Eligibility Determination."
- Your **physician will** need to **fill out Sections II and III and sign the form**.

IF THIS FORM IS NOT COMPLETELY FILLED OUT OR IS NOT SIGNED BY YOUR PHYSICIAN, IT WILL BE RETURNED TO YOU TO BE COMPLETED. THIS WILL DELAY THE PROCESS.

Make an appointment with your physician as soon as possible. Take all of the green pages with you. Give the green pages to your physician. Your physician will need to fill out and sign the 90-L form. All parts of the form must be filled out.

Return the completed, signed 90-L form to OCDD immediately. This form is only active for a certain time period after it is signed. If it expires, you will have to get another form signed.

The fastest way to get the form to OCDD is to give your physician permission to fax the form to OCDD at 225-767-0502.

If your physician will not fax the form, mail the completed form in the second self-addressed, stamped envelope to:

Attachment 2.8.1 New Opportunities Waiver Offer- Request for Information

OCDD c/o Statistical Resources, Inc.
11505 Perkins Road, Suite H
Baton Rouge, LA 70810

I want to use NOW services later on. I have the supports I need right now.

If you are interested in using NOW services later on, you may ask for "Inactive Status." Inactive Status will hold your original protected request date. Then you can request NOW services when you are ready to use the services by writing to OCDD to ask for a waiver opportunity offer. Your written request must include your original protected request date and state that you want your name removed from Inactive Status.

If you want to ask for Inactive Status, complete the **yellow form** titled "Waiver Acceptance/Inactive Status/Declination Form." Mark on the form that you are not interested in the NOW at this time and would like your name placed on "Inactive Status." Return the form in the self-addressed, stamped envelope.

I do not want to use NOW services.

This option should only be selected if you do not want to use NOW services and are not interested in using NOW services at a later date. If you think that you may want to use NOW services in the future, consider requesting Inactive Status (see instructions in the section above).

If you are certain that you do not want to use NOW services, complete the **yellow form** titled "Waiver Acceptance/Inactive Status/Declination Form." Mark on the form that you are not interested in the NOW and do not wish to receive services through the waiver. Return the form in the self-addressed, stamped envelope.

Your name and original protected request date will be removed from the DD Request for Services Registry (RFSR) for NOW services. You will **not** receive an offer for NOW or any other waiver utilizing this RFSR in the future; you will **not** be contacted again regarding NOW.

After You Send the Forms In

This information applies **only** if you chose "I want to use NOW services as soon as I can qualify to get them."

As soon as we have received the completed yellow pages, you will be contacted by an OCDD representative or your selected support coordination agency to schedule an appointment to complete the SIS/LAPLUS. This assessment tool helps identify the amount of services you need. SIS/LAPLUS appointments should be scheduled when it is convenient for you.

Revised July 1, 2009
Replaces March 23, 2009 Issuance

OCDD-006-2
Page 3 of 4

If you do not send in your yellow pages immediately, it will delay the start of your services. However, you will not be removed from the DD Request for Services Registry for NOW services, nor will you lose this opportunity.

After the successful completions of the SIS/LAPLUS and the 90-L, your support coordinator will contact you to begin the planning process. The planning process is based upon the results of the SIS/LAPLUS assessment. The planning must be completed before the start of NOW services.

In addition, before you are approved for NOW services:

1. Financial eligibility must be determined by the DHH Bureau of Health Services Financing (Medicaid), and
2. Medical eligibility must be determined by OCDD.

When you are approved, OCDD will provide a certification for you to receive Medicaid and NOW services. An OCDD representative will discuss your requirements for waiver participation, including your rights and responsibilities. Your support coordinator will work with you to complete these processes.

Quick Guide to the Packet

Blue The Fact Sheet about NOW gives you basic information about the waiver and what services are available.

Yellow

- **If you wish to begin waiver services as soon as you can qualify to get them, fill out both yellow forms, sign them and return them immediately.**

Only fill out and return the "Waiver Acceptance/Inactive Status/Declination Form" if:

- **You wish to receive waiver services later.** This places you on inactive status. You can request in writing a waiver opportunity offer when you are ready to use the services.
- **You do not want to use NOW services.** You will not be contacted again regarding NOW.

Make sure your choice is **clearly** marked.

Green All of this information should be given to your physician. Before going for your appointment with your physician, you may fill out Section I (Recipient Information) of the 90-L form. The top of this form says "Request for Medical Eligibility Determination." **Your physician must complete and sign this form**. The form must be returned to OCDD **quickly**. Consider asking your physician to fax the form to OCDD at 225-767-0502. This will help make sure it gets in on time.

Need Help with Something?

If at any point you have questions or need assistance, call **1-866-517-7687.** An OCDD representative will respond to your request.

Sincerely,

Ted Kleamenakis
OCDD Executive Director of Waiver Supports and Services

c: Regional Waiver Office

Revised July 1, 2009
Replaces March 23, 2009 Issuance

OCDD-006-2
Page 4 of 4

Attachment 2.8.2 Waiver Acceptance/Denial/Inactive Status Form

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES (OCDD)

NEW OPPORTUNITIES WAIVER (NOW)
[FORMERLY KNOWN AS THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED (MR/DD) WAIVER]

WAIVER ACCEPTANCE/INACTIVE STATUS/DECLINATION FORM

☐ ***YES***, I would like to participate in the New Opportunities Waiver if I am determined eligible.

☐ ***NO***, I am not interested in the New Opportunities Waiver services ***at this time***. Please put my name in ***Inactive*** status. ***I understand that I must write to OCDD when I would like another waiver opportunity based on my original protected Request Date and wish for my name to be removed from Inactive status.***

☐ ***NO***, I am not interested in the New Opportunities Waiver services. ***I understand that my name will be removed from the DD Request for Services Registry.***

If you fail to return this form by DATE, this form will be considered NULL AND VOID. OCDD will consider that you are no longer interested in receiving NOW services and your name will be removed from the DD Request for Services Registry.

Requestor's Name:_____ Date of Birth:_____
(Please Print)
Requestor's Social Security Number: _____

Signature of Requestor/Legal Guardian:_____

Relationship to Requestor: ☐ Self ☐ Other _____

Address:_____

City:_____State:_____ Zip Code:_____

Daytime Phone:_____ Nighttime Phone: _____

Other Phone: _____ Date Signed:_____

Return to: OCDDC/O SRI, 11505 Perkins Road, Suite H, Baton Rouge, LA 70810
Phone #: 1-800-364-7828 Fax #: 225-767-0502

Reissued March 23, 2009
Replaces December 17, 2007 Issuance

OCDD-008
Page 1 of 1

Attachment 2.8.3 Request for Medical Eligibility Determination - BHSF Form 90-L

BHSF Form 90-L
Rev. 12/08
Prior Issues Obsolete

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient's Name:		SS #:	Medicaid #:
B. Address (City, State, Zip Code, Parish):		C. Responsible Party/Curator:	
		Address (City, State, Zip Code, Parish):	
Telephone #:	Race: Sex:		
Medicare #:	Date of Birth:	Relationship:	Telephone #:

D. What are/were the living arrangements: ☐Own home ☐ Relative's home ☐ Other:_____

E. What previous institutional care (including nursing facilities) has this person received?

Facility:	Date:	Facility:	Date:
Facility:	Date:	Facility:	Date:

F. What Home/Community-based services have been used/considered: ☐NOW ☐CC ☐Supports ☐Other:_____

G. Why were services not suitable?

H. Requesting Nursing Home placement: ☐Temporarily ☐Permanently

I. Applicant/Responsible Party Signature:_____Date:_____

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. ☐Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum.

B. ☐Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

C. ☐Skilled Care (maximum care required) - Indicate special level, if indicated: ☐TDC ☐ ID ☐ NRTP (☐Complex; ☐Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D. ☐ ICF/DD - Requires active treatment of developmental disability under supervision of a qualified developmental disability professional.

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days? ☐Yes ☐ No

F. Are Home/Community Based Services adequate to meet the needs of this patient? ☐Yes ☐ No

G. COMMENTS:

Attachment 2.8.3 Request for Medical Eligibility Determination - BHSF Form 90-L

III. MEDICAL INFORMATION

Recipient's Name:

A. Diagnosis:_____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES_____

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

C. Recent Hospitalizations: (include psychiatric)_____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

☐Yes (1, 2, 3) ☐No 1. Oriented	☐Yes (1, 2, 3) ☐No 4. Comatose	☐Yes (1, 2, 3) ☐No 7. Hostile
☐Yes (1, 2, 3) ☐No 2. Forgetful	☐Yes (1, 2, 3) ☐No 5. Confused	☐Yes (1, 2, 3) ☐No 8. Combative
☐Yes (1, 2, 3) ☐No 3. Depressed	☐Yes (1, 2, 3) ☐No 6. Wanders	

E. Activities of Daily Living: (check appropriate box)

SELF	ASSIST	TOTAL			
☐	☐	☐	1. Eating	☐ 11. Verbal	☐ 16. Impaired vision _____
☐	☐	☐	2. Bathing	☐ 12. Non-verbal	☐ Glasses
☐	☐	☐	3. Personal	☐ 13. Bowel Incontinence	☐ 17. Impaired hearing_____
☐	☐	☐	4. Oral Hygiene	☐ 14. Bladder Incontinence	☐ Hearing Aid
☐	☐	☐	5. Ambulation	☐ 15. Urinary Catheter	☐ 18. Dentures _____

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

☐ 1. Ostomy care_____	☐ 7. MRSA_____
☐ 2. Glucose Monitoring_____	☐ 8. Diet/Tube Feeding_____
☐ 3. Restraints _____	☐ 9. Dialysis_____
☐ 4. IV's_____	☐10. Respiratory _____
☐ 5. Suctioning_____	☐11. Decubitus_____
☐ 6. Specialized Rehab_____	☐12. Other_____

G. PHYSICAL EXAMINATION: Height_____Weight_____Pulse_____Resp_____Temp_____B/P_____

Lab Results: HCT_____HGB_____U/A_____	Radiology_____
General_____	Head and CNS_____
Mouth and EENT_____	Chest_____
Heart and Circulation_____	Abdomen_____
Genitalia_____	Extremities_____
Skin_____	Other_____

H. Physician's Name (Print)_____**PHONE**_____

Address:_____

Physician's Signature_____**Date**_____

Attachment 2.8.4 Support Coordination Choice and Release of Information Form (Example from OCDD Region 1)

SUPPORT COORDINATION CHOICE and RELEASE OF INFORMATION FORM
NEW OPPORTUNITIES WAIVER - DHH Region 1

To the recipient: Please fill out Sections 1, 2 and 3 of this form and return it as soon as possible to:

Statistical Resources, Inc. Case Management
11505 Perkins Road, Suite H
Baton Rouge, Louisiana 70810
Fax: (225) 767-0502

Recipient's Name: _____ Date of Birth: ___/___/____
Address: _____ City: _____
State: _____ Zip code: _____ Telephone Number: (_____) _____-___ or (_____) _____-_____
Social Security Number: _____-____-_____ Medicaid Number: _____
Population: ■ New Opportunities Waiver. Slot Type: ❑ Developmental Center ❑ OCS
Recipient currently resides in a Group Home, Developmental Center, or Nursing Home? ❑ Yes ❑ No

Section 1: Choice of Waiver Services

I understand that I have the right to choose between institutionalization and waiver services. I have opted for waiver and support coordination services.

_____ _____
Signature of Recipient / Legal Guardian Date

Section 2: Support Coordination Freedom of Choice B DHH Region 1

The state has contracted with several support coordination providers in your area. Included with this letter are brochures describing the services of each agency. Please choose a provider from among these agencies. We ask that you number your choices. Please write 1 (one) in the box by your first choice and write 2 (two) in the box by your second choice. If your first choice is full, you will be linked to your second choice if they are not full. You will be linked for a 6-month period, after which you have the option of changing agencies if space is available.

❑ Quality Support Coordination
❑ Easter Seals of Louisiana
❑ Ventilator Assisted Care Program of Children=s Hospital *(To make this choice, the recipient must be ventilator dependent, less than 22 years old, and meet the requirements of the program)*

_____ _____
Signature of Recipient / Legal Guardian Date

Section 3: Release of Information

I permit the release of any and all information which may be in the possession of DHH offices that pertain to my application(s) for services, including but not limited to OCDD statement of eligibility, OCDD Request for Services list, plans of support, generic service plans, doctor's reports/evaluations, psychological reports/evaluations, medical/social/educational assessments of any kind, including those provided by schools, other agencies, and /or organizations. This includes all third party information which may be in DHH's possession.

_____ _____
Signature of Recipient / Legal Guardian Date

Section 4: Transfer of Records (For Agency Use Only)

Indicate which of the required documents have been transferred from the following agency: _____

❑ 1. Discharge 148
❑ 2. Form 142
❑ 3. 18 LTC
❑ 4. 51NH
❑ 5. CPOC (current & approved)
❑ 6. Six months progress notes
❑ 7. Waiver slot letter (if not certified)
❑ 8. Social Evaluation
❑ 9. Psych. Evaluation
❑ 10. Medical Documentation
❑ 11. IEP
❑ 12. _____
❑ 13. _____
❑ 14. _____
❑ 15. _____

Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized.

_____ _____ _____ _____
Transferring Agency (Signature Required) Date Receiving Agency (Signature Required) Date

STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT MEETS THE OF THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

07/04/07

Attachment 2.8.5 Request for Medical Eligibility Determination - BHSF Form 90-L: Physician Letter and Instructions

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

Dear Physician:

Your client/patient has the opportunity to receive a New Opportunities Waiver opportunity. He/she needs your assistance to complete a required part of the eligibility determination process.

The New Opportunities Waiver is a Medicaid home and community-based waiver program. The waiver program allows for assistance in the home, giving some relief to the primary care-giver. The supports and services in waiver programs are targeted to supporting individuals to remain in their homes with their families and who would otherwise require institutionalization. Waiver services are delivered in addition to Medicaid State Plan benefits.

Part of the application process is to obtain medical information using the *Medical Eligibility Determination*-BHSF 90L form. We are requesting your assistance in completing the form to ensure medical eligibility for this individual.

- **Section I** should already have been completed by the individual/family/legal guardian. If not complete, please assist your client/patient in completion.
- **Section II** may be completed by a Nurse, Nurse Practitioner, Physician's Assistant or you.
- **Section III** may be completed by Nurse, Nurse Practitioner, or Physician's Assistant.
- **Section III, H,** Physician's Signature, ***MUST reflect your signature***.

Further instructions are with the form.

Section I, part F. should note that the individual is applying for developmental disabilities (DD) services. To be eligible to receive DD home and community-based services, including the New Opportunities Waiver, a person must meet ICF/DD level of care. Information describing level of care is on the reverse side of this page. Your completion of the 90-L form is integral in our determination of whether or not your client/patient meets ICF/DD level of care.

Once completed, signed and dated, the 90-L form is time-sensitive. We have encouraged your client/patient and his/her family/legal guardian to return the form immediately by mail. If mail will be used, please give the completed form to the individual/family/legal guardian. However, you may assist in assuring the timely submission of the form by requesting permission to fax the completed form to OCDD at 225-767-0502. Forms that are received and processed late will have to be filled out in entirety a second time.

Thank you for your time and assistance in this matter. If you have any questions, please feel free to contact 1-866-517-7687.

Bienville Building • 628 N. 4th Street • P.O. Box 3117 • Baton Rouge, Louisiana 70821-3117
Phone #:1-866-517-7687 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Issued March 18, 2009
Replaces October 22, 2008 Issuance (OCDDWSS-R-08-001)

Attachment 2.8.5 Request for Medical Eligibility Determination BHSF Form 90-L: Physician Letter and Instructions

FACT SHEET FOR LEVEL OF CARE: MEDICAID ELIGIBLITY DETERMINATION FORM 90-L

In order to qualify for Centers for Medicare and Medicaid Services' (CMS) Home and Community-Based Waiver services, a person must meet the definition for a developmental disability ***and*** the requirements for an Intermediate Care Facility for the Developmentally Disabled (formerly known as ICF/MR: Intermediate Care Facility for the Mentally Retarded) **level of care**, which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional. The definition of a developmental disability is provided in this fact sheet.

Checking the "ICF/DD" level of care on the Medicaid Determination for Eligibility Form 90-L does not always mean the person has to have a diagnosis of developmental disability, nor does it mean that the person currently requires the services of a group home or supports and services center.

CMS specifies that "In order for an individual to be considered to require a level of care specified for the waiver, it must be determined that: a) the person requires at least one waiver service…and b) requires the provision of waiver services at least monthly…to assure health and welfare. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to **avoid** institutionalization."

A developmental disability as defined by The Developmental Disability Law, Louisiana Revised Statutes 28:451.1-455.2, is as follows:

"Developmental Disability" means either:

(a) A severe chronic disability of a person that:
- (i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
- (ii) Is manifested before the person reaches age twenty-two.
- (iii) Is likely to continue indefinitely.
- (iv) Results in substantial functional limitations in three or more of the following areas of major life activity:
  - (aa) Self-care.
  - (bb) Receptive and expressive language.
  - (cc) Learning.
  - (dd) Mobility.
  - (ee) Self-direction.
  - (ff) Capacity for independent living.
  - (gg) Economic Self-sufficiency.
- (v) Is not attributable solely to mental illness.
- (vi) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph later in life that may be considered to be a developmental disability.

If you have any concerns or questions about the Medicaid Eligibility Determination Form 90-L and Level of Care, do not hesitate to contact the Office for Citizens with Developmental Disabilities at 1-866-517-7687 Monday through Friday from 8 am to 4:30 pm.

Issued March 18, 2009
Replaces October 22, 2008 Issuance (OCDDWSS-R-08-001)

OCDDWSS-R-09-001
Page 2 of 2

Attachment 2.8.6 Process for Request for Removal from Inactive Status

Office for Citizens with Developmental Disabilities *OI #D-8, Request for Services Registry. Adopted 2/29/08. Section II.C.7., page 10:*

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6. If the person/authorized representative accepts the waiver offer, the data contractor will link the person to the Support Coordination (SC) agency of his/her choice. If the SC agency chosen has reached the maximum capacity allowed by contract, the person will be linked to his/her SC agency of second choice. The SC agency will then assist the person to complete the necessary documentation to determine if the person meets the Level of Care specified for the waiver being offered as well as financial eligibility criteria for certification into the HCBS waiver opportunity being offered.

7. The person/authorized representative can request a status change regarding the person's position on the RFSR when a NOW or SW offer is submitted.

   a. The person/authorized representative may make a request to OCDD in writing, to be designated "inactive" on the RFSR. The person's original protected request date will remain the same.

   b. When the person/authorized representative who previously requested to be designated "inactive" on the RFSR chooses to be reinstated as active, he/she will request in writing that his/her name be removed from inactive status. His/her protected request date on the registry will be reinstated and an offer for the NOW or SW will be sent at the next available opportunity.

   c. The person/authorized representative may request to be placed in "inactive status" after they have accepted the NOW or SW offer and have been linked to a Support Coordination Agency, but only if a financial eligibility decision/certification has not been made. At the time the family chooses to go inactive after linkage, the regional office waiver staff will assist the person/authorized representative in completing a new Family Decision form OCDD-008-2 for the NOW and OCDD-401-2 for the SW (Appendix P-4 or P-5). The bottom portion of this form must be completed by regional office waiver staff. If the Medicaid office has already determined this individual eligible for Medicaid based on this waiver opportunity, then they will need to be notified immediately that the individual is not accepting the waiver offer at that time. The same procedure will be followed to be reinstated as active on the registry as per 7.b. above.

D. New Opportunities Waiver (NOW)

Individuals offered a NOW opportunity must follow the process as described above in "C. Waiver Offers" in order to be certified for NOW services. The next individual on the registry will be notified in writing that a waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment.

3

COMPLETING DISCOVERY ACTIVITIES FOR THE SUPPORT PLAN

3.1 Beginning Discovery Using the SIS/LA PLUS for Planning

3.2 Completing Discovery (Using the Personal Outcomes Interview/Mapping/Discovery Meeting)

3.3 Developing a Personal Vision and Goals

3.4 Establishing the Support Team

3.5 Meeting Preparation

3.6 Attachments

3.6.1 Personal Outcomes Worksheets - Support Plan Format

COMPLETING DISCOVERY ACTIVITIES FOR THE SUPPORT PLAN

Prior to planning for supports and service needs, information is gathered about the participant.

The support coordinator is responsible for completing Discovery activities prior to the planning meeting. The purpose of Discovery is to identify those things that matter most to the participant and to identify his/her support needs.

Discovery activities include:

1. A review of all records relevant to the participant's interest and needs for support (i.e., school, previous assessments, and medical records),

2. Completion and review of the SIS LAPLUS to determine interest and support needs in a variety of life areas,

3. Completion of needed interviews, observations, and professional assessments (i.e., OT, PT, Speech), and

4. Completion with the participant/guardian of a Personal Outcomes Assessment and Discovery Meeting (*Attachment* 3.6.1) using a variety of person-focused planning methods to determine the participants' life vision, goals, preference, interests, and challenges.

Discovery Activities are completed prior to the planning meeting.

Planning activities beyond Discovery require the assistance of a support team led by the support coordinator.

As Discovery activities progress, the support coordinator also works with the participant/guardian to establish his/her support team.

Attachment 4.4.1 contains details of timelines for initial support planning, including timelines for activities in the Discovery phase.

3.1 BEGINNING DISCOVERY USING THE SIS/LA PLUS FOR PLANNING

A. The SIS/LA PLUS assessments inform both the planning process and the recommended IFS hours.

B. The SIS/LA PLUS is completed no more than 90 days prior to the initial plan and the annual plan review. *See item F below if assessment is older than 90 days.*

C. Support coordinators use the SIS/LA PLUS assessment data for input into the planning process and into the support plan in at least five ways.

1. Demographic information – The demographic information on the SIS/LA PLUS provides input to the demographics page of the support plan including:

    a. Primary and secondary diagnoses,

    b. Mobility,

    c. Need for 24-hour service,

    d. Living situation, and

    e. Matching the participant's assessed needs, or appropriate referrals as a component of the plan.

2. Important Things to Know about the Individual – The SIS/LA PLUS provides information in the following areas:

a. Where and with whom the person lives,

b. Current and needed home modifications,

c. Importance of work to the participant,

d. Favorite activities, and

e. Important "to" activities reflected on the SIS/LA PLUS for home life, community life, social life, education and work.

3. Medical and Mental Health Concerns – Information in the support plan regarding the participant's medical status and conditions reflects the SIS/LA PLUS assessment of needs in the following areas:

a. Mobility, nutrition and communication,

b. Diagnoses,

c. Practitioner/doctor visits,

d. Psychiatric/behavior concerns,

e. Behavior support plan (Check yes if the score is 5 or greater on Part E, Positive Behavior Supports of the LA PLUS. A behavior support plan is required if the Part E Positive Behavior Supports on the LA PLUS score is 5 or greater. A behavior plan is required if the participant is a member of level 4 or level 6, unless determined otherwise by the GPSORC), and

f. Possible risk factors for the participant.

4. Medications and Treatments – Medications and treatments are consistent with the SIS/LA PLUS assessment of health including:

   a. Dose,

   b. Frequency, and

   c. Method of administration.

5. Support Type and Frequency - Identified services and supports in the support plan are consistent with the SIS/LA PLUS.

   a. The IFS hours used in the support plan are within those recommended by the Louisiana Resource Allocation System unless additional IFS hours above those suggested for the assigned level are requested and approved. (See Section 5.7-5.9 and Section 7.3.)

D. Once the SIS/LA PLUS is completed and information is included within the support plan, the support coordinator also reviews any other information or assessments available and places that information into the plan format as well.

E. If additional assessments are deemed necessary based upon the SIS/LA PLUS assessment or other information, attempts are made to acquire these assessments. If they cannot be completed prior to the planning meeting, part of the plan includes timeframes for completion. Depending on the results of these assessments, additional meetings and/or services may be needed.

F. If the SIS/LA PLUS assessment completed for the initial or annual plan is greater than 90 days old at the time of planning, the support coordinator must make a determination as to whether the assessment information is still current, or if the participant's support needs have changed. This determination is required before moving forward with planning using the SIS/ LA PLUS.

1. To determine whether the assessment information is current:

    a. Contact by phone the individual and family/guardian/staff who were the original respondents. Discuss key support items in the assessment. For example, ask if the participant still requires full physical support with home living activities, if the person still needs support for certain medical and/or behavioral conditions/concerns, if the person requires nighttime supports.

        i. If original respondents are unable to participate or cannot provide updated information, then the support coordinator must contact person(s) who know the participant well (e.g., having known and observed the participant in various settings for at least 3 months).

    b. Based upon the conversation, the support coordinator must determine if support needs remain consistent with the SIS/LA PLUS assessment or if support needs have changed.

2. If support needs **have not changed** and remain consistent with the SIS/LA PLUS assessment:

    a. The support coordinator may proceed with planning using the existing SIS/ LA PLUS assessment.

    b. Section II. General Health Profile, Part A. Health Status section of the support plan must include the following documentation:

        i. When the contact took place

        ii. Who was contacted

iii. The statement: "While the assessments are over 90 days, recent follow-up contact has found no significant support needs changes since the original contact and assessment."

3. If support needs **have changed** since the SIS/ LA PLUS assessment, the support coordinator (or a certified assessor) must re-administer the assessments per protocol.

4. Following completion of the reassessment, the support coordinator will notify the SIS/ LA PLUS Project Office via email.

   a. Subject Line: Updated SIS/ LA PLUS due to Prior Assessment Expiration

   b. Message Attachment: completed updated assessment

   c. Message Content: Explanation that reassessment occurred due to original assessment being older than 90 days and follow-up contact determining that support needs have changed, requiring reassessment.

5. The SIS/ LA PLUS Project Office will complete procedures discussed in Section 2.7.

6. After completion of these activities, the support coordinator may then use the SIS/ LA PLUS as described in this section (3.1) as a current assessment for planning.

7. The support coordinator must include a cover letter with the support plan submission. The cover letter must include the following items:

   a. Date of the original assessment

b. A statement indicating that the original assessment was older than 90 days when planning began and the reason for the planning delay

c. Who was contacted

d. When the updated contact with the original respondents occurred and if not the original respondents the reason why

e. A statement reflecting the determination that support needs have changed since the original assessment

f. The date of the updated assessment

g. A statement indicating that the plan is based on the updated assessment.

3.2 COMPLETING DISCOVERY (USING THE PERSONAL OUTCOMES INTERVIEW/MAPPING /DISCOVERY MEETING)

A. Discovering information about who the participant is and what is most important to him or her is central to person-centered planning and is a critical component of OCDD's planning process.

B. There are numerous methods for completing Discovery including use of a Personal Outcomes Interview (See *Attachment 3.6.1.*), Mapping, or a Discovery Meeting. The support coordinator may use any method based on the preferences of the participant and skills and training of the support coordinator.

C. The Discovery process provides information that assists the participant in determining what is most important to him or her in each life area, establishing his or her life vision, and setting personal goals.

D. Over time, the Discovery process provides reference points as goals are achieved and replaced by new personal goals.

E. Discovery occurs 90 days prior to the initial plan and before the annual review. Discovery must be completed at least two weeks prior to the planning meeting. This will allow the support coordinator to process the Discovery information, input the information into the support plan format, and distribute the information one week prior to the planning meeting (as described in Section 9.5.E.). (Note: Initial assessment for any new participant must begin within seven (7) calendar days of linkage.)

1. OCDD recommends that the Personal Outcomes Interview be completed at the ten (10) day face-to-face meeting post linkage for new waiver participants.

2. For participants in plan renewal, the Personal Outcomes information should be updated as needed during each quarterly review. The Personal Outcomes Worksheets must be completed and verified as accurate within 90 days prior to the expiration of the participant's support plan.

F. A focused support plan depends on understanding the following about each participant:

1. Priorities,

2. Perspectives, and

3. Preferences.

G. There should be recognition that everything a participant may want is not practical or achievable. The support team helps the participant in sorting through personal goals to focus on the highest priority outcomes.

H. It is the support coordinator's role to ensure that alternative strategies for achieving personal outcomes are reviewed and understood during the planning process.

I. Discovery is a fluid process. The support coordinator interacts with the participant and gathers information from the participant and those who know him/her best. Ideally, the support coordinator interacts and observes the participant across situations:

1. At home,

2. At work (with the approval of the employer),

3. With family and friends, and

4. With all support staff.

J. Information gathered from those who know the participant focuses on the participant's perspective (not their own opinions) and clarifies information obtained directly from the participant. Research shows that family members, providers and friends do not always share the same perspective as participants on the care and supports they receive.

K. When the participant has difficulty communicating, the Personal Outcomes Interview is more challenging and requires that the support coordinator spend additional time with the person recognizing that everyone communicates in some manner.

1. The support coordinator uses observations of the participant in multiple situations and from multiple secondary sources, as well as asks for specific events that provide examples relevant to the participant's personal priorities.

L. For participants already receiving services, the provider(s) is involved as appropriate for each participant's situation. Issues to consider in determining the need/benefit of including others in these Discovery activities include:

1. The participant's preference for who assists in providing information,

2. The participant's ability to communicate his/her interests and desires independently, and

3. The amount of support the participant needs and receives from others.

M. For annual planning purposes, the support coordinator uses the third quarterly review to complete Discovery activities in preparation for the annual planning meeting.

N. For an annual plan of care, the participant and his/her authorized representative are responsible for obtaining a completed 90-L from his/her primary care physician within 90 days before the annual plan of care start date.

1. The support coordinator reminds the participant and family of this requirement and assists the participant and family to obtain the completed 90-L as needed.

2. When there is a Supervised Living provider, this provider is responsible for assisting participants to obtain a completed 90-L on an annual basis.

O. If during Discovery, but subsequent to the SIS/LA PLUS being accepted to the database, the support coordinator or cupport coordinator supervisor discovers a significant oversight or error in SIS/LA PLUS ratings pertaining to medical or behavior support needs, the support coordinator should send a written request to the SIS/LA PLUS Project Office to alter the relevant ratings.

1. The written request should include specific and compelling justification for the request to alter assessment ratings based on the additional information the support coordinator obtained during Discovery.

2. The request should reference exactly which items/ratings the support coordinator is requesting be altered.

3. The request should reference the source of the additional information suggesting the rating(s) should be altered.

4. Examples of when alterations might be requested include:

    a. Failure to note in SIS section 3A a medical support issue, and there is clear evidence that this support need exists and should have resulted in different ratings.

i. *Example 1*: During SIS assessment, it was not reported that the person has diabetes. The medical diagnosis was discovered in reviewing medical records, and it was noted that in addition to being on medication, the person is on a special diabetic diet and that support is required for such.

ii. *Example 2*: During SIS assessment, the assessor was not made aware that the person has occasional asthma attacks. It is later reported during Discovery that the person requires inhaler treatments from time to time, and staff must closely observe for asthma symptoms during the winter months, particularly when he goes outdoors into the cold or when he exercises in the cold. The parent recalls an incident last year when failure to do this led to an attack.

b. Failure to note in SIS section 3B a behavioral support issue, and there is clear evidence that this support need exists and should have resulted in different ratings.

i. *Example 1*: During SIS assessment, it was not reported that the person has mental health treatment support needs. During Discovery, the support coordinator discovers that the person has had two previous psychiatric hospitalizations and currently receives ongoing preventative environmental or therapeutic supports to minimize recurrence of psychiatric symptoms.

ii. *Example 2*: During SIS assessment, it was not reported that a person has, in the past, engaged in episodes of stealing from various stores. It is later reported by the family that, while there have been no episodes of stealing in the past year, it is because they never take their son to stores; thus, he has not had the opportunity to steal.

5. After the written request has been submitted, the SIS/LA PLUS Project Office will:

a. Request the Support Coordinator submit a revised assessment

b. Request additional justification for the alteration of ratings, or

c. Instruct the Support Coordinator that the new information does not warrant revising the assessment.

6. If the SIS/LA PLUS Project Office requests the assessment be revised, revision should be submitted to the SIS/LA PLUS Project Office within 3 working days of the request.

P. If during Discovery but subsequent to the SIS/LA PLUS being accepted to the database, it is discovered that there has been a significant underestimation of the individual's support needs that is NOT limited to more isolated medical or behavior support needs discussed in O above, and there is compelling evidence that support needs were missed, procedures noted in Sections 7.3 should be followed. For these cases, a request to revise the SIS/LA PLUS ratings with written justification for the requested changes should be submitted to the Guidelines for Planning State Office Review Committee.

3.3 DEVELOPING A PERSONAL VISION AND GOALS

A. The plan is derived from a statement of the participant's personal vision and goals.

B. Vision is defined as "How does the person see his/her life in the next 3-5 years?" Not all participants are able to state their vision, and the support coordinator infers the vision from the information gathered. The vision sets the tone for the entire process and considers the following:

   1. Where the person will be living,

   2. What the person will be doing (work as well as fun stuff or community life), and

   3. Who will be in the person's life.

C. The goals are what the person wants to do within the next year to help him/her reach his/her vision. The goals are identified with the person and/or others that know him or her best. These are identified at the same time that the vision is determined. Examples of personal goals include:

   1. Getting a specific job,

   2. Taking a vacation, and

   3. Joining a club.

   (Note: Obtaining or maintaining supports under NOW are not appropriate personal goals.)

D. The process of developing a vision and goals takes into account the complex nature and multiple needs and roles of ALL persons. ALL participants have multidimensional lives with themes that are important to them in multiple life areas.

E. For some participants, it is more difficult to determine a vision and goals because the participant may be limited in how he/she is able to communicate them. In these instances, the support coordinator relies on people who know the person best to assist in determining what the person enjoys and does not enjoy. People who know the person best may assist in determining a possible vision and goals. Some examples are noted below.

1. A participant may appear to really enjoy being around people and interacting with others. Based upon this information, the team may determine that he/she would like to meet new people and make more friends.

2. A participant may respond positively to various types of sporting activities. Based upon this information, the team might determine that the participant would like to join/access a local sports gym or group.

3. A participant continues to leave his/her job site. Based upon this information, the team might determine that he/she would like to find another job. They may then use information about things he/she likes to determine possible job interests.

3.4 ESTABLISHING THE SUPPORT TEAM

A. The support coordinator facilitates the development of the participant's support plan with the participant and his/her support team.

B. The objective of the planning process is finding and acquiring supports that have real potential to put positive outcomes in the person's life based upon his/her vision and goals.

C. The primary team member is the participant.

D. The support coordinator reviews the support team membership with the participant during the Discovery process and assists the person in identifying his/her support team and who should be in attendance at the planning meeting.

E. The support coordinator assures that the person understands the role of the support team to ensure that they choose those people needed.

F. Required team members include a direct service provider representative able to make decisions about provider services along with a direct support staff member, if possible, and the participant's legal guardian, if applicable.

    1. If the participant receives day program services, a representative from his/her vocational/day program provider is included.

G. The support coordinator assists the participant/guardian in locating a provider if the participant does not yet have one (i.e., initial planning process or change in provider is needed).

H. Team members may also include family or friends, professionals providing supports, facility treatment team representatives (if person is moving from a facility), and any other person who knows the participant best.

I. Each member of the support team has specific roles and responsibilities to assist the participant in achieving his/her vision and goals.

1. The role of the participant (and family) includes:

a. Participate in interviews, etc. during the Discovery process to provide information regarding his/her (the participant's) wants and needs,

b. Advocate for himself/herself in the planning process,

c. Attend the planning meeting(s) and participate in the plan development,

d. Be accountable for cooperation with agreed upon plan and agreed upon responsibilities within the plan,

e. Acknowledge his or her rights and responsibilities in the planning and receipt of service,

f. Verify any interdiction or guardianship with documentation if applicable,

g. Attend meetings to review the plan including providing ongoing updates to vision and goals, and

h. Comment on satisfaction with services.

2. The role of the support coordinator in the planning process includes:

    a. Assess support needs,

    b. Coordinate the planning process,

    c. Facilitate the planning meeting and plan development including a draft of the plan in the required format,

    d. Assure development of the full array of support needed to assist the participant,

    e. Monitor delivery of services,

    f. Complete monthly contacts and quarterly reviews,

    g. Revise the plan as needed, and

    h. Provide information to other team members as needed throughout the process.

3. The role of the provider participant(s) includes:

    a. Participate in interviews, etc. during the Discovery process to provide information regarding the participant's wants and needs,

    b. Attend the planning meeting(s) and participate in the plan development,

c. Assure staff are trained to adequately implement the plan,

d. Implement the plan,

e. Complete documentation as per agreement in the plan (i.e., action steps and sustained supports, critical incident reporting, major life changes),

f. (For supervisory staff) Review plan and implementation at least quarterly and complete documentation as required for the support setting (Supervisory staff review includes monitoring of plan implementation and direct support staff documentation.),

g. Serve as note takers during the meeting if requested,

h. Submit a provider service plan and emergency/evacuation plan, and

i. Complete standardized documentation and interviews of direct support staff prior to annual planning.

4. The role of other team members depends on the member, but can include:

a. Participate in interviews, etc. during the Discovery process to provide information regarding the participant's wants and needs as needed for a particular program,

b. Attend the planning meeting(s) and participate in the plan development as available or as specified in the next section of this document,

c. Communicate with participant and support coordinator as needed throughout plan implementation,

d. Deliver and document services as specified in the plan, and

e. Attend review meetings.

3.5 MEETING PREPARATION

A. All team members are invited to the planning meeting. At a minimum, the participant/guardian, support coordinator, direct service provider representative and vocational/day program provider representative (if the participant receives these services) must be present.

B. If another support team member other than a required team member is unavailable to attend the meeting and has crucial information for the planning process, the plan coordinator completes the following activities:

1. **Contacts that person prior to the meeting -** The support coordinator assures that the recommendations from that member are clear and can be conveyed during the meeting. Discussions with the direct support staff when the participant receives such supports are required.

2. **Offers participation by phone -** The support coordinator invites participation during the meeting by phone or inquires about availability by phone should questions arise during the planning meeting.

3. **Provides further follow-up after the meeting -** The support coordinator contacts the other members as needed after the meeting to assure agreement with the resulting plan or to answer any unexpected questions from the meeting.

C. The support coordinator supports the person to accomplish the following:

1. Choose in consultation with core team members the date, time and place for the planning meeting;

2. Make arrangements for a location of the person's choice (Note: This is usually the person's home. Restaurants are not usually the best place to have a meeting

due to the privacy issue and needing space on the walls for flip chart paper.); and

3. Decide how the person will present his/her vision, which could be done in a number of ways including, but not limited to the following:

   a. Slide show,

   b. Video,

   c. Posters,

   d. Photo albums,

   e. Verbal presentations,

   f. Written information, and

   g. Graphics.

D. The support coordinator completes the following prior to the planning meeting:

1. Assists the participant in contacting in writing and/or by phone his/her family members and provider staff to schedule the planning meeting (The support coordinator provides written notice to plan participants 30 days prior to the meeting. The support coordinator makes phone contact reminding members of the meeting **two weeks prior** to the meeting and documents contacts in a progress note); and

2. Develops the agenda to address the person's support needs, natural and formal, which ensures that the meeting results in a single comprehensive support plan.

E. The support coordinator shares information with support team members **one week prior to the meeting by email or fax** by circulating to the support team a rough draft of the support plan document that includes key information from Discovery, the Personal Outcomes Assessment, and results of the SIS/ LA PLUS. The SIS in its entirety is not sent to team members. It is important that support team members have all of the information that has been gathered, along with the vision and outcomes which have been identified by the person, available to them in the plan format for review before the meeting. This allows time for the team to prepare for the meeting, including bringing any concerns and proposed strategies to address these concerns to the planning meeting for optimal team discussion.

1. The support plan rough draft does not need to be written to the quality and volume of content required in the final planning document; it is a *draft*. However, the support coordinator must include information in all plan sections that can be filled in with Discovery information.

   a. This includes information pertaining to criteria for shared supports.

   b. Support coordinators are not to complete the Personal Outcomes Table (Section 5 of the CPOC) other than the person's Vision.

2. In order to include shared supports information for roommates, the support coordinator and IFS provider must have held the roommate risk/benefit discussion prior to sending out the draft document (see Section 6.4).

3. **The support coordinator is responsible for assuring that the person understands that this information will be shared.**

Attachment 3.6.1 Personal Outcomes Worksheets - Support Plan Format

PERSONAL OUTCOMES WORKSHEETS
(Required as part of CPOC)

NAME: _____

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Attachment 3.6.1 Personal Outcomes Worksheets - Support Plan Format

"MY PERSONAL OUTCOMES" WORKSHEET **Confidential**

	CURRENT LIFE SITUATION	CURRENT SUPPORT SITUATION – NATURAL AND PAID (WHAT'S GOING ON THAT SUPPORTS MY DESIRED OUTCOME?)	CURRENT LEVEL OF SATISFACTION (1 TO 5 SCALE)
Identity – "Who Am I?"			
1. What Goals have I set for myself? 2. Where and with whom do I want to live? 3. What do I want to do for my work? 4. Who is closest to me? 5. How satisfied am I with the services and supports I receive? 6. How satisfied am I with my personal life situation?			
Autonomy – "My Space"			
7. What are my preferred daily routines? 8. Do I have the time, space, and opportunity for the privacy I need? 9. Am I in control of who knows personal information about me? 10. Do my home, work, and other environments support what I want and need to be?			
Affiliation – "My Community"			
11. Do I have access to the place I want to be? 12. Do I participate in what happens in my community? 13. Am I pleased with the type and extent of my interaction with other people in my community? 14. Am I known for the different social roles I play? 15. Do I have enough friends? 16. Am I respected by others?			
Attainment – "My Success"			
17. Are the supports and services I receive the ones I want? 18. Have I realized any of my personal goals?			
Safe Guards – "My Safe Guards"			
19. Am I connected to the people who support me the most? 20. Am I safe?			
Rights – "My Rights"			
21. Do I exercise the rights that are important to me? 22. Do I feel that I am treated fairly?			
Health and Wellness – "My Health"			
23. Is my health as good as I can make it? 24. Am I free from Abuse and Neglect? 25. Do I have a sense of continuity and security?			

CURRENT LEVEL OF SATISFACTION:

1 – NOT AT ALL SATISFIED: AREA DISCUSSED BUT NO PLANS TO ADDRESS – NOT AT ALL SATISFIED/NO PROGRESS
2 – NOT VERY SATISFIED: AREA DISCUSSED BUT NO ADEQUATELY ADDRESSED/PLANNED FOR – LITTLE OR NO SATISFACION/PROGRESS
3 – SOMEWHAT SATISFIED: AREA DISCUSSED AND ADDRESSED/PLANNED FOR – SOME SATISFACTION/PORGRESS
4 –SATISFIED: AREA DISCUSSED/PLANNED FOR – MOSTLY SATISFIED WITH NOTICEABLE PROGRESS
5 –VERY SATISFIED : AREA DISCUSSED AND ADEQUATELY PLANNED FOR (I.E., TO MAINTAIN CURRENT STATUS, CONTINUE WITH CURRENT OR ADJUSTED PLAN, ETC.) – VERY SATISFIED AT THIS TIME

NAME: _____

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Attachment 3.6.1 Personal Outcomes Worksheets - Support Plan Format

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

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Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want?
(Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

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4

DEVELOPING THE PARTICIPANT'S SUPPORT PLAN

4.1 Facilitating the Planning Meeting

4.2 Developing Plan Strategies and Actions

4.3 Using Natural and Community Supports

4.4 Attachments

4.4.1 Timelines for Initial Support Planning

4.4.2 Support Plan Format

DEVELOPING THE PARTICIPANT'S SUPPORT PLAN

After completion of the SIS/LA PLUS, review of any other relevant information/assessments, completion of Discovery, and definition of the vision and goals, the support coordinator schedules a planning meeting with the participant and his/her support team.

The planning meeting begins with a review of personal outcomes and goals and important information gathered from assessments.

Once there is consensus and familiarity with the participant's desired outcomes, the support coordinator facilitates discussion to develop actions and strategies to address identified goals and support needs.

Attachment 4.4.1 contains details of timelines for initial support planning, including timeframes related to developing the participant's support plan.

4.1 FACILITATING THE PLANNING MEETING

A. The support coordinator begins the planning meeting by assisting the participant in presenting his/her vision and goals. As noted in the previous section, the vision may be presented in any manner the participant desires. The support team then has an opportunity to ask questions and request clarification regarding the person's vision and goals prior to beginning planning to meet the person's vision and goals.

B. The support coordinator is responsible for facilitating discussion that encourages active participation of all support team members throughout the planning meeting.

   1. Some team members may be quiet and may need to be "invited" throughout the meeting to comment or contribute important information.

   2. Other team members may get "ahead" of the process or get stuck on a topic. When this occurs the support coordinator is responsible for bringing the team back into focus about the current topic of discussion and assist in moving forward with planning.

C. Facilitating discussion may also involve other activities that assist the team in completing the plan, including:

   1. Redirecting discussion based upon new information,

   2. Restating or summarizing information to assist the team in moving forward,

   3. Providing input from professionals who are unable to attend the meeting,

   4. Highlighting conflicting information and assisting the team in determining a course of action to address the conflict, and

5. Assisting the participant in advocacy efforts regarding his/her interests and needs.

D. The support coordinator assures that the meeting ends with a full plan which includes actions and strategies related to each outcome or support need, designation of responsibility, frequency, target date for completion/review, and method for measuring progress.

4.2 DEVELOPING PLAN STRATEGIES AND ACTIONS

A. For each personal outcome/goal, the support team:

1. Identifies strengths that can be used to achieve personal goals:

   a. Strengths, skills and abilities of the participant (i.e., specific job skills that assist the participant in meeting his/her goals),

   b. Social and community connections of the participant and other support team members (i.e., a support team member knows the owner of a local scrapbooking store and a participant wishes to take up this hobby), and

   c. Environmental positives (i.e., lives on a bus route which helps with transportation issues);

2. Identifies challenges or barriers:

   a. Health issues requiring treatment (i.e., diabetes, seizures),

   b. Mental health and behavioral issues requiring intervention/support (i.e., depression, aggression),

   c. Risk factors (i.e., person receives medication placing him or her at risk for a medical condition; person lives in a neighborhood with safety concerns),

   d. Environmental barriers (i.e., person has no reliable means of transportation and lives in a rural area), and

e. Other participant specific challenges;

3. Develops strategies to achieve goals and overcome barriers;

4. Identifies known needed treatments/medications (i.e., medication for seizures);

5. Identifies assistance/support from others needed (i.e., staff need to assist the person in lying down and moving furniture/etc. out of the way during a seizure);

6. Identifies skills the participant could learn to assist him or her (i.e., the participant may be able to learn improved eating habits to address diabetes); and

7. Identifies opportunities for increased independence to achieve personal goals, including the following examples:

   a. Increasing independence in key daily living areas for a goal of living independently or increased privacy; and

   b. Learning to bank online for someone who wants to budget and acquire some preferred living situation or item.

B. Personal goals, goals related to removal of identified barriers, and goals related to increasing independence (where appropriate) are entered in planning profile.

C. The planning profile *(Attachment 4.4.2)* then allows for recording the support strategies to achieve each goal including:

1. Specific actions listed in sequence,

2. Who is responsible to assist/support/complete each action,

3. Where the action will take place,

4. What equipment/assistive devices are needed for the action to occur,

5. Frequency of support,

6. How each support will be measured/assessed for completion, and

7. Date for completion or review of each action/support.

D. The planning meeting is not concluded until all items are completed for all identified goals.

4.3 USING NATURAL AND COMMUNITY SUPPORTS

A. The use of natural and community supports is a key component of the "Guidelines for Support Planning." Natural and community supports are represented in the support plan.

B. Natural and community supports allow the participant to accomplish the following:

   1. Build relationships,

   2. Play different social roles,

   3. Stabilize his/her care since there is less turnover in natural and community supports, and

   4. Reduce isolation and enhance integration.

C. The support coordinator, prior to utilization of paid supports, explores supports and activities available through the following:

   1. Family and friends,

   2. Neighbors, church members, support organizations, and volunteers,

   3. Informal and public transportation, and

4. Community classes and organizations.

D. The support coordinator will utilize strategies to appropriately involve a participant's roommate who is not receiving services and is a competent major (not a dependant child) as a natural support.

1. If a participant chooses to live with a person not using OCDD services who meets the definition of a relative as defined in Section 8.5, then the participant meets criteria for the Lives with Family allocation.

2. If a participant chooses to live with a person not using OCDD services who is unrelated, then the participant meets criteria for the Lives Independently allocation.

3. With the participant's permission, the roommate might become part of the support team and be included in the provision of appropriate unpaid natural supports hours and in evacuation and emergency plans. The support team should plan for any necessary training, as described in Section 8.2.

E. The "Guidelines for Support Planning" assumes that natural supports are utilized in conjunction with paid supports.

ATTACHMENT 4.4.1 TIMELINES FOR INITIAL SUPPORT PLANNING

A. Following linkage, the support coordinator has 3 business days to contact the participant or his/her authorized representative by phone to introduce himself/herself, explain support coordination services and the planning process, and to schedule the SIS/LA PLUS assessment and face-to-face meeting with the participant and his/her family.

B. Within 10 calendar days following linkage, the support coordinator meets face-to-face with the participant and his/her authorized representative to begin discovery activities, complete the SIS/LA PLUS and other assessments, and discuss the plan for selecting providers through the Freedom of Choice (FOC) process. Within one business day of the participant's selection of an Individual and Family Support (IFS) and day program provider, the support coordinator contacts the provider(s) by phone to inform the agency of the initial planning meeting.

C. Within 30 calendar days following linkage, the support coordinator submits the approvable SIS/LA PLUS to the OCDD SIS Project Office.

D. Within 10 calendar days following the receipt of the SIS/LA PLUS approval, the support coordinator holds the planning meeting with the participant and his/her support team, including the participant's family, friends, IFS provider, and day program provider.

E. Within 7 calendar days following the planning meeting, the support coordinator must develop the support plan, and the provider concurrently must develop the participant's individualized service plan, back-up plan, and emergency evacuation plan based on the consensus reached at the planning meeting.

F. The support plan is then sent to the participant and the provider for review and agreement. If the person is moving from a facility (e.g., ICF/DD, nursing home, hospital), the persons representing the facility treatment team on the support team must also review and provide agreement with the support plan.

G. The provider has 5 calendar days to review the support plan and return the signed support plan, participant's service plan, back-up plan, and emergency evacuation plan to the support coordinator.

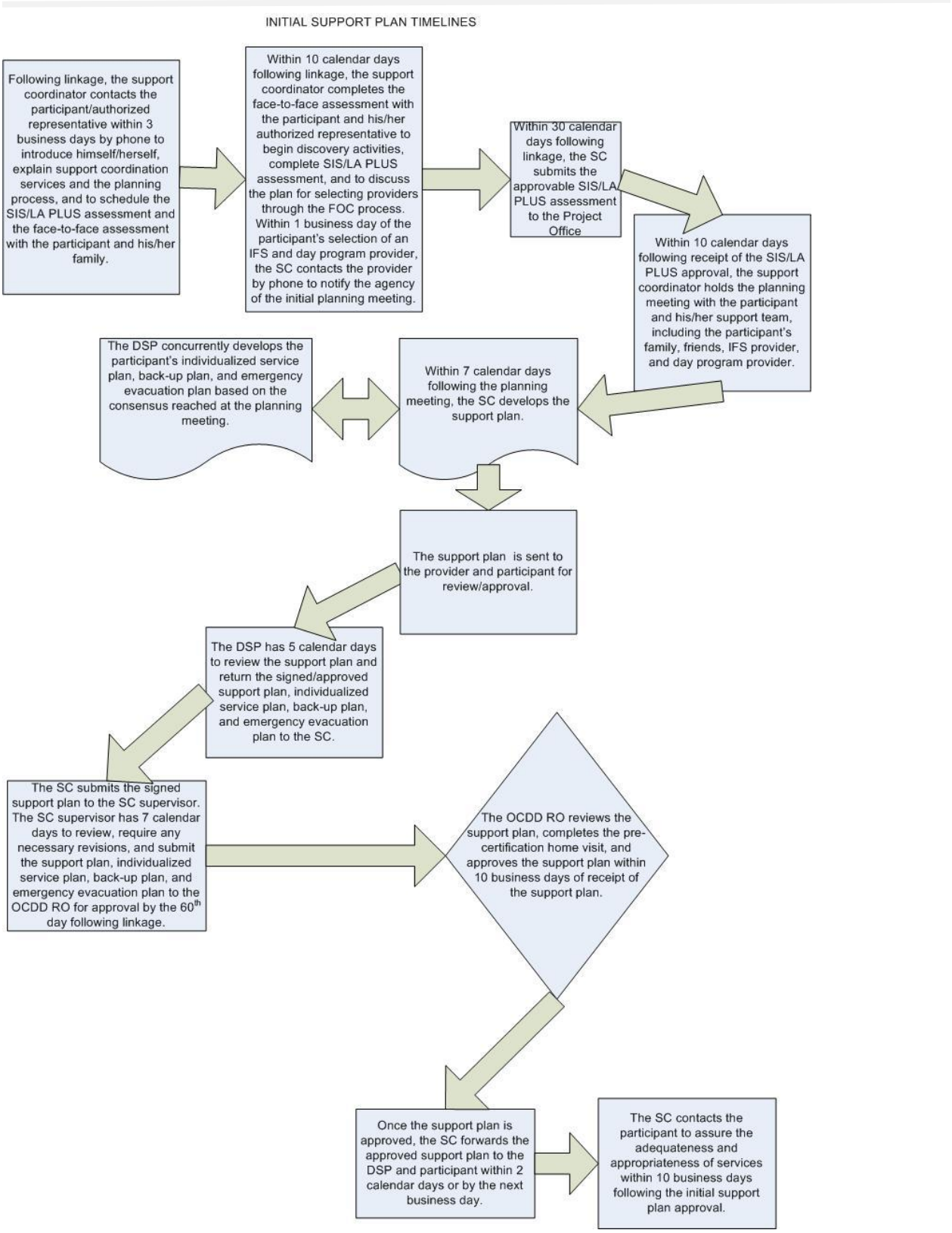
H. The support coordinator then submits the signed support plan to the support coordinator supervisor. The support coordinator supervisor has 7 calendar days to review, require any necessary revisions, and submit the approvable support plan, provider's service plan, emergency evacuation plan, and back-up plan to the OCDD Regional Waiver Office for approval. Submission to the OCDD Regional Waiver Office for approval should occur within 60 days following linkage.

I. The OCDD Regional Waiver Office is responsible for reviewing the support plan, completing the pre-certification home visit, and approving the support plan within 10 business days following receipt of the approvable plan.

J. Once the support plan is approved, the support coordinator forwards the approved support plan to the provider and the participant within 2 calendar days or by the next business day.

K. The support coordinator then contacts the participant to assure the adequateness and appropriateness of service within 10 business days following the approval of the initial support plan.

Attachment 4.4.1 Timelines for Initial Support Planning



Attachment 4.4.2 Support Plan Format

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OCDD WAIVER SUPPORTS AND SERVICES
NEW OPPORTUNITIES WAIVER (NOW) - COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

TYPE: ☐ INITIAL ☐ ANNUAL
WAIVER: ■ NOW
LEVEL OF CARE: ■ ICFMR
☐ LEVEL ____
☐ SHARED SUPPORT

INDIVIDUAL'S NAME (LAST NAME, FIRST NAME)		LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER	DOB / /	RELATIONSHIP	
MEDICAID #	MEDICARE #	LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER _____	
ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)	ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)
CITY/STATE/ZIP CODE	PARISH	CITY/STATE/ZIP CODE	PARISH
DAY PHONE	NIGHT PHONE	DAY PHONE	NIGHT PHONE
CASE MANAGEMENT AGENCY (NO ABBREVIATIONS)		PROVIDER NUMBER	
CASE MANAGEMENT AGENCY ADDRESS		SUPPORT COORDINATOR (TYPE/PRINT)	SC SUPERVISOR (TYPE/PRINT)
CITY/STATE/ZIP CODE		TELEPHONE NUMBER	

SEX: ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ AFRICAN-AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ ASIAN ☐ OTHER
EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ N/A **90L:** PHYSICIAN DATE: _____ CM REC'D: _____
PRIMARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /
SECONDARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /
MR: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER:

ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND
AMBULATION: ☐ INDEPENDENT ☐ WITH PERSONAL ASSISTANCE ☐ WITH ASSISTIVE DEVICE(S) ☐ DOES NOT AMBULATE
SIL: ☐ YES ☐ NO **24-HOUR SERVICE:** ☐ YES ☐ NO
PRIMARY MODE OF LOCOMOTION: ☐ AMBULATION ☐ WHEELCHAIR WITHOUT ASSISTANCE ☐ WHEELCHAIR WITH ASSISTANCE ☐ OTHER
EMERGENCY SELF-EVACUATE: ☐ YES ☐ NO **Attach Individualized Emergency Evacuation/Response Plan**
EMERGENCY RESPONSE: ☐ **LEVEL 1** TOTAL ASSISTANCE WITH LIFE SUSTAINING EQUIPMENT ☐ **LEVEL 2** TOTAL ASSISTANCE
☐ **LEVEL 3** CAN RESPOND/NEEDS TRANSPORTATION ☐ **LEVEL 4** CAN RESPOND INDEPENDENTLY

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO IF YES, WHEN & PROPOSED ADDRESS?
IS THIS A TRANSITION FROM A DEVELOPMENTAL CENTER OR NURSING FACILITY? ☐ YES ☐ NO DEPOSIT REQUIRED? ☐ YES ☐ NO
ARE THERE MULTIPLE WAIVER RECIPIENTS IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____
ARE THERE MULTIPLE INDIVIDUALS WITH DISABILITIES (NON-RECIPIENT) IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____
ARE PAID CARE GIVERS RELATED TO INDIVIDUAL? ☐ YES ☐ NO IF YES, RELATIONSHIP & SERVICE PROVIDED
DO PAID CARE GIVERS LIVE WITH RECIPIENT? ☐ YES ☐ NO IF YES, NAME & SERVICE(S) _____
DOES INDIVIDUAL RECEIVE HOME HEALTH SERVICE ? ☐ NO ☐ YES IF YES, ATTACH A HOME HEALTH PLAN.

Present Housing
☐ Own Home (Alone)
☐ Own Home (With Partner)
☐ Own Home (With Others)
☐ Other's Home
ANTICIPATED HOUSING:
☐ ICF/MR
☐ NURSING FACILITY
RENT HOME: ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY
RENT APARTMENT: ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY

FOR WSS USE ONLY: HIGH RISK RECIPIENT? ☐ YES ☐ NO (IF YES, WSS WILL ADD TO HIGH RISK TRACKING)

CPOC BEGIN DATE:		**CPOC END DATE:**	

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Attachment 4.4.2 Support Plan Format

Section I: Emergency Information **Confidential**

Attach Individualized Emergency Evacuation/Response Plan

INDIVIDUAL'S NAME: _____ **AGE:** _____

ADDRESS: _____

DIRECTIONS TO MY HOME: _____

PERSON RESPONSIBLE FOR EVACUATING/BRINGING SUPPLIES TO INDIVIDUAL'S HOME:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

FAMILY MEMBERS/OTHER TO CONTACT IN CASE OF EMERGENCY (INCLUDING PROVIDERS):

1. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

2. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

3. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

EMERGENCY EQUIPMENT IN HOME:

☐ FIRE EXTINGUISHER: LOCATION _____

☐ HOME EVACUATION PLAN: LOCATION: _____

☐ SMOKE DETECTOR(S): LOCATION: _____

☐ FIRST AID SUPPLIES: LOCATION _____

☐ SPECIALIZED MEDICAL EQUIPMENT: (E.G., VENTILATOR, SUCTION MACHINE, ETC.)

LOCATION: _____

☐ OTHER _____

SPECIAL CONSIDERATIONS/NECESSITIES (DETAILED INFORMATION REQUIRED): UTILIZES ASSISTIVE TECHNOLOGY, DEPENDENT ON VENTILATOR, MEDICATIONS, ETC. (SEE INDIVIDUAL EMERGENCY EVACUATION/RESPONSE PLAN)

DOCTOR'S NAME: _____ PRIMARY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME _____ SPECIALTY _____ PHONE: _____

NAME: _____

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Attachment 4.4.2 Support Plan Format

SECTION II: Health Profile **Confidential**

A. Health Status

1. PHYSICAL (e.g., GENERAL HEALTH, MOBILITY, ASSISTIVE DEVICES):

2. ALLERGIES (e.g., MEDICATION, FOOD, ENVIRONMENTAL):

DESCRIBE WHAT HAPPENS WHEN THERE IS AN ALLERGIC REACTION

3. MEDICAL DIAGNOSES/SIGNIFICANT MEDICAL HISTORY/CONCERNS:

4. DOCTOR VISITS (PAST YEAR AND SCHEDULED VISITS):

5. PSYCHIATRIC/BEHAVIOR CONCERNS:

6. BEHAVIOR SUPPORT PLAN ATTACHED (IF NEEDED): ☐ YES ☐ NO

7. INCIDENT REPORTS (FOR PAST 6 MONTHS):

A. CRITICAL INCIDENTS	
1. UNPLANNED HOSPITAL	#
2. ER VISITS	#
3. PSYCHIATRIC ADMITS	#
4. ABUSE/NEGLECT	#
5. OTHER	#
B. NON-CRITICAL INCIDENTS	#
C. HOSPITAL ADMISSIONS	#
D. EMERGENCY DOCTOR VISITS	#
E. PSYCHIATRIC HOSPITAL ADMISSIONS	#

ADDITIONAL INFORMATION/SUMMARY:

NAME: _____

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B. LIST OF MEDICATIONS: (INCLUDING OVER THE COUNTER MEDICATIONS) **Confidential**

MEDICATIONS	WHAT IS IT FOR?	DOSAGE/FREQUENCY	HOW IS IT TAKEN?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	
6.				☐	
7.				☐	
8.				☐	
9.				☐	
10.				☐	

C. LIST OF TREATMENTS (e.g. CATHERIZATIONS, TUBE FEEDING, DRESSING CHANGES, SUCTIONING, OXYGEN, SPLINTS, BRACES, ETC.)

TREATMENTS	WHAT IS IT FOR?	FREQUENCY	HOW IS IT PERFORMED?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	

NAME: _____

Attachment 4.4.2 Support Plan Format

Section III. All About Me **Confidential**

Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best.

A. HISTORICAL INFORMATION: INFORMATION in this section includes historical issues, for example, nature and cause of person's disability, person's age at onset of disability (if not known, please indicate by writing "unknown" in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.
B. CURRENT LIVING SITUATION: INFORMATION in this section includes family's involvement and understanding of individual's strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual's/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.
C. CURRENT COMMUNITY SUPPORTS OR OTHER AGENCY INVOLVEMENT: Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.

NAME: _____

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SECTION IV: Things You Need to Know to Support Me

Confidential

A. My gifts and talents:

B. I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):

List of non-verbal ways I communicate in this communication log

When I do this	It means this

C. I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):

D. I need help with:

E. When I am scared I need someone to:

F. When I am angry I need you to:

G. Things that work/things I like (favorite things such as…food hobbies, past time):

H. Things that don't work/things I dislike:

I. Other things I'd like you to know about me:

NAME: _____

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SECTION V: PERSONAL OUTCOMES Confidential

Vision:

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Review Date Accomplished**
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

NAME: _____

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SECTION V: PERSONAL OUTCOMES (CONTINUED) **Confidential**

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Review Date Accomplished**
4.	**4.**	**4.**	**4.**

NAME: _____

SECTION VI: IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

CONFIDENTIAL

IDENTIFIED SERVICES AND SUPPORTS THAT WILL HELP ME MAINTAIN AND/OR ACHIEVE MY PERSONAL OUTCOMES.

NOW	NOW	MEDICAID FUNDED SERVICES	NON-WAIVER SUPPORT
☐ Individual/Family Support (IFS)	☐ **Supported Employment**	☐ Dental	☐ OCDD
☐ Day (D)	☐ Transportation – REG	☐ Eye Glasses	
☐ Night (N)	☐ TRANSPORTATION – W/C	☐ Home Health Extended	
☐ SHARED SUPPORTS	☐ EMPLOYMENT-RELATED TRAINING	☐ Hospice	☐ LRS
☐ IFS – D	☐ DAY HABILITATION	☐ Medical Transportation	
☐ IFS – N	☐ DAY HAB/EMPLOYMENT-RELATED TRAINING SERVICES TRANSPORTATION	☐ Mental Health	
☐ SKILLED NURSING	☐ TRANSPORTATION – REG	☐ Podiatry Services	
☐ CID	☐ TRANSPORTATION – W/C	☐ Substance Abuse	
☐ SUBSTITUTE FAMILY CARE		☐ Prescriptions/Medication	☐ DSS
☐ CENTER-BASED RESPITE		☐ Others	
☐ PROFESSIONAL CONSULTATION			

NOW – CONVERSION(S)

	Converted Service & Hours	Added Service & Hours
☐ PROFESSIONAL SERVICES		
☐ TRANSITION PROFESSIONAL SUPPORT		
☐ SKILLED NURSING SERVICES		
☐ ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS		
☐ Specialized Medical Equipment and Supplies		
☐ Personal Emergency Response **SYSTEM (PERS)**		
☐ Community Integration Development **(CID)**		
☐ Supported Independent Living (SIL)		
☐ One-Time Transitional Expenses		

NOTE: Informed individual of all state plan services. Support coordinator Initials: _____

NAME: _____

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Attachment 4.4.2 Support Plan Format

Section VII: Typical Weekly Schedule

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
NS = NATURAL SUPPORTS	
S = SELF	
SC = SCHOOL	
W = WORK	
PW = PAID WAIVER (IDENTIFY SERVICE)	
P = PAID SUPPORT (LRS, ETC.)	
Total # of Weekly Hours	

COMMENTS:

NAME: _____

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Attachment 4.4.2 Support Plan Format

Section VIII – Typical Alternate Schedule\Conversion

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE.

JANUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

MARCH 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

APRIL 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

MAY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

JULY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

AUGUST 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

SEPTEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

OCTOBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

NAME: _____

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SECTION IX (A): POC Requested Waiver Services (Budget Sheet) – Typical Weekly & Alternate Schedule **Confidential**

List The Individual's Requested Services As Described In The POC. _____

TYPICAL WEEKLY SCHEDULE – DAILY SERVICE TOTALS

PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	TOTAL WEEKLY # OF UNITS OF SERVICE

TYPICAL ALTERNATE SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

			MTH/ DAY/ YR _____ MTH/DAY/YR- ---------- 1ST PARTIAL QUARTER		MTH/YR---------- MTH/YR. ---------- 1ST FULL QUARTER		MTH/YR._____ MTH/ YR._____ 2ND QUARTER		MTH/YR._____ MTH/ YR._____ 3RD QUARTER		MTH/ /YR_____ MTH/DAY/ / YR._____ 4TH PARTIAL QUARTER		TOTAL ALT. COST FOR ALL QUARTERS
PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL UNITS (+ OR -)	DATE/ PURPOSE	
											TOTAL TYPICAL ALTERNATE SCHEDULE COST		

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT TO PROVIDE SERVICES OUTLINED ABOVE:

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Support Coordinator Signature: _____ Agency: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE _____ Date_____

OCDD Approval Signature: _____ Date: _____

NAME: _____

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SECTION IX (B): POC Requested Waiver Services (Budget Sheet)

1. Provider Name (Full Name)	2. Provider #	3. Service Type	4. Procedure Code(s)	5. Typical Weekly # Of Units	X	6. Cost/ Rate Per Unit	=	7. TOTAL TYPICAL Weekly Costs	X	8. # of Weeks in POC Year (52 weeks in a Yr.)	=	9. Total Typical Annual Costs
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	

10. Total Typical Schedule Annual Cost	
11. Total Typical Alternate Schedule Annual Cost	
12. Total Combined Typical & Alt. Schedule Annual Cost	

*Provider agrees to return signed budget sheet to support coordinator within 2 working days following Plan of Care meeting after reviewing and verifying service and calculation accuracy. The provider agrees to provide the services as outlined in the Guidelines for Planning. SC will not change or alter document after the provider signs the budget sheet.

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Support Coordinator Signature: _____ Agency: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: PARTICIPANT/GUARDIAN SIGNATURE _____ Date _____

FOR OCDD USE ONLY:

APPROVED: _____ DENIED: _____ APPROVED POC BEGIN DATE: _____ APPROVED POC END DATE: _____

OCDD AUTHORIZED REPRESENTATIVE: INITIALS DATE:

NAME: _____

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Attachment 4.4.2 Support Plan Format

Section X: POC Participants **Confidential**

Participants must sign that they attended in the planning meeting.	
PLANNING PARTICIPANTS	**Relationship**

SUPPORT COORDINATOR **Date**

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify the support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify the support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I have been informed of my rights and responsibilities regarding the HCB Waiver Services and have been given the OCDD Rights and Responsibilities Form_____ **(Recipient's/Authorized Representative's Initials)**

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with OCDD and/or a fair hearing by the DHH Appeals Bureau within 30 days of the approved/denied decision. Contact your OCDD Regional Office for an informal discussion. I understand that a DHH Appeals Bureau Fair Hearing may be requested by contacting the DHH Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA 70821-4183.

I have been informed of all state plan services _____ **(Recipient's/Authorized Representative's Initials)**

RECIPIENT'S SIGNATURE/GUARDIAN SIGNATURE DATE

WITNESS DATE

Reviewed by Support coordinator Supervisor Signature/title:_____ date:_____

FOR OCDD USE ONLY:

RECIPIENT'S NAME: PROGRAM TYPE: NEW OPPORTUNITIES WAIVER

DATE COMPLETE POC RECEIVED IN OCDD RO: OCDD PRE-CERT HOME VISIT DATE:

THIS POC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: ☐ APPROVED ☐ DENIED

WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE RECIPIENT WOULD QUALIFY FOR INSTITUTIONAL CARE: ☐ YES ☐ NO

APPROVED POC BEGIN DATE: **Approved POC End Date**

SERVICES APPROVED:

SIGNATURE/TITLE OF OCDD REPRESENTATIVE: DATE:

NAME: _____

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5

PLANNING FOR THE USE OF RECOMMENDED IFS HOURS

5.1 Working within the Recommended Hours

5.2 Using the Conversion Table to Establish a Typical Weekly Schedule

5.3 Planning for Known and Predictable Deviations from the Typical Schedule

5.4 Planning for Unpredictable Deviations from the Typical Schedule: Flexible Hours

5.5 Using the IFS Flex Conversion Table with Flexible Hours Management

5.6 Planning Examples

5.7 When Additional IFS Hours are Needed

5.8 Justifying the Need for Additional IFS Hours

5.9 Temporary Requests and Phase-in to the Recommended Number of IFS Hours

5.10 Attachments

5.10.1 Recommended IFS and Day Program Hours by Level- Lives with Family

5.10.2 Recommended IFS and Day Program Hours by Level- Lives Independently

5.10.3 Conversion Table

5.10.4 Weekly Schedule and Budget Pages with Instructions

5.10.5 IFS Flex Conversion Table

PLANNING FOR THE USE OF RECOMMENDED IFS HOURS

As a component of the support plan, the support coordinator and support team build a typical weekly schedule, alternate schedules, and develop a budget that reflects these schedules. This Section describes the operational procedures and provides guidance in the development of the typical weekly schedule and budget components of the support plan.

Developing a typical weekly schedule, planning for known deviations from the typical schedule and using flexible hours for the unpredictable are addressed. This Section also provides sample planning scenarios to assist the support coordinator and clarify OCDD policy.

Some participants, such as a person living independently whose level of need and IFS recommendation assumes shared supports, may require that the plan phase-in to the guideline (e.g., over 12 months). (See Section 5.9.) Phase-in plans require approval by the Guidelines for Planning State Office Review Committee (GPSORC) as described in Section 7.3.

Not all of the recommended IFS hours are used by some participants and others may require more hours. In general, if the support team concludes that the participant's support needs are no more than ten percent above the guideline hours, the support coordinator must make every attempt to restructure the plan with the team within the recommended hours.

5.1 WORKING WITHIN THE RECOMMENDED HOURS

A. The typical weekly schedule and budget process under the Louisiana Resource Allocation System are completed using the steps listed below working from least to most amount of support needed:

1. Begin by noting times of significant meaningful day activities whether they are supported or not,

2. Fill in times when the person can be alone,

3. Fill in times when natural supports are available,

4. Fill in times where other community supports are available and additional IFS supports would not be needed,

5. Fill in work/school hours not requiring IFS support,

6. Fill in hours for other state services if appropriate,

   a. For participants receiving Long Term – Personal Care Services (LT-PCS), the IFS hours available through the NOW should be assumed to replace the LT-PCS hours. Level of care requirements for the NOW are focused on need for skills training focused on independence as opposed to the basic care model for LT-PCS. Thus, participants in the NOW are most appropriately served using the IFS hours.

   b. In limited situations, a participant may be better served with LT-PCS or some combination. For example, participants of retirement age may not have an expectation of increased independence. In these circumstances, the LT-PCS hours (or some of them) may remain appropriate. The total

hours must still be within the maximum IFS hours available for the resource allocation level or justification for additional hours must be submitted as noted later in this section.

7. Consider using the recommended IFS for some or all the remaining hours of direct support need. [See *Attachment 5.10.1* (for persons living with family) and *Attachment 5.10.2* (for persons living independently) for recommended hours.],

   a. If two participants are married, living together, and are both using OCDD services (no matter the type), then both participants are considered as Living Independently.

   b. If a participant is married and living with or otherwise lives with as a roommate a person (1) who does not use OCDD services and (2) who is a competent major (not a dependant child), the support team must determine the appropriate membership and course of action based upon Section 4.3.D.1-3.

8. Use conversions according to the conversion table for additional needed hours (See Section 5.2.),

9. Determine if additional hours are needed beyond the recommended hours, and

10. Consider shared supports (See Section 6 for details on Using Shared Supports.).

    a. Total shared and non-shared hours cannot exceed the maximum IFS hours for each person for the assigned acuity level. (See Sections 5.7-5.9 for addressing need for additional hours.)

b. If recommended hours are inadequate after the steps above have been taken, request additional hours in accordance with Sections 5.7-5.9 and 7.3 and determine if the plan can be safely implemented while the request for additional hours is underway. If not, request an expedited review.

B. Support teams may propose in the support plan programmatically appropriate phasing-in of unsupported hours. This entails a gradual reduction in 1:1 supports or shared supports. The reduction of paid support must be conducted with the participation of the entire team and must be done in accordance with plan strategies to meet personal goals, requirements for indentified support needs, and appropriate risk mitigation.

1. If a participant requests unsupported time, the support team must assess the request on a case-by-case basis to insure that all factors pertaining to a person's individualized situation are considered and fully addressed.

2. Any request for unsupported time occurring after plan approval should be discussed with the support coordinator during the monthly phone call (Section 9.1) and addressed by the support coordinator at the next quarterly review (Section 9.2). Plan revision, if needed, is submitted per timelines. It is not appropriate to defer the issue to the next annual planning meeting.

C. The unit calculations for the budget are completed as they are currently done for the support plan. (See *Attachment 5.10.4* for the weekly schedule and budget pages with instructions.)

5.2 USING THE CONVERSION TABLE TO ESTABLISH A TYPICAL WEEKLY SCHEDULE

A. The Resource Allocation System proposes specific types of IFS hours (day 1:1, day shared, night 1:1, night shared) and a day habilitation allotment for each level. These hours are not intended to create a "cookie cutter" schedule. According to Section 5.1, each person's typical weekly schedule is individualized through the person-centered planning process.

B. In order to create an individualized typical weekly schedule, conversion of types of hours within a level may be required.

   1. The Conversion Table (*Attachment 5.10.3)* is a tool for use in converting allocated IFS hours. It may also be used to convert day habilitation hours to IFS hours.

   2. When establishing a typical weekly schedule, any hours may be converted as deemed appropriate by the support team.

   3. The resulting schedule (post conversion) must be within the recommended IFS hours and Day program hours assigned by the Resource Allocation System level, or approval from the GPSORC is required. (GPSORC is discussed in Section 7.3.)

C. The conversion table is organized into six sections representing the type of hours in the Resource Allocation System that can be converted one to another.

   1. IFS Day – 1 Person

   2. IFS Day – 2 Persons

   3. IFS Night – 1 Person

4. IFS Night – 2 Persons

5. ERT/Day Hab to IFS hours

6. SE Mobile Crew to IFS hours

D. With regard to Day program hours (also SE Mobile Crew), the following guidelines apply:

1. The NOW service limits allow for more hours in Day program than those in the chart specify for each level. Therefore, a person may access more Day program hours if he/she chooses to work more. Participants must stay within the NOW service limits. This means that there is no need to convert IFS hours to get additional Day program hours.

2. Only the Day program hours in the chart may be used for conversion purposes. The participant may not convert the Day program hours in the chart and then access more Day program hours.

5.3 PLANNING FOR KNOWN AND PREDICTABLE DEVIATIONS FROM THE TYPICAL SCHEDULE

A. Alternate schedules are used for planned events that cause a deviation from the participant's prior authorized typical weekly schedule. Alternate schedules specify a day or consecutive days when a participant will need additional hours of supports based on possible projected needs that occur on a non-routine basis.

B. Anticipated deviations included in alternate schedules are short-term, or temporary, requests for additional hours.

1. Long-term deviations (generally exceeding a quarter) require a longer-term alternate schedule or a complete plan and schedule revision. When looking at deviations, teams must consider if support needs have changed and revise the plan accordingly. Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1*.

2. Before requesting additional hours, support teams are required to consider utilizing natural supports, other unpaid supports, intermittent supports, or sharing supports with other persons to maintain the allotment of hours.

3. Any change in hours use from the typical weekly schedule must be consistent with risks and benefits discussed by the support team and documented in the support plan. For example, it is not appropriate for a participant to substitute paid hours with intermittent supports or unpaid hours (alone time) if the support team has documented the need for supervision during specific times/activities.

4. Any deviation in the participant's schedule must be "consumer driven" or requested by the recipient or family.

5. Examples of use of alternate schedules:

a. <u>An example of appropriate use of an alternate schedule exceeding one quarter with support plan revisions due to change in support needs:</u>

William had a scheduled surgical procedure in mid-February that would result in a significant change in his Activities of Daily Living (ADL) supports. Instead of being fully independent in toileting, bathing, and moving around, he would have a full leg cast for up to six weeks and would require hands-on supports in daily activities. The team submitted an alternate schedule request for the quarter that included the six weeks of one-to-one staffing for William's recovery period. With the alternate schedule request, the team also submitted a support plan revision to reflect the change in William's support needs for the period. The alternate schedule and plan revision were approved by the OCDD Regional Waiver Office and by the Guidelines for Planning State Office Review Committee, as the request exceeded William's recommended IFS hours per his level. Unfortunately, William developed an infection a week after surgery. After talking with William's physician about how the infection

would impact William's recovery, his team felt that an additional three weeks of enhanced supports would be required. This would take William past the quarter in which his alternate schedule was approved. The team developed the request and justification using the physician's information, and the support coordinator presented the information to the OCDD Regional Waiver Office. The Guidelines for Planning State Office Review Committee reviewed the request and approved it.

b. <u>An example of an inappropriate request for an alternate schedule and increase in IFS hours (The appropriate request was for a plan revision.)</u>:

Virginia was volunteering one time per month at the local food bank bagging canned goods. She was accompanied by a staff person during volunteer time and used her one-to-one hours for this activity. Virginia made friends with some other ladies who volunteered there weekly. Virginia asked to volunteer weekly as well, since she was enjoying the work and spending time with her new friends. Virginia's support team developed an alternate schedule request to provide Virginia with additional one–to-one hours to accommodate her increase in volunteer time (from one time a month to one time per week). The request was for three additional afternoons per month of one-to-one supports. Her support coordinator submitted the request to the OCDD Regional Waiver Office and the Guidelines for Planning State Office Review Committee, since the alternate schedule request would exceed Virginia's recommended IFS hours for her level. The alternate schedule request was returned to the team unapproved. The review recommended to

the team that a support plan revision and new typical weekly schedule was required, since the change in volunteering was not projected to be short term or temporary. In addition, Virginia's team must work with her to develop a new typical weekly schedule that would stay within her recommended IFS hours for her level. The team could explore use of natural supports during volunteer times provided by some of the ladies that Virginia has become friends with at the food bank. The team could also explore Virginia's using shared supports more frequently during other times of the week. Virginia's team met again and discussed the needed changes in her support plan and typical weekly schedule. Virginia's support coordinator and IFS provider contacted the food bank and some of the other volunteers regarding assisting Virginia during volunteer hours. They were happy to participate and receive information about how to support Virginia. In addition, Virginia agreed to inclusion of a few more shared hours on Sunday afternoons. These changes resulted in a typical weekly schedule consistent with the recommended IFS hours for Virginia's level. The plan revision was prepared and submitted by Virginia's support coordinator to the OCDD Regional Waiver Office. It was approved.

C. Alternate schedules are discussed at the time of annual planning and submitted for approval with the support plan. In annual planning, the support team takes into consideration the 240 days per year of Day program available, and the team looks at each quarter and determines if there are known deviations, such as:

1. Holidays/ vacation days,

2. Christmas events and travel,

3. School or work vacations,

4. Planned caregiver absence,

5. Planned occasions (firm date, time, length) for use of casual shared supports on an infrequent basis and non-typical basis (i.e., person normally uses 1:1

supports but plans to share supports on a temporary basis for a specified activity such as vacation or a 12-week art class.), and/or

6. Illness (i.e., person requires scheduled procedures/treatment that the team knows about in advance or person has documented unstable medical health which results in frequent hospitalizations or stay-at-home periods). (Note: Plans with "sick days" will not be approved. Illness requests must be justifiable as described.)

D. During each quarterly meeting, the team must review the approved alternate schedule(s) and discuss whether any additional need for alternate scheduling is known.

1. If additional alternate schedule(s) are needed, they must be submitted by the support coordinator as a plan revision for OCDD Regional Waiver Office approval. The support coordinator must submit the schedule(s) for approval within seven (7) business days of the anticipated change. Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1.*

2. Participants must notify their support coordinator of an anticipated change ten (10) business days before the date of the change. Changes may include vacation or change in work schedule.

3. Teams must evaluate if support needs have changed and revise the plan accordingly. Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1.*

E. Revisions to approved alternate schedules may also be submitted to the OCDD Regional Waiver Office at any time for approval. Unanticipated circumstances may arise that require additional hours, such as caregiver absence or illness, shared supports interruption due to illness or injury, or loss of housing. Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1*.

F. Alternate schedules are approved for use in specific quarters.

1. The support coordinator notes for each day an alternate schedule is requested, the number and type of hours requested and a justification.

G. The quarter requested must be clearly documented in the support plan (Sections VIII and IX of the CPOC) for approval. Specifying a particular date is desirable, but not required.

5.4 PLANNING FOR UNPREDICTABLE DEVIATIONS FROM THE TYPICAL SCHEDULE: FLEXIBLE HOURS

A. Support teams are expected to develop a typical weekly schedule and accompanying alternate schedules to best align with the participant's daily routine and preferences. However, every individual will inevitably have deviations from his/her typical schedule that are unpredictable and where the need for support is greater or less than usual. People may occasionally make choices about their daily routine that impact their typical weekly schedule.

B. While flexibility is allowed in the individual's plan for recommended IFS hours, documentation is required and must reflect that any change in the use of hours is "consumer-driven." (See Section 8.4 for plan implementation documentation.)

1. Each quarter, the individual's prior approved IFS hours can be moved or converted for flexibility in the typical weekly schedule. Prior approved alternate schedule hours are included in the quarterly total of available IFS hours.

2. Flexible hours can be moved around within a typical weekly schedule.

   a. A participant may choose to use 1:1 hours on a Monday afternoon instead of on Saturday, as specified in the typical weekly schedule.
   b.

3. Flexible hours can be converted within the IFS provider agency. (See Section 5.5.)

   a. A participant may choose to share 3:1 going to a ballgame, instead of sharing 2:1 according to the typical weekly schedule.

   b. A participant may be ill and unable to share supports. Shared IFS hours would then be converted to 1:1, using the IFS Flex conversion table. (See Section 5.5.)

4. A participant may not convert Day program or vocational hours to IFS hours after the support plan is approved.
   a. Flexible hours are only available through the approved IFS hours. Thus, any unpredictable absence from Day program or work that requires use of IFS hours must be carefully managed by the participant and IFS provider to assure that the participant stays within his/her IFS allotment for the quarter.

5. Flexible hours may be moved from week to week within the quarter as long as the individual not go over the total allotment of IFS hours in the quarter. Hours are approved for use in a quarter only and do not roll over.

6. Participants are required to stay within their IFS allotment for the quarter when using flexible hours. Flexible hours are not in addition to approved hours. Staying within the allotment is achieved by:

   a. Moving around hours within the typical weekly schedule as an even exchange.
      i. Thus, using the 1:1 hours scheduled for Saturday on Monday evening and then using shared 2:1 hours regularly used on Monday on Saturday. By the end of the day Saturday, the alteration in Monday's schedule will be balanced in terms of use of allocated hours. Using 1:1 hours on Monday and Saturday both would not be an even exchange and would leave the participant with a deficit in allocated IFS hours for the quarter.
   b. Using shared 2:1 or 3:1 hours instead of scheduled 1:1 hours.
      i. The conversion of 1:1 hours to shared hours will "credit" the balance of approved IFS hours for the quarter.
      ii. This strategy is recommended as a way to address a deficit in allocated IFS hours for the quarter.
   c. Substituting paid hours with natural supports or other unpaid supports.
   d. Using intermittent supports or unpaid hours (alone time).

7. Support teams work with participants on creative approaches to managing allocated IFS hours and maximizing flexibility.

   a. Any change in hours used from the typical weekly schedule must be consistent with risks and benefits discussed by the support team and documented in the support plan. For example, it is not appropriate for a participant to substitute paid hours with intermittent supports or unpaid

hours (alone time) if the support team has documented the need for supervision during specific times/activities.

C. The following guidelines are applicable to flexible hours:

1. Flexible hours may be used, if appropriate, for individuals with plans that primarily rely on one-on-one staff support but who would like to share supports for specific activities. (See Section 6 for guidelines for individuals using shared supports.)

2. A request for revision to the plan is made when unpredictable activities become regular and predictable or the person is nearing the maximum number of hours allotted in the quarter. (Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1.*)

3. The direct support provider is responsible for tracking the use of prior authorized IFS hours of service and documenting deviations from the typical weekly schedule.

4. Statistical Resources Inc. (SRI) provides the service provider with a daily 24 hour documentation sheet for each individual prior authorized, outlining the approved typical weekly schedule hours and any alternate schedule hours per quarter. The direct service workers document times worked and any schedule deviations on this documentation sheet.

D. Participants or their authorized representatives are responsible for immediately notifying the support coordinator of any emergency changes that affect the support plan. Emergency situations could include a hurricane, tornado, flooding, or other acts of God. Emergency situations may also include death in the family (of caregiver), caregiver illness, and participant illness, including need of assistance following hospital stay.

1. The support coordinator is responsible for submitting the emergency revision to the support plan to the OCDD Regional Office within 24 hours or by the next

business day of the occurrence. Plan revisions are discussed in Section 8.1 and *Attachment 8.6.1.*

2. OCDD Central Office, Regional Offices, direct service provider agencies, and support coordination agencies have additional responsibilities when a hurricane threatens Louisiana. (See Appendix 15 for Emergency Protocol for Tracking Location Before, During, and After Hurricanes.)

E. Any deviation from the typical or alternate schedule requires documentation by the service provider. (Service documentation is described in Section 8.4.) Documentation is also required on the 24-hour documentation sheet as described in C.4 above. Failure to adequately document changes in the individually approved schedule may result in denied billing or recoupment of Medicaid funds.

5.5 USING THE IFS FLEX CONVERSION TABLE WITH FLEXIBLE HOURS MANAGEMENT

A. When participants use flexible hours, conversion may be required.

1. Conversion of hours is not required if hours are moved around in an even exchange.

2. Conversion of hours is required if a different type of IFS hour than what is specified in the typical weekly schedule is used and there is no even exchange (e.g., if a day 1:1 hour is used instead of a day 2:1 hour.)

B. The IFS Flex Conversion Table (*Attachment 5.10.5)* is a tool for use in converting allocated IFS hours. For the purposes of conversion with flexible hours, neither day program nor SE mobile crew prior approved hours can be converted. These hours are not included on the conversion table. Only IFS hours types can be converted for flexible hours.

C. The IFS Flex Conversion Table displays the type of hours in the Resource Allocation System that can be converted one to another in order to use flexible hours in the typical weekly schedule. Hours available for flex include:

1. IFS Day – 1 Person,

2. IFS Day – 2 Persons,

3. IFS Day – 3 Persons,

4. IFS Night – 1 Person,

5. IFS Night – 2 Persons, and

6. IFS Night – 3 Persons.

D. Participants and teams must follow the guidelines discussed in Section 5.4 when utilizing flexible hours.

5.6 PLANNING EXAMPLES

A. The following planning examples are designed to assist support coordinators, participants and families in understanding OCDD policies with regard to the use of IFS hours.

1. Two brothers, one 25 and one 30 years old, live at home and both are served by OCDD. Each is assigned Level 3 within the resource allocation system. Level 3 includes only IFS Day 1 Person hours and provides 30 Day program hours. The brothers and the family would like to convert some IFS Day hours to Night support because their mother works an overnight shift every other week.

   Provided that the risk assessment indicates that these modifications can be done safely, the plan of care for the two brothers can include the following:

   - Use maximum Day program hours,
   - Convert IFS Day to IFS Night, and
   - Share IFS supports and, in this case, increase total available hours for support.

   The IFS Flex Conversion Table *(Attachment 5.10.5)* is used for the conversion of hours as presented in this section. For example, if the family would like to convert 4 hours of IFS Day, they would have 10 hours of IFS Night. (The total shared hours is not 20 hours even though both brothers convert.)

   These modifications to accommodate the preferences of the brothers and family are within the Louisiana Resource Allocation System. An exception request is not required.

2. A woman, who is assigned Level 5, is served by OCDD and lives with her elderly parents who are experiencing significant health issues. The elderly parents are no longer able to provide the night time natural supports called for in Level 5. The daughter is not ambulatory, is bed-confined and requires turning and positioning every two hours.

The support coordinator can consider planning for a short-term approach while looking at longer-term solutions:

- In the short-term: The team should determine what supports the woman needs in terms of frequency and intensity. In this woman's case, she may not be able to use unsupported hours, so that option may not be a ready solution. Second, the team should consider and assist the woman and her family to look at other available natural supports, such as siblings, extended family, or friends. If it is appropriate, the woman may consider using shared supports on a casual basis (perhaps out of their home). The woman may use skilled nursing supports through the waiver and convert her IFS-day services to IFS-night. Requests for additional hours by the team should be made as a last resort. Requests for additional hours may be granted on a temporary (up to 6 month) basis. Approvals for additional hours are time-limited and will not be granted on a continual basis indefinitely (See Section 5.9).

- In the long-run, the support coordinator should work with the woman and her family to plan for the permanent change in support circumstances. Perhaps another relative is willing to offer in-home supports. The woman and family may wish to explore shared independent living arrangements in anticipation that the family home will not likely be available in the future. Or, if the family situation and home permits, perhaps a roommate or continued shared supports may be appropriate. Involving the family in long-term planning instead of simply requesting more hours as a short-term solution will result in the best outcome for the woman. The support team should work proactively and in collaboration with the PASARR process to prevent unnecessary institutionalization, should elderly parents enter a nursing home.

3. Additional IFS hours are needed quickly (at any Level) due to the sudden death of the sole caregiver.

As a first step, flexible hours can be used immediately to meet the person's needs. The support team should convene immediately to come up with an interim and long-range plan to meet the person's needs. Plan revisions should be submitted per policy.

4. A person has an emergency, such as surgery, and requires support during the recovery period in the home.

   Flexible hours set aside for unpredictable events are used for this purpose. If flexible hours are not sufficient, the support coordinator requests a temporary increase in hours for the recovery period only as described in Sections 5.9 and 7.3. No permanent revision is made to the plan.

5. Two participants, who currently share services, receive very different resource allocation levels (e.g., Level 1B and Level 4). Can these participants continue to share?

   Yes, they can continue to share provided that the risk assessment or steps to mitigate risk indicate that sharing can be accomplished safely.

6. There are two homes both using shared supports with the same IFS provider agency.

   Home 1 with Persons A and B:
   A likes football B likes soccer
   Home 2 with Persons C and D:
   C likes football D likes soccer

   Can Home 1's staff take A and C to a football game and let Home 2's staff take care of B and D?

   Yes, they can so long as this can be done safely and A and C and B and D are not precluded from sharing.

7. Will older family members' health be considered for justification for additional hours as well as single parents?

   Yes, provided that other options for converting hours, sharing hours, and using flexible hours are considered first. See the response to number 2 above.

8. What if the caregiver is hospitalized?

   Flexible hours are used first. If these are not sufficient, a temporary request for an exception to allocated hours is requested as described in Section 5.8.

9. What if the person lives in an area in which there is no vocational or habilitation program available or there is a waiting list for these services?

   People may request permission from their local OCDD Regional Waiver Office to cross regional lines in order to access services needed. Support teams should incorporate strategies into the support plan that include meaningful activities by using community supports and shared supports for persons before requesting additional 1:1 hours. Any requests for hours exceeding the suggested allocation must include individual justification as described in Section 5.8.

10. What if roommates are both coming out of an institution, like and ICF/DD, and one roommate is ready to move before the other? Are services put on hold until both are ready to move?

    The roommate who is ready to transition may move out and live by him/herself until the other person is ready to move. The roommate that moves out can request additional 1:1 hours (if needed) under the phase-in strategies described in Section 5.9.B.2. If one roommate moves before the other and plans to live alone temporarily, teams must determine whether sufficient resources (e.g., finances to cover rent and utilities) are available for the person to live alone.

5.7 WHEN ADDITIONAL IFS HOURS ARE NEEDED

A. OCDD recognizes that the resource allocation system must make accommodations for participants with atypical or specialized needs in order to be responsive to all service recipients; certain people have unique needs that must be addressed outside the guidelines.

   1. Section 5.8 provides examples of the types of situations that may justify additional IFS hours both temporarily and on a permanent basis. Section 7.3 describes the process established to review these requests.

B. National experts with Resource Allocation Models have indicated that a small percentage of participants are outliers of any model – meaning they have resource needs outside of the Allocation System. Louisiana's Resource Allocation System has procedures to address this issue.

   1. Requests for IFS hours above the guidelines are submitted and reviewed through the OCDD Guidelines for Planning State Office Review Committee, and procedures are described in Sections 5.8, 5.9, and 7.3.

5.8 JUSTIFYING THE NEED FOR ADDITIONAL IFS HOURS

A. IFS hours requested above the guidelines require justification by the support coordinator based on the unique needs of the participant. All requests for additional hours must be distinctive to the participant. The request must specify how the need for additional hours distinguishes the person from others at the same resource allocation level. Only participant specific requests with clear information about why the exception is required can be approved.

B. Additional support hours may be considered in specific instances.

1. A participant falls into a category where sharing is not advisable (See Section 6.8.) but falls into an allocation level that includes sharing (e.g., all Living Independently levels other than 6 include sharing as presented in 5.10.2).

2. A participant has few general support needs and falls into Level 1A, 1B or 2 but has a highly contagious disease or significant behavioral issue (e.g., Prader-Willi syndrome requiring limiting food in the home).

3. A participant requires extensive physical assistance to participate in most home and community activities (e.g., a two person lift even with assistive devices).

C. Support coordinators follow the procedures described in Section 5.9 when:

1. Recommended IFS hours do not safely meet the participant's needs,

2. Temporary changes in support hours required result from caregiver absences and flexible hours are not sufficient,

3. Permanent changes in support hours required result from a significant change in living situation and/or needs (SIS/LA PLUS reassessment required) and allocated IFS hours are no longer sufficient, or

4. A participant is seeking a phase-in plan to the recommended number of IFS hours as described in 5.9.

D. Exceptions to the IFS guidelines, other than changes supported by the SIS/LA PLUS reassessment and assignment of the appropriate resource allocation level, are time-limited. Support coordinators are responsible for review and update to the support plan in the timeframe specified in the approval of the exception.

5.9 TEMPORARY REQUESTS AND PHASE-IN TO THE RECOMMENDED NUMBER OF IFS HOURS

A. IFS hours above the guidelines may be required on a temporary basis including the following instances:

A phase-in period is needed to secure a shared living situation or for a current client with a history of supports above the guidelines levels when the guideline is initially applied or there is a change in the SIS assessment and assignment to a lower resource allocation level;

Caregiver is absent or becomes ill;

Shared services are interrupted due to illness or injury; or

The residence of the participant is damaged and is temporarily not inhabitable.

All requests for additional temporary hours above the IFS guidelines are time limited. The support coordinator reviews the plan of care for temporary awards of IFS hours no less than quarterly and more frequently where the exception was approved for a shorter period by the GPSORC as described in Section 7.3. The support coordinator must resubmit a request for continuation of temporary increases every six months or more frequently as specified by the GPSORC in the approval of the initial request.

.

For participants residing at home with their families who are moving to independent living and need time to develop shared supports, supports may be provided to the participant at home until the shared living situation is set up.

For participants moving from an ICF to an independent living situation, an assessment is made regarding projected time to set up the shared living situation. Requests for temporary need for additional hours are considered while the shared living situation is developed based upon each individual situation.

The expectation is that development of shared living circumstances is normally completed within six months. Exceptions are considered on an individual basis.

For participants currently receiving individualized IFS hours and living independently whose needs cannot be met within the level allocation, an assessment is made regarding projected time to set up a shared living situation or to make adjustments to the person's daily schedule to include sharing options or other appropriate supports. Requests for temporary need for additional hours are considered while the shared living situation or other adjustments are developed based upon each participant's situation.

Attachment 5.10.1 Recommended IFS and Day Program Hours by Level - Lives with Family

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

GUIDELINES FOR PLANNING:

RECOMMENDED IFS AND DAY PROGRAM HOURS BY LEVEL

Lives with Family							
	1A	**1B**	**2**	**3**	**4**	**5**	**6**
IFS Day	25	32	46	56	62	62	82
IFS Day Shared	0	0	0	0	0	0	0
IFS Night	0	0	0	0	0	0	0
IFS Night Shared	0	0	0	0	0	0	0

Day Program Hours	20	30	30	30	30	30	12
Total Paid Hours	**45**	**62**	**76**	**86**	**92**	**92**	**94**
Natural Supports Hours	123	106	92	82	76	76	74
Total Hours	**168**	**168**	**168**	**168**	**168**	**168**	**168**
<18 years = -7 hrs IFS Day	-7	-7	-7	-7	-7	-7	-7
>55 years add = +7 hrs IFS Day	+7	+7	+7	+7	+7	+7	+7

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

GUIDELINES FOR PLANNING:
RECOMMENDED IFS AND DAY PROGRAM HOURS BY LEVEL

Lives Independently							
	1A	**1B**	**2**	**3**	**4**	**5**	**6**
IFS Day	10	10	10	10	14	14	112
IFS Day Shared	35	40	72	72	68	86	0
IFS Night	0	0	0	0	0	0	56
IFS Night Shared	0	40	56	56	56	56	0
Day Program Hours	30	30	30	30	30	12	0
Total Paid Hours	**75**	**120**	**168**	**168**	**168**	**168**	**168**

Natural Supports Hours	93	48	0	0	0	0	0
Total Hours	**168**	**168**	**168**	**168**	**168**	**168**	**168**
>55 years add = +7 hrs IFS Day	+7	+7					

Attachment 5.10.3 Conversion Table

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
GUIDELINES FOR PLANNING SERVICE HOURS CONVERSION TABLE
EFFECTIVE 9/24/2008

IFS - DAY 1 PERSON	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	2	3	2	2
2	2	3	4	5	5	4
3	3	4	5	8	7	6
4	4	6	7	10	9	8
5	5	7	9	13	11	10
6	6	8	11	15	14	12
7	7	10	12	18	16	14
8	8	11	14	20	18	16
9	9	13	16	23	20	18
10	10	14	18	25	23	20

IFS - DAY 2 PERSONS	IFS DAY 2P CONVERSION	IFS DAY 1P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	1	2	2	1
2	2	1	3	4	3	3
3	3	2	4	6	5	4
4	4	3	5	7	7	6
5	5	4	6	9	8	7
6	6	4	8	11	10	9
7	7	5	9	13	11	10
8	8	6	10	15	13	12
9	9	6	12	17	15	13
10	10	7	13	18	16	14

IFS - NIGHT 1 PERSON	IFS NIGHT 1P CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	1	1	1	1
2	2	1	2	3	3	2
3	3	2	2	4	4	3
4	4	2	3	6	5	5
5	5	3	4	7	6	6
6	6	3	5	9	8	7
7	7	4	5	10	9	8
8	8	5	6	11	10	9
9	9	5	7	13	12	10
10	10	6	8	14	13	11

Attachment 5.10.3 Conversion Table

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
GUIDELINES FOR PLANNING SERVICE HOURS CONVERSION TABLE
EFFECTIVE 9/24/2008

IFS - NIGHT 2 PERSONS	IFS NIGHT 2P CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	0	1	1	1	1
2	2	1	1	1	2	2
3	3	1	2	2	3	2
4	4	2	2	3	4	3
5	5	2	3	3	4	4
6	6	2	3	4	5	5
7	7	3	4	5	6	5
8	8	3	4	6	7	6
9	9	4	5	6	8	7
10	10	4	5	7	9	8

ERT/DAY HAB	ERT/DAY HAB CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	SE MOBILE CREW CONVERSION
1	1	0	1	1	1	1
2	2	1	1	2	2	2
3	3	1	2	2	3	3
4	4	2	2	3	4	4
5	5	2	3	4	6	4
6	6	3	4	5	7	5
7	7	3	4	5	8	6
8	8	4	5	6	9	7
9	9	4	6	7	10	8
10	10	4	6	8	11	9

SE - MOBILE CREW	SE MOBILE CREW CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION
1	1	1	1	1	1	1
2	2	1	1	2	3	2
3	3	2	2	3	4	3
4	4	2	3	4	5	5
5	5	3	3	4	6	6
6	6	3	4	5	8	7
7	7	4	5	6	9	8
8	8	4	6	7	10	9
9	9	5	6	8	11	10
10	10	5	7	9	13	11

3/23/2009 OCDD

Attachment 5.10.4 Weekly Schedule and Budget Pages with Instructions

Section VII: Typical Weekly Schedule

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
NS = NATURAL SUPPORTS	
S = SELF	
SC = SCHOOL	
W = WORK	
PW = PAID WAIVER (IDENTIFY SERVICE)	
P = PAID SUPPORT (LRS, ETC.)	
Total # of Weekly Hours	

COMMENTS:

NAME: _____

Reissued November 18, 2003

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Attachment 5.10.4 Weekly Schedule and Budget Pages with Instructions

Section VIII – Typical Alternate Schedule\Conversion

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY SUPPORT COORDINATOR AS SOON AS POSSIBLE.

JANUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

MARCH 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

APRIL 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

MAY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

JULY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

AUGUST 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

SEPTEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

OCTOBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

NAME: _____

Reissued November 18, 2003

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OCDD-POC-NOW

SECTION IX (A): POC Requested Waiver Services (Budget Sheet) – Typical Weekly & Alternate Schedule **Confidential**

List The Individual's Requested Services As Described In The POC. _____

TYPICAL WEEKLY SCHEDULE – DAILY SERVICE TOTALS

PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	TOTAL WEEKLY # OF UNITS OF SERVICE

TYPICAL ALTERNATE SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

			MTH/ DAY/ YR _____ MTH/DAY/YR- ---------- 1ST PARTIAL QUARTER		MTH/YR---------- MTH/YR. ---------- 1ST FULL QUARTER		MTH/YR._____ MTH/ YR._____ 2ND QUARTER		MTH/YR._____ MTH/ YR._____ 3RD QUARTER		MTH/ /YR_____ MTH/DAY/ / YR._____ 4TH PARTIAL QUARTER			TOTAL ALT. COST FOR ALL QUARTERS
PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL # OF UNITS	DATE/ PURPOSE	TOTAL UNITS (+ OR -)	DATE/ PURPOSE		
											TOTAL TYPICAL ALTERNATE SCHEDULE COST			

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT TO PROVIDE SERVICES OUTLINED ABOVE:

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Support Coordinator Signature: _____ Agency: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE _____ Date_____

OCDD Approval Signature: _____ Date: _____

NAME: _____

Reissued March 16, 2009

SECTION IX (B): POC Requested Waiver Services (Budget Sheet)

1. Provider Name (Full Name)	2. Provider #	3. Service Type	4. Procedure Code(s)	5. Typical Weekly # Of Units	X	6. Cost/ Rate Per Unit	=	7. TOTAL TYPICAL Weekly Costs	X	8. # of Weeks in POC Year (52 weeks in a Yr.)	=	9. Total Typical Annual Costs
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	

10. Total Typical Schedule Annual Cost	
11. Total Typical Alternate Schedule Annual Cost	
12. Total Combined Typical & Alt. Schedule Annual Cost	

*Provider agrees to return signed budget sheet to support coordinator within 2 working days following Plan of Care meeting after reviewing and verifying service and calculation accuracy. The provider agrees to provide the services as outlined in the Guidelines for Planning. SC will not change or alter document after the provider signs the budget sheet.

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Support Coordinator Signature: _____ Agency: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: PARTICIPANT/GUARDIAN SIGNATURE _____ Date _____

FOR OCDD USE ONLY:

APPROVED: _____ DENIED: _____ APPROVED POC BEGIN DATE: _____ APPROVED POC END DATE: _____

OCDD AUTHORIZED REPRESENTATIVE: INITIALS DATE:

NAME: _____

NOW POC Instructions

SECTION VII - TYPICAL WEEKLY SCHEDULE

PURPOSE

The intent of this schedule is to assist participants and their families in assessing and planning for services and supports that will help them move closer to their desired personal outcomes. Utilization of this section and subsequent planning will help assure continuity of care and reduce redundant and/or unnecessary service delivery. Services should be provided in accordance with what is requested and needed by the participant, no more, no less. Simply list the source of service provision when applicable. In addition, for waiver support simply mark the time the participant typically receives supports by using the "Pw" coding. The service delivery schedule **is not** to be used for daily monitoring of service delivery or monitoring of the participant's daily activities.

This section is for planning purposes only**. It is understood that this schedule is flexible and a participant's daily routine may change based on need or preference. The waiver supports that are initially requested will be based on this planning document.**

Subsequent changes must to be requested by the participant, and/or their authorized representative, and processed through the support coordinator utilizing the appropriate Revision Request forms (see Revision Request Form in Appendix A of this instruction manual).

TYPICAL WEEKLY SCHEDULE

The top of this section lists the participant's desired/needed supports. For each hour indicate how the participant will typically spend their time using the codes listed below.

CODES: Ns = Natural Supports

S = Self

Sc = School

C = Companion

Pw = Paid Waiver Support

P = Paid Support*

*Note: Paid Support is support provided by another funding source besides waiver funding (For example, Louisianan Rehab. Services (LRS), private pay funds, etc.).

When listing Paid Waiver Support (Pw), identify the waiver support (For example, PW – IFS, PW – Day Hab, etc.).

An example of a typical weekly schedule is:

TIME	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**	**SUN**
12pm	Pw – Individual Family Support (IFS)	Pw –Supported Employment (SE)	Ns	Pw – SE	Self (S)	S	Ns

After completing the Typical Weekly Schedule, tally the hours by codes (For example Pw) and enter the number of hours next to the appropriate code in the box located on the bottom left-hand corner of the page. The total number of hours in a week is 168.

NOW POC Instructions

SECTION VIII - TYPICAL ALTERNATE SCHEDULE

(For Planning Purposes Only)

Purpose

The purpose of the Typical Alternate Schedule is to provide families flexibility in the utilization of units based on possible projected needs, (for example holidays, school closures, work schedule changes, etc.). Proper planning for the participant will allow for flexibility for families and the reduction of the need for revisions. This section is to assist with planning for holiday/vacation schedules, and to assure continuity of supports and services during those times when additional supports are requested**. It is understood that the schedule remains flexible**. Planning for holiday/ vacation or other alternate schedule time will ensure the participant will have access to the needed supports in a timely, consistent manner. **This page is simply designed to provide a visual overview of service delivery during holiday/vacation, or other alternate schedule time.**

Subsequent changes must be requested and processed through the support coordinator utilizing the appropriate Revision Request forms (See Appendix A of this Instruction Manual).

Typical Alternate Schedule Calendar

The Typical Alternate Schedule calendar contains the twelve (12) months of the year followed by the year: "20_____" (the appropriate year will need to be filled in). This calendar should begin and end with the months for that particular POC year. The dates when alternate services have been requested by the participant, and/or his/her authorized representative/guardian should be marked (this can be done by marking an "X" for appropriate date(s), by shading dates, or other means of marking dates. **Important Note:** Prior planning and consideration of all possible dates a participant may need alternate services at the POC planning meeting will provide families flexibility in the utilization of service units based on possible projected needs, and will minimize the need for revisions during the POC year.

For Example:

January 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

March 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS: Jan. 1 to 3, 2004 – School Winter Break, 1/19/04 – Martin Luther King, Jr. Holiday, 2/23 – 25, 2004 – Mardi Gras Holidays, 3/12/04 – Early dismissal – ½ day at school.

NOW POC Instructions

SECTION IX: - POC REQUESTED

WAIVER SERVICES (BUDGET SHEET)

Section IX (A) - Typical Weekly Schedule & Section IX (B) - Typical Alternate Schedule

Purpose

The purpose of this section is to document all services a participant and/or his authorized representative/guardian have requested in accordance with information gathered and documented during the POC planning process. In addition, this section identifies whom the participant and/or his authorized representative/guardian have chosen to provide the specified service(s), the frequency, amount (units of service) and duration of each requested service for that particular POC year.

The Budget Page is divided into two (2) Sections - IX (A) and (B).

Section IX (A): List the Typical (Routine) Weekly Schedule – Daily Service Totals of services a participant has requested for that POC year. This schedule is reflected on a weekly schedule.

Section IX (B): List the Typical Alternate (Holiday/Vacation/Other) Schedule – Total Additional Units of Service being requested per each quarter of the POC year. This schedule is reflected on a quarterly basis.

Signatures of the participant and/or his or her authorized representative, the chosen provider and support coordinator appear on this page documenting review and approval of services as reflected on Budget Sheets as written during the POC planning meeting.

OCDD is responsible for assuring that all information on the Budget Sheets is accurate before signing their approval of the POC as written.

The POC is a **legal document** and must be treated as such. The POC Budget Sheets must be completed in blue or black ink**.** **ALL** corrections must be made by **marking through an error only once and initialing each correction as such.**

Complete Section IX (A) & (B) of the POC (Budget Sheets) as follows:

SECTION IX (A) – BUDGET SHEET:

SSN#: Indicate the participant's SSN#

Attachment 5.10.4 Weekly Schedule and Budget Pages with Instructions

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NOW POC Instructions

TYPICAL WEEKLY SCHEDULE – DAILY SERVICE TOTALS

List the participant's requested services as described in **Section V** of the participant's POC: **Identified Services, Needs, and Supports, Section VII: Typical Weekly Schedule**, and **Section VIII: Typical Alternate Schedule.** It is very important that the Budget Sheet (Section IX (A) & (B) be accurately and thoroughly completed so that delivery of supports and services is not adversely affected or delayed. Failure to do so will affect data input into the Prior Authorization system, which will ultimately **affect billing and delay reimbursement.** Each section should be completed as follows:

PROVIDER NAME: List provider agency to provide NOW service (Full Name, no acronyms).

SERVICE PROCEDURE CODE(S): List the NOW procedure code(s) for each requested service(s) (See attached NOW PROCEDURE CODES AND SERVICE RATES chart).

SERVICE TYPE: List the type of NOW service provided (For example, IFS, Day Hab, etc.)

MONDAY – SUNDAY: List the units of service for each NOW Procedure Code you have listed, under the day of the week they have been requested for. For services that are billed in 15 minute units, the units are computed by multiplying the number of hours per day by four. For example, if a participant receives Day Habilitation services five hours per day, Monday through Friday, then the Day Habilitation unit per day would equal 20 and the total Day Habilitation weekly units would equal 100.

TOTAL WEEKLY # OF UNITS OF SERVICE: List the total weekly number of units of service for each NOW Procedure Code listed.

TYPICAL ALTERNATE SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

PROVIDER NAME:	List the name of the provider agency that has been chosen by the participant/authorized rep. /guardian to provide the service (Full Name, no acronyms).
SERVICE	
PROCEDURE CODES:	List the NOW procedure code(s) for each service listed. (See attached NOW PROCEDURE CODES AND SERVICE RATES chart.)
SERVICE TYPE:	List the type of NOW service being requested (For example, IFS, Day Hab, etc.).

Attachment 5.10.4 Weekly Schedule and Budget Pages with Instructions

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TOTAL # OF UNITS

(+ or -): Add **(+)** or subtract (-) total # of units of service for each additional service requested. **For example**: A participant receives Day Hab 3 days a week, 5 hours a day (20 Units per day, 60 units per week). During your POC planning meeting you learned that Day will be closed during the Christmas holidays for the 3 days this participant would normally attend Day Hab. The participant is requesting an additional 5 hours a day (an additional 20 Units per day, 60 units per week) of Individual Family Support (IFS) services for the 3 days during the Christmas holidays the Day Hab will be closed. You would subtract (-) the 3, 5 hour days of Day Hab Service (20 Units per day, 60 units per week) of Day Hab services for the appropriate POC Quarter and add (+) an additional 5 hours a day (an additional 20 Units per day, 60 units per week) of IFS for the appropriate POC quarter.

DATE/PURPOSE: Provide the date(s) when a request for alternate services are being added or subtracted and make a brief note indicating the purpose for additional (+) or for units of services being subtracted (-) (For example, "Holidays", "Early School Dismissals", "Vacation", "Illness" etc.)

QUARTERS: There are five sections listed. The first is a partial quarter, then the first full quarter, 2nd full quarter, 3rd full quarter and 4th partial quarter. The year that quarter is in should be noted at the top of each quarter by the "Yr. ___" Blank. **Be especially sure to note what year you are referring to for those times when alternate services may be covered in two different years for the same month. For example, a POC with alternate services requested for all quarters with a begin date of July 15, 2009 would also cover alternate services through July 15, 2010.**

TOTAL ALT.

COST FOR ALL

QUARTERS: List the total cost for each quarter in the POC year (This is the total sum of each POC Quarter)

TOTAL TYPICAL ANNUAL ALTERNATE SCHEDULE

COST:	List the total cost for all Alternate units of service listed (Add or subtract each of the cost listed in this column to give you a Total Alternate Schedule Cost)

Attachment 5.10.5 IFS Flex Conversion Table

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

GUIDELINES FOR PLANNING

IFS FLEXIBLE SERVICE HOURS CONVERSION TABLE

IFS DAY 1P (1:1)	IFS DAY 2P (2:1)	IFS DAY 3P (3:1)	IFS NIGHT 1P (1:1 night)	IFS NIGHT 2P (2:1 night)	IFS NIGHT 3P (3:1 night)
0	0	0	0	1	1
1	2	2	2	3	4
2	3	3	3	5	6
3	4	5	5	7	9
4	5	6	7	10	12
5	7	8	9	13	15
6	8	9	10	15	18
7	10	11	12	18	21
8	11	12	14	20	23
9	12	14	16	23	26
10	14	16	17	25	29
11	15	17	19	28	32
12	16	19	21	31	35
13	18	20	23	33	38
14	19	22	25	36	41
15	21	24	26	38	44
16	22	25	28	41	47
17	23	27	30	43	50
18	25	28	32	46	53
19	26	30	34	48	56
20	28	32	35	50	59
21	29	33	37	54	62
22	30	35	39	57	65
23	32	36	41	59	68
24	33	38	42	61	70

6

USING SHARED SUPPORTS

6.1 Benefits of Sharing Supports

6.2 General Requirements for Sharing Supports

6.3 Requirements when Sharing Supports in Casual/Everyday Situations (Non-Roommate)

6.4 Requirements for Sharing Supports Among Roommates

6.5 NOW Protocol for Support Coordination and Sharing IFS Supports

6.6 Roles and Responsibilities of the IFS Provider with Service Delivery of Shared Supports

6.7 Roles and Responsibilities of the Participant when Sharing Supports

6.8 When Not to Share Supports

6.9 Using Intermittent Supports

6.10 Attachments

6.10.1 Shared Supports Brochure

6.10.2 HIPAA 404P

6.10.3 Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW)

USING SHARED SUPPORTS

Current NOW policy and procedures allow up to three participants who may or may not live together to share Individual and Family Supports.

Participants may share when the circumstances of the sharing are agreed to by each party and when the health and welfare can be assured for each participant.

Participants are required to share supports in the same setting, at the same time, while receiving supports from the same direct support person. A setting may include the home of one of the participants or a community setting.

A few examples of ways to share supports are listed below:

- weekend activities/hobbies/church/movies/sporting events
- morning/evenings (before/after work/day program)
- living with one or two persons (housemate)

Persons who do not live together may use intermittent supports, which involve a single direct support staff moving between residences to support each participant independently. Intermittent supports are not "shared," but rather are an individual (one-to-one) service.

6.1 BENEFITS OF SHARING SUPPORTS

A. Sharing supports provides opportunities for a person to get to know others, expand one's social support network, and become better integrated into one's community.

   1. Opportunities are available for a person to gain independence in day-to-day skills and increase self-confidence in his/her own abilities.

   2. Sharing supports (and expenses) by having one or two housemates allows people to share their monthly living expenses, including rent, utilities, and food costs. This may result in improved housing options and having additional funds for recreation, leisure, and personal activities.

   3. Sharing supports may lead to learning opportunities through exposure to other people, customs, and ways of life.

   4. Even when sharing, people have opportunities for non-shared or one-to-one hours.

   5. Sharing supports can lead to friendships and reduce isolation.

   6. Relationships developed through sharing supports challenge individuals to try new things and grow.

B. Shared supports are included in all living independently guidelines (*Attachment 5.10.2*). Sharing supports for participants living with family can have similar benefits and extend the total hours of services available.

C. OCDD has a brochure available about sharing supports. (See *Attachment 6.10.1*.)

6.2 GENERAL REQUIREMENTS FOR SHARING SUPPORTS

A. Participants sharing supports are required to have the same IFS provider.

B. Both support plans must include authorized units for shared supports (two persons or three persons). The IFS provider bills for all participants simultaneously using the appropriate shared supports coding. The billing submission is required to match among participants served by the IFS provider.

Rate Example*:

1 person and 1 staff	$4.00 per 15 minutes for one–to-one staffing
2 persons and 1 staff	$2.88 per 15 minutes person 1
	$2.88 per 15 minutes person 2
TOTAL	$5.76 per 15 minutes for providing shared supports

*Rates are subject to change. Refer to the NOW Rate Code Sheet available on the OCDD web site for the most current rates.

C. Both support plans must include documentation that shared supports are appropriate service utilization.

D. The staff person who provides shared support services is required to be present with the participants at all times in order to bill for the service delivery.

1. "Present" indicates proximity in a shared space, while allowing for independent movement and utilization of the environment.

2. In the case of home delivery of shared supports, the IFS staff does not have to be in the same room with all participants, but may move freely between indoor and outdoor spaces related to the home to assist persons in choice activities. Staff must be available to respond readily to support needs.

3. In the case of a community-based event, IFS staff may maintain proximity with visual and auditory contact, offering hands-on assistance when appropriate. By maintaining proximity, staff must be capable of providing prompt assistance and of quickly responding to support needs. For example, if two persons go to the park, staff may sit on a bench with one person, while maintaining visual/auditory contact with the other person who is playing fetch with his dog. Any break in contact, for example for toileting, must be brief.

    a. Determining length/type of brief breaks in contact and the physical distance from the staff support is done on a case-by-case basis, taking into account the acuity level of each person, the particular community location, and the specific factors within the environment that may impact the health and safety of the persons supported.

E. Participants sharing supports are required to be present within the same residence, house, or apartment.

1. Participants are not required to live together to share supports. However, in-home supports may not be shared between people who live in distinct residences when the persons are in their own respective homes. Participants are required to be in one residence together to share supports.

2. Persons living next door to each other may not share supports when each is in his/her own home, including persons who live in separate apartments within one complex. (See Section 6.9 for discussion of Intermittent Supports.)

F. IFS Shared supports may be provided across settings so long as they are not billed during the same days and hours as the following other supports: Day Habilitation, Supported Employment, Employment Related Training, Transportation for Habilitative Services, Professional Consultation,

Transitional Professional Support Services, Center-Based Respite, Skilled Nursing Services, Day-Night Individualized and Family Supports or Community Integration Development. (See Louisiana Medicaid Program Chapter 32 Section 32.10.3 and 32.10.3.1 for complete details.)

6.3 REQUIREMENTS WHEN SHARING SUPPORTS IN CASUAL/ EVERYDAY SITUATIONS (NON-ROOMMATE)

A. Support teams must discuss the appropriateness of shared supports for the participant. Teams must specifically address casual/everyday situations that may occur in the typical week, taking into account the following five items.

1. **Activities of Daily Living (ADL)** support requirements during mealtimes and toileting. Does the person require hands-on, eyes-on at all times? If so, they will not be able to share a single staff with another person who also requires this level of care. Consider the length of time: Are there amounts of time where sharing is okay and then when sharing may not be okay? For example, a person with significant ADL support needs may be able to share supports for two hours, but sharing for six hours may put the person at risk.

2. **Medical support needs** that may act as an exclusion to sharing with particular persons or during particular times, including medication administration, positioning and changing schedules, etc.

3. **Behavioral support needs** that may act as an exclusion to sharing with particular persons or during particular times.

4. **Personal preferences and interests** as identified in Discovery and throughout plan implementation. Participants should be supported to share when taking part in activities based on their own personal preferences and interests. These interests must be listed in the support plan. Any situations where shared supports should not occur should be clearly documented in the plan according to Section 6.3, B (below).

5. **Emergency situations** and the type of intervention and assistance that may be required in such situations. Teams should assume a reasonable, prudent level of risk based upon a community standard.

B. Information relevant to sharing supports must be clearly documented in the support plan Section III.C, "Current Community Supports or Other Agency Involvement." For example, the plan may include the following information to assist with shared supports service implementation:

1. The person becomes frightened and agitated by crowds, so he/she should not attend events where this may be an issue.

2. The participant requires constant hands-on support for mealtimes and is at high risk for choking, thus he/she should not share mealtime staff supports in the community with other persons who also need this level of support.

   (Note: Sharing when eating out is probably best done with a person who is independent with dining and has no food-related behavioral support needs that may necessitate interruption.)

B. Each participant must agree to inclusion of shared support hours in his/her support plan. This agreement is indicated by the participant's signature on the final version of the support plan and any revisions.

C. No signed agreement is required between service participants for casual/everyday sharing. The names of participants do not have to be listed in the support plan. Participants must utilize the same IFS provider. This means that a participant is free to share supports, within plan guidelines, with any individual also using the same IFS provider's services.

D. Participants are responsible for making their preferences related to specific persons and specific activities known to their IFS Provider.

F. IFS providers must implement support plan elements as specified in the plan. This includes making accommodations to offer shared supports based upon personal preferences and interests, including with whom the person shares and preferences for certain types of activities. A person's preferences and interests, including who they wish to spend time with and how they wish to spend their time, may change

during the plan year. Thus, if new preferences/interests are identified that are not listed in the support plan, the IFS provider may provide opportunities and activities that reflect these new preferences/interests. All service delivery must be consistent with goals and strategies in the support plan and with risk mitigation requirements. Changes in activities, preferences, and interests should be discussed with the support coordinator at the monthly call and quarterly meetings. The annual Personal Outcomes Assessment should also take any changes into account and incorporate the newly identified interests and preferences into the next annual plan or sooner if indicated.

G. Any significant change in information must be communicated to the support team immediately for discussion and revision of sharing criteria. Sharing criteria should be discussed at each quarterly meeting.

H. Both the participant and IFS provider should carefully evaluate any financial impact that sharing supports may have. Some activities such as dining out, going to the movies, or going shopping, if done every week, may put a strain on a fixed income. Thus, planning for free or low-cost activities that utilize community spaces and community events should occur. Going to church events, the park, free concerts, or the library may be good alternatives. Learning activities may also be low cost (learning to do own laundry, cook meals, etc.).

6.4 REQUIREMENTS FOR SHARING SUPPORTS AMONG ROOMMATES

A. Finding a person or persons to share supports within one's home is based upon the choice and preferences of the participants involved. However, both support coordination agencies and IFS provider agencies are expected to assist participants with the process of selecting a roommate. Appropriately matching people who are compatible takes time and thought. If it is done well at the outset, it will reduce the likelihood that frequent, time-consuming revisions will have to be made later in plans.

B. A participant may already have an idea with whom he/she may like to live. If at all possible, persons completing the NOW offer activities (Section 2) are encouraged to choose the same support coordination agency as their prospective roommate. This will facilitate information sharing in the planning phase.

C. Participants must choose an IFS agency. Persons sharing supports must use the same IFS agency.

D. If the participant knows who he/she would like to live with, that preference should be indicated to the support coordinator during Discovery.

   1. For those participants who have requested to be roommates, but currently use different IFS provider agencies, the participants involved must negotiate between themselves and come to an agreement on which IFS provider agency they will use. They may choose one of the agencies currently being used by one of the (potential) roommates, or they may choose a new agency. The support coordinator(s) involved will assist participants to exercise freedom of choice, but no support coordinator, OCDD affiliate, or provider staff may suggest or encourage participants to choose a particular IFS provider agency.

E. If the participant does not know who he/she would like to live with, the support coordinator notifies the chosen IFS provider and requests assistance.

1. The chosen IFS agency gets Discovery information from the support coordinator to evaluate the support needs and preferences of the person.

2. The chosen IFS agency suggests persons served/other incoming persons who may have similar interests.

3. The chosen IFS agency arranges formal and informal meetings, including meeting with families and/or in the person's homes for possible roommates.

4. The participant completes the meetings and provides information on his/her preferences to an IFS agency representative participating in his/her planning.

5. The IFS agency representative gathers information relevant to sharing supports according to the indicated preferences.

F. If the person who is being considered as roommate does not utilize the same support coordination agency, the IFS provider agency explains the process and requests that both persons complete an information release (HIPAA 404P) (See *Attachment 6.10.2.*) for the opposite support coordinators representing the potential roommate situation. These releases are required so that support coordinators representing the two participants may openly discuss risks and benefits to sharing supports as roommates. When completing the HIPAA 404P form, the IFS provider should note the expiration date as one year from the "Request Date" (top section, first line of form). A new HIPAA 404P form is required each year for persons using different support coordination agencies. <u>No information release is required if the participants share the same support coordination agency.</u>

G. The IFS provider agency representative (able to make decisions about agency capability) and support coordinators assigned to the individuals must hold a discussion **<u>without the individuals present</u>** regarding the IFS provider agency offering services to the proposed pair. The discussion must include consideration of risks and benefits. In accordance with DHH HIPAA policies, this discussion occurs among the IFS provider and support coordinator(s) post-Discovery and is done in confidence to protect sensitive information about participants that may not be appropriate for release to the entire support team or to other participants. The

Support Coordinator facilitates discussion of risks, benefits, and plan structure associated with a participant's sharing supports with one or more specific individuals as roommates. The focus of the discussion is on whether the IFS provider can reasonably meet the support requirements and assure health and safety. The following are areas covered in this discussion.

1. *Activities of Daily Living*:

   a. Source: SIS/LA PLUS, current team (if coming from ICF or community home), interview with person and family, previous or current staff.

   b. Discuss: Primary mode of mobility. Level of assistance needed (verbal prompting, modeling, hands-on) to complete everyday activities of daily living - transferring, toileting, eating, bathing, dressing, grooming. Can the person independently complete an ADL task and know the appropriate time in which to do so (e.g., washing hands after going to rest room)? How quickly does the person learn a new task?

2. *Medical*:

   a. Source: SIS/LA PLUS, current team (if coming from ICF or community home), current physician, interview with person and family, previous or current staff.

   b. Discuss: Types and amount of physical assistance and/or equipment needed. Types of nutritional assistance needed. Known conditions or illnesses which result in departures from planned schedules or events. Known conditions or illnesses which require use of additional safety precautions. Medication administration including dosage time(s) and side effects. Incident reports related to medical issues.

3. *Behavioral/psychiatric:*

   a. Source: SIS/LA PLUS, current team, current psychologist, psychiatrist or therapist records, police reports (history of arrests), interview with person and family, previous or current staff, incident reports related from current/previous provider.

   b. Discuss: Frequency, intensity, and duration of behavioral and/or psychiatric issues. Axis I and II diagnoses. Predictable and progressive behavioral patterns. Needed behavioral interventions.

4. *Personal preferences:*

   a. Source: Interview with person and family, staff, current team, LA PLUS

b. Discuss: Are there close friends or existing roommates who may wish to share supports? What type of people does he/she get along well with? Does he/she enjoy spending lots of time with others, or does he/she prefer to spend most time alone? What types of activities does he/she enjoy doing with others?

5. *Similar routines*:

a. Source: Interview with person and family, staff, current team.

b. Discuss: Does this person have a consistent morning and/or evening routine? Is this routine similar to one or more persons being considered? Are there income considerations - sufficient funding for the planned living situation or activities? Are there transportation considerations, including availability of accessible transportation?

6. *Common interests*:

a. Source: Interview with person and family, staff, current team, results of Personal Outcomes Assessment, LA PLUS

b. Discuss: Will the two or three participants most likely maintain shared supports for a consistent period of time? Do they have a relationship, or is there indication that one is likely to develop? Do they have clearly indicated common interests or a common goal? Have certain local activities, hobbies, or classes been identified which appeal to all participants sharing?

7. *Consistency in decisions:*

c. Source: Interview with person and family, staff.

d. Discuss: Is the person unpredictable? Does he/she often change his/her mind about planned activities at the last minute? How will this impact participants sharing supports with him/her? What will the team do to encourage the participant to indicate changes in preferences in an appropriate and timely manner?

H. To move forward with planning, the discussion must result in a recommendation from the IFS provider and support coordinator(s) that the roommate match may be accommodated by the IFS provider and is appropriate within service requirements for health and safety assurance. If not appropriate, then the discussion should move to any alternate(s) proposed by the participant. If there are no alternate(s) proposed, the support coordinator and IFS provider must complete action at Section

6.4, I. (below) and assist the participant to resume facilitated meetings and continue the selection process.

I. The respective support coordinator(s) communicates the outcome of the discussion with the participants involved. All communication must respect minimum necessary information and federal HIPAA privacy standards. No protected health information or other privacy-protected information may be shared. The participants indicate their final preference regarding who is to be their roommate. The support coordinator and team must work to resolve outstanding barriers and issues related to the proposed living circumstance, removing barriers where possible while ultimately preserving health and safety of participants involved.

1. The participant will choose with whom he/she will live. Neither the support coordinator(s) nor the provider may mandate roommate choice.

2. The IFS provider may state that the agency is unable to accommodate the roommate request. In this circumstance, the support coordinator(s) provide assistance to the participant(s) to locate another IFS provider that is capable of accommodating the roommate request. The support coordinator is obligated to assist the participant to address barriers to service access/delivery and must exert effort to do so.

3. Competent individuals of age have the responsibility to choose with whom they live. In the waiver service, participants are subject to the judgment of the support team and OCDD Regional Waiver Office regarding health and safety assurances. If a participant makes choices in opposition to required waiver assurances, then that participant risks disenrollment and discharge from the waiver service.

4. The OCDD maintains administrative authority to approve or deny support plans based upon health and safety assurances. Corrective action requests are made, with timelines to complete interventions. OCDD Regional Waiver Offices, OCDD Regional Offices/ Human Services Districts & Authorities, and the OCDD Central Office are responsible for participating in interventions, including assisting the participant to find ways to address barriers and identify other persons with whom to share supports. If interventions fail, the OCDD Regional Waiver Office

may take steps to disenroll the participant from the waiver service *(See Section 10.1 Disenrollment, Decertification, and Discharge Procedures.)*

J. If the team, inclusive of the participants' consent, reaches consensus, and roommates are identified, then participants who will live together as roommates must be named in Section III.B of the CPOC, "Current Living Situation: Information."

K.. The outcomes of the risk/benefit discussion must be documented in Section III.B of the support plan, "Current Living Situation: Information" and in Section III.C of the support plan, "Current Community Supports or Other Agency Involvement."

1. Documentation must comply with minimum necessary information and HIPAA privacy standards for protection of sensitive health information. For example, a plan may specify "Universal precautions are required," but may not state "Stacy's roommate Mary has hepatitis, so staff must use universal precautions."

L. Participants who live together as roommates and who agree to share supports must sign the Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW) (*Attachment 6.10.3).*

1. The Documentation of Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW) form provides release of information so that each participant's name(s) may be used in the support plan, progress notes, provider service plan, etc. of other individuals with whom one shares.

a. The support coordinator must explain participant rights according to HIPAA and protected health information (PHI). Participants may choose to reveal PHI to their roommates, but PHI will not be discussed in the roommate's team meetings or documented in the roommate's support plan.

b. A participant's roommate does not have access to his/her support plan unless the participant provides permission. A participant may provide permission for a roommate to receive a copy of the support plan by

completing the HIPAA 404P form (*Attachment 6.10.2).* He/She must check the "OTHER" box and specify "support plan" in the space provided.

2. The Documentation of Authorization *(Attachment 6.10.3)* explains that participants have a right to refuse or discontinue shared supports with their roommate(s). This right to refusal is conditional based on the following:

   a. Notification of the other participant(s) and support coordinator must be made 30 days prior to the requested effective date. This ensures adequate time to develop short and long-range planning for all participants impacted by the change.

   b. If a participant is at imminent risk, the shared situation may be discontinued immediately. All applicable reporting requirements must be followed.

   c. Not all requests for discontinuation may be granted in the timeframe requested, due to complications with legal agreements (marriage, lease agreements, judicial placements/orders), housing arrangements, or other health and safety concerns that would jeopardize waiver eligibility. The participant should be informed of any complications and assisted by his support coordinator and IFS provider to develop an appropriate and timely resolution. Persons who vacate the premises prior to resolving legal obligations may be subject to liability as a result of these obligations.

M. If family members of competent individuals of age voice objections regarding the roommate choice or plan elements for in-home supports, the support team should acknowledge appropriate concerns and ensure that any valid concerns are adequately addressed in the support plan.

1. Teams review the roommate risk/benefit discussion. If needed, the team should hold further team discussion to insure that all reasonable risks and valid concerns have been addressed appropriately. The support coordinator documents the required information in the support plan, making change updates (if plan not yet approved) or revisions as needed.

2. Plan elements and strategies must respect the competent individual's rights and the rights of the roommate, while meeting the programmatic requirements and assurances of the waiver program.

3. Examples of family objections:

   a. Anne has a history of changing her mind frequently. She has never had a roommate before and may not fully understand the commitment she is making, instead thinking that she can leave when she feels like it.

      i. *Strategy to address*: Involve Anne and her new roommate in choosing their apartment, selecting furnishings and decorations together, and moving in at the same time. (Responsible: IFS Provider and family) Provide ongoing education and reinforce points with Anne about the responsibilities of having a roommate. (Responsible: IFS Provider and family) Speak with Anne monthly about her roommate and what is working/not working. Ask her if she wants to continue living with her roommate. (Responsible: Support Coordinator)

   b. The family takes Frank on a one week vacation in the spring and home for the major holidays- Thanksgiving, Christmas, Easter, Fourth of July, Mother's and Father's day, and his birthday. We don't see this noted in his support plan or schedule. We are assuming that taking Frank home for a few days might interfere with his roommate's schedule for shared supports. Does this need to be addressed in Frank's plan and also considered by his roommate's team?

      i. *Strategy to address*: Update or revise Frank's support plan to include the planned natural support holidays. Firm up the exact dates and duration of the natural supports to finalize alternate schedule days for Frank. (Responsible: Support Coordinator) Speak with his roommate's team about Frank's anticipated holidays and the need for his roommate to utilize other sharing options, natural/community supports, or one-to-one hours, as appropriate. (Responsible: IFS Provider)

N. Plans for participants sharing supports among roommates are submitted at the same time (together) to the OCDD Regional Waiver Office. Each support coordinator (if different among roommates) is responsible for following the applicable timelines and process for submission of plans, whether the plan is an initial, annual, or revision. Support coordinators have a responsibility to maintain open communication with the other support coordinator involved to align their timelines and ensure that plans are submitted together.

O. Plans require review and prior approval by the same OCDD Regional Waiver Office staff.

P. In order to receive approval, plans must include:

1. Signed Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW) *(Attachment 6.10.3*). This form must accompany all plans involving roommates, regardless of whether the plan is an initial, annual, or revision;

2. Listing of all names of roommates in Section III.B of the CPOC, "Current Living Situation: Information" and documentation of discussion of risks and benefits in the same section (Plans must match up between participants.); and

3. Copies of budget sheets of all participants with whom the person may share as a roommate (Budget sheets and typical weekly schedules must match up between participants in terms of overnight shared hours, early morning, and late evening.).

Q. **Special instruction for those plans involving roommates during the 2009-2010 implementation year**: If one roommate's annual date is earlier than the other's and a roommate's plan is in the old CPOC format, the plan in the old format will require an addition/revision to Section III.B to comply with the plan review/approval requirements. Section III.B must be updated by documenting the outcome of the roommate risk/benefit discussion and the name of the participant's roommate(s). The typical weekly schedule, alternate schedule(s), and budget sheet must be updated/revised as appropriate.

R Even if roommates have the same support coordinator, joint team meetings are not recommended due to confidentiality concerns. At all times, confidentiality protections must be observed by both the support coordinator(s) and IFS provider agency.

6.5 NOW PROTOCOL FOR SUPPORT COORDINATION AND SHARING IFS SUPPORTS

A. It is recommended that participants sharing supports use the same support coordination agency if possible. This is not a requirement.

B. When the individuals have a common agency, OCDD encourages the agency administration to assess the appropriateness of a common support coordinator to maximize collaboration and coordination of supports.

C. When the individuals have different support coordination agencies or different support coordinators within the same agency, the expectation is that the support coordinators collaborate and coordinate services, including meetings, as appropriate and necessary.

D. The role of support coordinator includes completing assessments in the Discovery phase that assist in determining the appropriateness of shared supports and in planning for sharing opportunities. Assessments include:

1. SIS/LA PLUS,

2. Discovery Phase,

3. Initial planning for support needs (frequency and intensity),

4. Day activities planning,

5. Risk assessment, and

6. Setting the minimum adequate staff supports for each individual.

E. The support coordinator is the primary responsible party for identifying interests and preferred activities, routines, and preferences regarding shared supports (during Discovery) and documenting these in the support plan for implementation by the IFS provider.

F. The support coordinator is responsible for completing a risk assessment that takes into account shared supports. First, the determination must be made whether the participant may share supports at all, then the following:

1. Identify circumstances in which the participant can share supports,

2. Identify certain risk factors which may make the participant's sharing supports difficult in given situations,

3. Contextualize 1 and 2 above for team discussion according to instructions for team discussion of casual/everyday sharing (Section 6.3) and sharing with a roommate (Section 6.4), and

4. Facilitate discussion of risk assessment results and other assessment/Discovery information with the participant's team.

G. The support coordinator must focus the team on development of creative solutions and options that are consistent with preferences and support needs. This includes leading team discussion in creative ways of addressing preferences for use of IFS hours and mitigating risk (e.g., use of intermittent supports, assistive technology, equipment, or environmental modifications).

H. The support coordinator must assure the availability of ongoing opportunities (through the IFS provider) for making new friends and exploring new casual sharing partners or roommates, as desired.

I. The support coordinator works to maximize collaboration among support teams for persons considering/sharing supports.

J. The support coordinator must adhere to HIPAA and confidentiality requirements, and facilitate team members following established requirements.

K. Support coordinators are responsible for appropriate plan documentation and plan revision for shared supports prior authorization.

1. All shared supports hours are included in the budget sheet and require prior approval.

2. People who agree to share supports in casual settings have plan documentation as described in Section 6.3.

3. People who agree to share supports as roommates complete all steps described in Section 6.4.

6.6 ROLES AND RESPONSIBILITIES OF THE IFS PROVIDER WITH SERVICE DELIVERY OF SHARED SUPPORTS

A. NOW protocol does not require persons sharing supports to have the same support coordinator or support coordination agency. The commonality is the IFS provider. Thus a fair amount of responsibility lies with the IFS provider to assist with the initial and ongoing matching of participants who wish to share supports.

B. The IFS provider must offer opportunities for persons supported by the agency to meet each other. This facilitates matching participants to share supports in casual/everyday situations and as roommates. Formal and informal meetings hosted by IFS providers are for: (1) people coming into NOW and needing help locating persons to share supports with and/or (2) people already using NOW who want to explore sharing options.

C. IFS providers assist participants to use shared supports with person(s) of choice as specified in the support plan.

D. IFS providers should anticipate changes in casual/everyday sharing configurations, as participants' needs and preferences change. People may develop new friendships and relationships. Thus, the IFS provider must equip staff to effectively support multiple persons and changing configurations of sharing partners in home and community settings.

E. IFS providers must implement a process by which participants supported by their agency may make shared supports changes in a uniform manner.

4. Items covered in the process may include: roommate change, apartment/home change, staff changes, staff preferences, alternatives to be attempted before resorting to changing shared supports and schedules, etc.

5. The agency must be prepared to respond to questions and complaints about their process.

F. IFS providers must implement a continuing education program to keep participants informed of shared supports options.

1. The IFS provider must be able to provide answers to questions about changing roommates, changing schedules, emergencies, etc. within the scope of the IFS provider's agency. Also, people should learn from other participants who have tried different configurations of shared supports (e.g., sharing daytime hours with one person and evening/night supports with a roommate).

2. IFS providers must share general information about shared supports provided by OCDD.

G. IFS providers discuss at the initial planning meeting and following planning meetings the outcomes of facilitated meetings, discussions with the participant regarding preferences, and formal requests made by the participant. The IFS provider agency completes steps in the process discussed in Section 6.4 for assistance in choosing a roommate and completing planning for roommates.

H. IFS providers assist participants to track utilization of flexible hours and alternate schedule hours as described in Section 5.

6.7 ROLES AND RESPONSIBILITIES OF THE PARTICIPANT WHEN SHARING SUPPORTS

A. NOW participants assume the following roles and responsibilities when sharing supports:

1. Collaborate with one's IFS provider to meet other waiver participants and establish compatible sharing partner(s).
2. Provide ongoing feedback to his/her support coordinator and IFS provider about preferences with regard to participants with whom to share supports, as well as how he/she would prefer to share time with such person(s).
3. Agree to adhere to his/her typical weekly schedule.
4. Agree to terms of use of alternate schedule(s).
5. Make preferences known regarding choice of flexible hours use.
6. Agree to his/her responsibilities and timelines in regards to requesting changes to the typical weekly schedule (using flexible hours) as established in NOW policy, support coordination policy, and IFS agency policy.
7. Complete HIPAA/confidentiality release (Form 404P) for discussion of personal information in the support coordinator/IFS team meeting on roommates.
8. Sign Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW) *(Attachment 6.10.3)* with any roommate(s) listed in the approved support plan.

6.8 WHEN NOT TO SHARE SUPPORTS

A. There are some situations that are not conducive to sharing supports. The support coordinator must carefully assess the risks of sharing before proceeding.

B. The following list provides suggestions for situations in which sharing supports may exceed a reasonable level of risk. Individual cases that meet criteria below can be proposed as an exception through the Regional Waiver Office to the GPSORC for approval of shared supports.

1. An individual who has been a sexual offender.

2. An individual with high intensity aggressive episodes that have resulted in injury or were life-threatening (particularly if directed towards a roommate) in the past.

3. An individual with a diagnosis of paranoid schizophrenia, anxiety disorder, or autism who exhibits a strong avoidance of social contact or has a history of significant altercations or injury to roommates.

4. A person who has been a victim with a person who has a history of victimizing others.

5. An individual with a significant wandering/elopement history that necessitate staff search and chase for extended periods of time (unless there is another mechanism for locating the missing roommate).

6. An individual with a Borderline Personality Disorder diagnosis with significant history of false accusations or difficulty getting along with roommates.

7. An individual with a highly infectious medical condition with someone else who requires extensive supports as well.

8. Other situations and/or conditions which may preclude sharing supports.

C. If a participant is unable to share supports when his/her recommended IFS hours include shared supports, the support team requests an exception with justification. The support coordinator prepares and submits a justification that is unique to the participant and directly tied to needs that distinguish the participant from others in their level membership.

1. Status is reviewed at least quarterly or more frequently with a significant change in the participant's circumstances.

2. Sections 5.7 to 5.9 provide more information about justifying the need for additional IFS hours.

6.9 USING INTERMITTENT SUPPORTS

A. Participants sharing supports at home are required to be present within the same residence, house, or apartment. For people who do not have a roommate, sharing supports overnight and at early morning and late hours within the Resource Allocation System may be challenging. In these cases, intermittent supports may be programmatically appropriate.

B. Intermittent supports are non-continuous paid supports delivered in appropriate time increments, ranging from 15 minutes to an hour. The direct support worker is not physically present for a continuous period of time, but rather comes in and out of the home or community setting in prescribed time increments.

C. Support teams must discuss risks and benefits associated with using intermittent supports and record the discussion outcome in the support plan (CPOC Section III.B). Teams should focus on supporting participants to be as independent as possible, while also assuring health and safety. Reasonable risk is an expected part of utilizing intermittent supports. Technology, natural supports (such as neighbors), or creative alternatives to mitigating risk may be utilized.

D. Support plans (CPOC Sections VI and IX) and billing are required to reflect appropriate use of intermittent supports.

E. In the event of nearness of residences (apartments in the same complex), supports delivered in home may be intermittent coupled with shared instances when persons do things together, like watch TV or share a meal. The following example provides a scenario of intermittent supports coupled with shared supports:

Intermittent Supports Coupled with Shared Supports Example:

Sally and Ann live next door to each other. Sally and Ann use the same IFS provider and receive intermittent supports in the morning to get ready for

work. The staff person visits Sally at 6:30 AM to wake her up and prompt her to brush her teeth and dress. The staff person prepares breakfast and leaves it on the table for Sally. At 7:00 AM, the staff person visits Ann to do the same. At 7:30 AM, the staff person checks back with Sally to ensure that she is ready to go to work. At 7:45 AM, the staff person checks with Ann to make sure she is ready to go to work. Sally and Ann leave together with their staff at 8:00 AM to go to the lobby of their apartment building and wait for the bus, which usually comes between 8:15 AM and 8:30 AM.

Scheduling Intermittent and Shared Supports

	Sally	Ann
6:30 AM	S5125 U1	--
6:45 AM	S5125 U1	--
7:00 AM	--	S5125 U1
7:15 AM	--	S5125 U1
7:30 AM	S5125 U1	--
7:45 AM	--	S5125 U1
8:00 AM	S5125 U1, UN	S5125 U1, UN
8:15 AM	S5125 U1, UN	S5125 U1, UN

6.10.1 Shared Supports Brochure

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS | Public Information Series

Sharing Supports in Waiver Services

Choices in Community Living

Office for Citizens with Developmental Disabilities
628 North Fourth Street, P.O. Box 3117
Baton Rouge, LA 70821-3117
Phone: 1-866-783-5553
Fax: (225) 342-8823
Email: OcddInfo@dhh.la.gov
Web site: www.ocdd.dhh.louisiana.gov

Sharing supports works for us!

Wayne shared an apartment with two friends for 4 years. After his friends moved closer to their families, Wayne looked for another roommate. His friend from his old community home, also named Wayne, was considering waiver services. Wayne and Wayne, along with their families, met to talk about living together. Although they have 20 years' difference in age and don't share a common routine, they have enjoyed living together for the past 7 months. Wayne is retired and stays home with staffing all day. His roommate works. They share staffing in the evenings and nights and enjoy a quiet and relaxed night life. Sharing expenses allows them to do many activities on the weekends. They often go places independently due to preferences.

Georgia moved into her own apartment 4 years ago. But one year later, she decided to move into a much larger apartment with a neighbor and friend, Florance. They share living expenses and evening/night supports. The ladies each chose staff for daytime supports. Georgia says, "I picked the people I wanted, and the lady, she picked who she wanted. So that made it a loveable place to live!" Georgia works in the afternoons, while Florance works earlier in the day. Georgia has decorated her home, making it "beautiful." Georgia says, "I love it a lot."

Brenda and Angelique were friends while living in an ICF/DD. They have lived for almost 3 years in a house with a yard, a dream of Angelique's. The house is in a nice neighborhood near family. Sharing expenses helped, but they wanted more flexible finances. After talking to their provider, they decided to invite Sheila to live with them. Each has her own bedroom, but they enjoy decorating and spending time with each other in the common areas, like the living room and kitchen. Two staff support them during the day, and one at night. Brenda and Angelique work in different places, while Sheila attends a habilitation program during the week.

Facts about Shared Supports

Sharing supports is a choice! As a waiver recipient, you may choose to share supports in a way that meets your needs and preferences.

Sharing supports doesn't always mean having a roommate. You may have the same routine or interests as a friend and want to share staffing and maybe even transportation supports for specific activities/times.

- Traveling together cuts down on transportation costs.
- Creative staffing options are available. For example, if neighbors plan to watch football each Saturday in the fall, they can share a single staff in that home during the games. At night, each person goes home with their own staff support.

Everyone sharing supports must have the same Individual and Family Support Provider.

Shared Supports are available in the *New Opportunities Waiver (NOW) in the Individual and Family Support service only.* Up to three people may share supports within a single home or during specific activities/times.

The Residential Options Waiver (ROW) is a new waiver coming out in late 2009. ***ROW offers shared supports in a variety of residential settings.*** Ask your local community service office for more information about ROW's shared supports options.

LOUISIANA Department of HEALTH and HOSPITALS
Office for Citizens with Developmental Disabilities

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For more information visit: www.ocdd.dhh.louisiana.gov or call 1-866-783-5553

Benefits when Sharing Supports

Companionship

Friendships help keep people emotionally and physically healthy.

- Having a friend to talk to
- Not being lonely
- Having a friend to do fun things with, like going shopping or to the movies
- Knowing someone who cares about you is at home waiting for you

Relationships challenge people to try new things and grow.

- Learning new things with someone
- Sharing ideas and interests with someone

Sustaining a healthy partnership leads to relationship skills building and making more friends.

- Having a friend to go with to an event or new group and help break the ice with others
- Learning how to communicate thoughts, feelings, and wants with peers
- Building self-esteem and confidence
- Enjoying events with peers while the group is accompanied by fewer paid staff

Safety

Extra help in time of need may include calling for help in emergencies

- Reducing vulnerability to crime by being in a pair or group

Links to others may offer additional back-up supports.

- Accessing the family and friends of your roommate who may assist in time of need
- Enrolling neighbors to participate in emergency training and offer help in time of need

Standard of Living

Sharing expenses means more flexibility.

- Living in a nicer apartment or home with two incomes contributing to expenses
- Having more money left over after living expenses for fun, including shopping, travel, vacation, and other choice activities.

Sharing expenses may be a step toward more independence.

- Learning how to budget and manage money while having another income to assist with costs
- Building credit for the future
- Having more money left over after living expenses to save toward purchase of your own home or desired items to furnish an apartment.

Your Routine & Privacy

Sharing supports does not mean that you have to do things with your roommate all the time. You may have family, friends, or natural supports that you wish to do things with independent of your roommate. Waiver services allow for alternate schedules and flexibility.

You have a right to privacy and confidentiality of your support plan and medical information. Your roommate will only know things about you that you or your family choose to talk about.

You may also choose to end the shared supports if they do not work out for you or your roommate. This will involve changes to your Individual Support Plan and may also involve other changes, such as a move. Talk to your support coordinator about this.

Talking to your Support Coordinator & Provider about Shared Supports

Tell your support coordinator and provider that you are interested in sharing supports with another person. Talk about the kind of person (people) you might like to share with.

Talk with your support coordinator and provider about the benefits and potential risks for you in a shared supports situation. Talk about things that may be good for you, as well as things that may not be good.

Let your support coordinator and provider know if you think you might like a roommate or if you think you would like to share supports for some specific times and activities. If you would prefer to share only for specific times and activities, tell them details about how you would like the shared supports to work.

If after talking about it, you think you want to pursue shared supports, request that your provider help you to explore interest with other people who use your provider.

Finding the right Person to Share Supports with

- Consider friends whom you see often and share some common interests.
- *Explore the interest of neighbors already living in your apartment complex or subdivision.*
- Consider people that you see frequently at similar community events or who belong to the same clubs or organizations.
- *Request that your provider talk to other people using their agency and find out if someone else is interested in sharing supports and/or being roommates.*
- If you are moving from an ICF/DD, explore interest in sharing supports and/or being roommates with other people who are moving.
- *Remember that you can also share supports for specific activities/times, even if you do not have a roommate.*
- As your needs and interests change, you can always make the decision to stop sharing supports or to share with a different person.

6.10.2 HIPAA 404P

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID # or Social Security #:

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

❒ **TO RELEASE Information TO** **OR** ❒ **TO OBTAIN Information FROM**
(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians

❒ Research related treatment ❒ Creating health information for disclosure to a third party.

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒ Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____

For Agency Use When Requesting Records
I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____
Signature and Title of Agency Representative Date

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Issued 4/14/03

6.10.2 HIPAA 404P

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, we may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, we will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DHH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DHH.

You may cancel an authorization in writing at any time. We can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.

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6.10.3 Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW)

DOCUMENTATION FOR AUTHORIZATION OF SHARED STAFF AND RELEASE OF INFORMATION FOR NEW OPPORTUNITIES WAIVER (NOW)

This form must be completed for roommates sharing supports in the NOW.

We the undersigned participants of the New Opportunities Waiver (NOW) hereby agree to utilize shared supports as identified on our support plans:

SERVICE	PROVIDER AGENCY
Individualized and Family Support-Day	
Individualized and Family Support- Night	
Community Integration Development	
Skilled Nursing Services	

We further understand that we have the right to refuse this service and discontinue our shared support at any time, but if we wish to do so, we must notify the other participant(s) with whom services are being shared, and our Support Coordinator, in writing within 30 days.

We understand that if there is an imminent risk situation, that this agreement may be discontinued immediately with the assistance of our Support Coordinator.

We give permission for our names to be used in the support plan, progress notes, provider service plan, etc. of the other individuals with whom we will share. These individuals are named in our support plans and on the Participant Signature Page.

We understand that permission to release this information may be canceled at any time in writing, but the cancellation will have no effect on information that has already been released.

NOTE TO SUPPORT COORDINATORS:

This signed authorization must accompany submission of each individual's support plan documentation, including the budget page, to the OCDD Regional Waiver Office.

Support plans for persons who share NOW services must be reviewed at the same time by OCDD Regional Waiver Office personnel. Thus, support plans and plan revisions for all persons sharing must be submitted concurrently.

March 23, 2009 DRAFT

6.10.3 Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW)

DOCUMENTATION FOR AUTHORIZATION OF SHARED STAFF AND RELEASE OF INFORMATION FOR NEW OPPORTUNITIES WAIVER (NOW)

PARTICIPANT SIGNATURE PAGE

Page ____ of _____

NOW Participant's Name (Print):	DOB:

_____ _____
Signature of NOW Participant or Authorized Representative Date

_____ _____
Signature of Support Coordinator Date

Support Coordination Agency:_____

NOW Participant's Name (Print):	DOB:

_____ _____
Signature of NOW Participant or Authorized Representative Date

_____ _____
Signature of Support Coordinator Date

Support Coordination Agency:_____

NOW Participant's Name (Print):	DOB:

_____ _____
Signature of NOW Participant or Authorized Representative Date

_____ _____
Signature of Support Coordinator Date

Support Coordination Agency:_____

March 23, 2009 DRAFT

7

SUPPORT PLAN APPROVAL PROCESS

7.1 Supervisory Review

7.2 OCDD Regional Waiver Office Review

7.3 OCDD Guidelines for Planning State Office Review Committee

7.4 Attachments

7.4.1 Individual Supports Review (ISR)

SUPPORT PLAN APPROVAL PROCESS

In order to assure that the "Guidelines for Support Planning" are implemented consistently for all individuals receiving NOW services, OCDD has restructured the support plan approval process.

The approval process is built on a three-tiered review and approval system. The review is based upon criteria detailed in the Individual Support Review Protocol *(Attachment 7.4.1).*

1. Review and approval by the support coordinator supervisor to assure plan compliance with established criteria and provide ongoing supervision, feedback, and training to all Support Coordinators.

2. Review by the OCDD Regional Waiver Office to assure that all CMS and OCDD requirements are met and that health and safety can be assured.

3. Review by the OCDD Guidelines for Planning State Office Review Committee when exceptions to recommended IFS hours are requested, when any element of a proposed plan is appealed, when the participant's plan indicates significant risk issues as determined by the committee, when the participant's SIS/LA PLUS indicates an outlier or atypical score profile, and upon request.

4. Review by the OCDD Regional Waiver Office and the OCDD Guidelines for Planning State Office Review Committee to certify support coordinators and supervisors in use of the "Guidelines for Support Planning."

Attachment 4.4.1 contains details of timelines for initial support planning, including timeframes related to the support plan submission and approval process.

7.1 SUPERVISORY REVIEW

A. Upon completion of the support plan, the support coordinator submits the plan to his/her supervisor for review and approval. Support coordination agencies must work internally to complete this review within the timeframes required for plan development (See Section 4 and *Attachment 4.4.1*).

B. The support coordinator supervisor reviews the plan using the Individual Supports Review (ISR) Protocol (*Attachment 7.4.1*). For each item, the supervisor uses the guidelines within the ISR to determine the rating for each item and places a mark in the appropriate column for the rating.

C. The table on the last page of the ISR is completed after all items are scored. ALL REQUIRED items must achieve a compliance rating, and 85% of the remaining items must achieve a compliance rating for the plan to be recommended by the supervisor to the OCDD Regional Waiver Office for approval. Plans are submitted for approval to the OCDD Regional Waiver Office only after the supervisor verifies the plan meets the compliance criteria.

D. ISR protocol required items are items that must be fully described and addressed prior to approval of any plan. These items tend to focus on significant issues for the person, Centers for Medicare and Medicaid Services (CMS) requirements, and health and safety concerns. If these items are not completely addressed, there will likely be negative consequences for the individual.

E. ISR protocol non-required items are also important. They must be addressed at least to some degree in the plan, but often reflect issues that are developmental in nature and can be shaped for each individual over time. The more these items are addressed, the greater the likelihood for significant positive outcomes for the participant. There is not likelihood for negative consequences if these items need improvement.

F. ISR protocol required areas not scored as in compliance must be corrected by the support coordinator prior to submission to the waiver regional staff. Once corrected

the supervisor notes the correction and changed rating on the Individual Supports Review.

G. For items on the ISR that are not noted as required, the supervisor provides feedback, including feedback received from the OCDD Regional Waiver Office as described in Section 7.2, and suggestions to the support coordinator for improvement.

1. Improvements that can be completed quickly or are determined by the supervisor to be essential to other plan issues are completed prior to submission to the waiver regional staff.

2. The remaining items can be shaped and corrected over time with actions in the support plan where appropriate. For these remaining items, the supervisor provides notes about the corrections and plans on the Individual Supports Review.

H. If during ISR review, the support coordinator supervisor discovers a significant oversight or error in the SIS/LA PLUS ratings pertaining to medical or behavioral support needs, the supervisor will require that the support coordinator send a written request to the SIS Project Office requesting permission to alter the relevant ratings.

1. The written request should include specific and compelling justification for the request to alter assessment ratings based on available information about the person.

2. The request should reference exactly which items/ratings the support coordinator is requesting be altered.

3. The request should reference the source of the information suggesting the rating(s) should be altered.

4. Examples of when alterations might be requested include:

   a. Failure to note in SIS section 3A a medical support issue, and there is clear evidence that this support need exists and should have resulted in different ratings.

      i. *Example 1*: During SIS assessment, it was not reported that the person has diabetes. The medical diagnosis was discovered in reviewing medical records, and it was noted that in addition to being on medication, the person is on a special diabetic diet and that support is required for such.

      ii. *Example 2*: During SIS assessment, the assessor was not made aware that the person has occasional asthma attacks. It is later reported during Discovery that the person requires inhaler treatments from time to time, and staff must closely observe for asthma symptoms during the winter months, particularly when he goes outdoors into the cold or when he exercises in the cold. The parent recalls an incident last year when failure to do this led to an attack.

   b. Failure to note in SIS section 3B a behavioral support issue and there is clear evidence that this support need exists and should have resulted in different ratings.

      i. *Example 1*: During SIS assessment, it was not reported that the person has mental health treatment support needs. During Discovery, the support coordinator discovers that the person has had two previous psychiatric hospitalizations and currently receives ongoing preventative environmental or therapeutic supports to minimize recurrence of psychiatric symptoms.

      ii. *Example 2*: During SIS assessment, it was not reported that a person has, in the past, engaged in episodes of stealing from various stores. It is later reported by the family that, while there have been no episodes

of stealing in the past year, it is because they never take their son to stores; thus, he has not had the opportunity to steal.

5. After the written request has been submitted, the SIS/LA PLUS Project Office will:

   a. Request the Support Coordinator submit a revised assessment,

   b. Request additional justification for the alteration of ratings, or

   c. Instruct the Support Coordinator that the new information does not warrant revising the assessment.

6. If the SIS/LA PLUS Project Office requests the assessment be revised, revision should be submitted to the SIS/LA PLUS Project Office within 3 working days of the request.

I. If during the CPOC review, the Support Coordination Supervisor believes that there are general fundamental rating errors in the SIS/LA PLUS with regard to the support needs of the individual, errors that extend beyond specific medical and behavior support items addressed in section H above, the support coordinator should follow procedures outlined in section 7.3 of this manual relative to requesting review of the assessment and plan by the Guidelines for Planning State Office Review Committee.

1. *Example*: The person has a severe or profound intellectual disability and receives a level of 1A. Upon reviewing ratings in Section A of the SIS, it appears that the assessor grossly underscored Frequency and Daily Support Time support needs. In this example, procedures in section 7.3 should be followed.

7.2 OCDD REGIONAL WAIVER OFFICE REVIEW

A. Following completion of the plan by the support coordinator, the support plan and the supervisory review consistent with Section 7.1, along with all required documentation and assessments, are sent to the regional waiver staff for review and approval prior to implementation of the plan. Required documents and assessments include:

1. Supports Intensity Scale and Louisiana Plus (SIS/LA PLUS),
2. 90-L,
3. Behavioral assessment for individuals with behavior plan,
4. Psychiatric evaluation for individuals receiving psychotropic medication,
5. Most recent support plan and last year's worth of quarterly reviews from the Supports and Services Center if moving from a Supports and Services Center,
6. Any other assessments/documents used in the planning process, and
7. If the request is for an exception, permanent or temporary, to the Louisiana Resource Allocation System hours, a written justification for the exception including other options explored and the expected period of time the exception will be required.

B. Upon receipt of the support plan, the Assistant Community Services Regional Administrator assigns a waiver regional staff member to complete the approval process.

C. The assigned regional waiver staff reviews the plan using the Individual Supports Review (ISR). Plans are reviewed within ten (10) working days of submission of the plan and required documentation. For each item, the staff member uses the guidelines within the ISR to determine the rating for each item and places a mark in the appropriate column for the rating according to protocol established on the ISR.

D. The table on the last page of the ISR is completed after all items are scored. In order for a plan to be approved, ALL REQUIRED items must achieve a compliance rating and in addition, 85% of remaining items must achieve a compliance rating.

E. The assigned regional waiver staff compares his/her ratings to the submitted support coordination supervisor ratings. Reliability of the ratings between the support coordinator supervisor and the OCDD Regional Waiver Office staff are

calculated by dividing the number of items in agreement by the total number of items.

F. The OCDD Regional Waiver Office staff maintains documentation of the following components of the review and approval process:

1. name of the support coordinator,

2. name of the support coordinator supervisor,

3. name of the OCDD Regional Waiver Office staff completing the review,

4. name of the participant,

5. date of support plan,

6. date of linkage,

7. date of submission,

8. date of review,

9. approval status,

    a. approved,

    b. approved with recommendations,

c. approved for 90 days,

d. returned for corrections,

10. date returned with corrections (if applicable),

11. date approved,

12. initial ISR scores, and

13. ISR scores at time of approval.

G. If the plan indicates needs for review, the plan and supporting documentation is forwarded to the OCDD Guidelines for Planning State Office Review Committee as described in Section 7.3.

H. If during ISR review, it is the opinion of the OCDD Regional Waiver Office that a significant oversight or error in SIS/LA PLUS ratings of medical or behavior support needs has occurred, the assigned regional waiver staff should instruct the support coordinator to 1) make revisions to the assessment, 2) submit revisions to the SIS/LA PLUS Project Office, and 3) send with revisions a written request to the SIS/LA PLUS Project Office requesting consideration that the revised assessment be submitted to the database. See Section 7.1.H.4 for examples of when alterations may be requested.

1. The written request should include specific and compelling justification for why ratings were revised based on specific available information about the person.

2. The request should reference exactly which items/ratings the support coordinator has altered.

3. The request should reference the source of the additional information suggesting the rating(s) should be altered.

I. The support coordinator should make revisions only at the instruction of the assigned OCDD Regional Waiver Office staff.

J. Revisions and justification should be submitted to the SIS/LA PLUS Project Office within 10 working days of the request by the OCDD Regional Waiver Office.

K. After the written request has been submitted by the support coordinator, the SIS/LA PLUS Project Office will:

1. Submit the revised assessment to the database and if necessary provide the support coordinator with a new Level. The revised assessment will replace the previous assessment only after the SIS/LA PLUS Project Office has verified that the revisions were warranted,

2. Request from the support coordinator additional justification for the revised assessment, or

3. Notify the support coordinator that the new information does not warrant revising the assessment.

L. If during the CPOC review, the assigned OCDD Regional Office Waiver staff believes that there are general fundamental rating errors in the SIS/LA PLUS with regard to the support needs of the individual, errors that extend beyond specific medical and behavior support items addressed in Section 7.1.H.4, the procedures outlined in section 7.3 of this manual relative to requesting review of the assessment and plan by the Guidelines for Planning State Office Review Committee should be followed.

Example: The person has a severe has a severe or profound intellectual disability and receives a Level of 1A. Upon reviewing ratings in Section A of the SIS, it appears that the assessor grossly underscored Frequency and Daily Support Time support needs. In this example, procedures in section 7.3 should be followed.

7.3 OCDD GUIDELINES FOR PLANNING STATE OFFICE REVIEW COMMITTEE

A. OCDD developed the Guidelines for Planning State Office Review Committee (GPSORC) and process to perform oversight functions required for implementation of the "Guidelines for Support Planning." The committee's duties include:

1. Review of support plans for each support coordinator and supervisor following the "Guidelines for Support Planning" training in accordance with OCDD quality review protocols;

2. Review of plans that request hours above the IFS hours recommended for the individual's acuity level, including requests for temporary changes, phase-in to the guidelines and permanent changes;

3. Review of plans and SIS assessments that show atypical score profiles and potentially signify outliers to the Resource Allocation Model;

4. Review and recommendation of changes to the "Guidelines for Support Planning"; and

B. <u>Committee Membership</u>

1. The OCDD Guidelines for Planning State Office Review Committee is chaired by the OCDD Associate Clinical Director, the Clinical Director, or designee. Committee members include:

   a. NOW Program Manager,

   b. OCDD Central Office Staff as determined by the Assistant Secretary,

c. A member of the SIS/LA PLUS Project Office,

d. Assigned OCDD Regional Waiver Office staff in the region submitting the plan or requesting an exception (Assistant Community Services Regional Administrator, Regional Office Specialist, and assigned regional office waiver staff),

e. Designated Supports and Services Center (SSC) staff for individuals moving from an SSC (Clinical Director or other designated staff as determined by the Administrator), and

f. A self-advocate

C. Process and Procedure

1. An initial person-centered plan is completed for all individuals using the support plan and process discussed in Sections 3 through 6.
2. The plan is forwarded to the OCDD Regional Waiver Office for review and approval according to current approval process. The plan is reviewed consistent with Sections 7.1 and 7.2.
3. The Assistant Community Services Regional Administrator (CSRA) forwards plans needing GPSORC discussion to the OCDD Associate Clinical Director within one working day of receiving the plan. The following additional information must accompany each plan and budget:
   a. Supports Intensity Scale and Louisiana PLUS (SIS/LA PLUS),
   b. 90-L,
   c. Behavioral assessment for individuals with behavior plan,
   d. Psychiatric evaluation for individuals receiving psychotropic medication,
   e. Most recent support plan and last year's worth of quarterly reviews from the Supports and Services Center if moving from a Supports and Services Center,
   f. Any other assessments/documents used in the planning process, and
   g. If the request is for an exception, permanent or temporary, to the Louisiana Resource Allocation System hours, a written justification for the exception including other options explored and the expected period of time the exception is required.
      i. If there is a concern that there may be a problem with the assessment (e.g., there has been a significant underestimation of the individual's

support needs), then the written justification should note specific concerns/issues with the assessment. The written justification may reference supporting information or documentation.

ii. If the concern with the assessment is discovered after the SIS has been accepted to the SIS database and AFTER the plan has been written, then the assessment, the plan, and any other written justification and supporting documentation demonstrating inaccuracies with the assessment should be submitted to the GPSORC.

iii. If the concern with the assessment is discovered after the SIS assessment has been accepted to the SIS database but BEFORE the plan is written, then the assessment and all written justification and supporting documentation demonstrating inaccuracies must be submitted to the GPSORC before the plan is written. This is to insure that the review and corrections to the assessment (if judged to be warranted by the GPSORC) can proceed with minimal delays.

iv. If there has not been a significant underestimation of the individual's support needs, but rather more isolated medical or behavior support needs were incorrectly rated and there is clear and compelling evidence that the support need was missed, procedures noted in Sections 3.2., 7.1, and/or 7.2 should be followed. As noted in these sections, requests to revise isolated medical or behavior rating problems should be forwarded directly to the SIS/LA PLUS Project Office and do not warrant GPSORC review. Examples of isolated medical or behavior rating problems are included in Sections 3.2.O.4 and 7.1.H.4.

4. The GPSORC forwards the plan and/or assessment (and accompanying documentation) to the committee members with notice of review scheduled for the next GPSORC meeting.
5. The committee is scheduled to meet every week. All reviews must be completed within five working days of receiving the plan.
6. The committee completes a review using the Individual Supports Review Checklist as described in the previous two sections (*Attachment 7.4.1*).
7. The committee makes one of the following recommendations relative to the assessment:
   a. The assessment is adequate considering newly presented information (It adequately captures the support needs of the individual in areas of general, medical, and behavioral supports.);
   b. The assessment contains minor inaccuracies but does not result in inaccurate level membership, does not substantially alter the support plan, and does not negatively impact allocated resources (Some information on the SIS/LA PLUS needs to be adjusted in collaboration with the support coordinator after considering newly presented information.);
   c. The assessment results do not adequately reflect the needs of the person.
      i. If is it determined from the review process that the assessment inadequately captured the individual's support needs (e.g., the assessment over predicts or under predicts the support needs of the

individual and/or fails to capture important general, medical, or behavior support needs), then a new SIS/LA PLUS needs to be completed.

ii. The support coordinator is informed of the areas of suspected deficiency in the assessment and asked to schedule another assessment of the individual within three days of announcement of the decision in the matter.

iii. Once completed, this new assessment is submitted to the SIS/LA PLUS Project Office for review and level assignment. After the support coordinator is informed of the results and level assignment, he/she is to begin revising the support plan based on the revised assessment data and other recommendations from the committee.); or

d. More information is needed before a determination can be made (The support coordinator is responsible for gathering and forwarding the information to the GPSORC for determination.).

Note: Because the SIS requires specialized training and certification to administer and score, it will not be subject to appeal after the reviews noted above.

8. The committee makes one of the following recommendations relative to the plan:
   a. The plan meets the individual's identified needs and outcomes, and no alternate strategies exist to meet the identified needs and outcomes (If additional hours have been requested, then the hours are approved. Approved hours are time limited, and the Committee specifies the timeframe for the approval.);
   b. The plan meets the individual's identified needs and outcomes, but strategies exist that should be considered by the support team (If additional hours have been requested, then they are not approved, and recommendations for modifications are forwarded to the support team.); or
   c. The plan does not meet the individual's identified needs and outcomes (Specific recommendations regarding plan supports in excess of need, unaddressed needs and unaddressed outcomes are forwarded to the support team.).
9. The recommendation is forwarded by the committee chair (or designee) to the OCDD Regional Waiver Office and support coordinator within two working days of the decision.
10. The recommendations are addressed and implemented by the individual's support team with assistance from the OCDD Regional Waiver Office as needed. When there are questions, concerns or alternate proposals to the recommendations, the support team, led by the support coordinator, discusses options with the OCDD Regional Waiver Office waiver staff.

11. A response addressing the recommendations is forwarded through the OCDD Regional Waiver Office to the committee chair within specified timelines determined in the review.
12. Each month the GPSORC submits a report to the OCDD Quality Improvement Committee and OCDD Executive Management Team regarding the following:
    a. Number of plans reviewed,
    b. Percentage of plans meeting Individual Supports Review requirements,
    c. Percentage of plans meeting support needs within the IFS hours allocated,
    d. Percentage of plans meeting supports needs but requiring additional IFS hours,
    e. Total number of approved hours above the IFS hours allocated (Monthly and Year to Date) by Level and living arrangement,
    f. Summary of the factors justifying the approval,
    g. Percentage of plans for which alternate programmatic options could be explored,
    h. Types of alternate options proposed, and
    i. Reasons for eliminating possible alternate options

D. Notification to Initiate Services:
1. The GPSORC Chair electronically sends notice, including information about IFS hours approved above the maximum recommendation for the participant's level, to SRI and the OCDD Regional Waiver Office within one working day of plan approval.

Attachment 7.4.1 Individual Supports Review (ISR)

INDIVIDUAL SUPPORTS REVIEW PROTOCOL

Please print the name of the SC completing the plan, the date of this review, the name of the person whose plan is being reviewed, the name of the SC agency and the name of the IFS provider.

CPOC COMPLETED BY: _____ REVIEW DATE: _____

PERSON'S PLAN UNDER REVIEW: _____ SC Agency: _____ IFS Provider: _____

For each item check the appropriate compliance rating using the following guidelines and specifics noted for each item:

- Compliance = ALL of the information required is present and there are NO REQUIRED changes.
- Partial Compliance = SOME BUT NOT ALL of the information required is present and there are REQUIRED changes.
- Non-Compliance = NONE of the required information is present.

I. TIMELINES/DISCOVERY INFORMATION	Comp	Partial	Non-Comp	Approval Instructions
a. SIS/LAPlus is completed prior to linkage (NOW/ROW) OR no later than 14 days prior to the annual CPOC meeting. (SIS/LAPlus must not be more than 90 days old at the planning meeting.) NOTE: For designated offers only in FY 08-09 • **SIS/LAPlus must be completed and passed through initial review by SIS/LAPlus Project Team for a plan to be approved** *Rating Instructions:* ***Compliance** ratings apply to assessments with no inconsistent information within the SIS/LAPlus itself and no more than 90 days old.* ***Partial Compliance** should be scored when the assessment(s) are greater than 90 days old OR inconsistencies are identified within the assessment(s) itself.* ***Noncompliance** only applies if the assessment is not completed.*				**Approve unless > 90 days old**
b. Personal outcomes assessment is completed prior to the CPOC with summary pages included (For the annual CPOC, Discovery information must not be more than 90 days old at the planning meeting.) • **Personal Outcomes worksheets must be completed and attached to the plan for a plan to be approved** *Rating Instructions:* ***Compliance** ratings apply to assessments with specific information included for each area, clearly identified personal goals important to the individual and no more than 90 days old.* ***Partial Compliance** should be scored when the worksheets are greater than 90 days old or the information is not adequate to address the questions and identify areas of interest/need or inconsistencies are identified between the worksheets and the plan or other documents.* ***Noncompliance** only applies if the worksheets are not completed.*				**Approve unless > 90 days old**
c. Needed/required assessments are completed and reviewed prior to the CPOC meeting.				**Approve unless 90-**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

• **90L** (& any other available medical assessments) • Psychological/Psychiatric (if diagnosis, medication or behavior plan – **Must be present for all individuals assigned to level 6 prior to approval; for individuals assigned to level 4 a determination will be made on an individual basis following review of information**) • Previous plans from other programs (i.e., SSCs, private ICF, school, etc.) *Rating Instructions:* ***Compliance** ratings apply when all needed/required assessments are completed for the participant prior to the planning.* ***Partial Compliance** should be scored when any of the required assessments are not completed prior to the planning or if a needed assessment is not completed and there is no plan within the support plan to address it,* ***Noncompliance** only applies if none of the required assessments are completed.*				**L or Psych. (if BSP) is missing**
d. CPOC developed within the specified time frame following linkage (NOW/ROW); 275-365 days after previous plan (annual plans in all services). *Rating Instructions:* ***Compliance** ratings apply if time requirement is met* ***Partial Compliance** does not apply.* ***Noncompliance** only applies if the timeframe is not met.*				NA
e. All appropriate team members (most importantly the individual and his or her identified family and friends) were present at the CPOC planning (see signature sheet if not at meeting). *Rating Instructions:* ***Compliance** ratings apply when all individuals required and needed are present.* ***Partial Compliance** should be scored when identified but not routinely required members are absent (i.e., person lives with mom who is not legal guardian but mom is included in plan as a responsible person)* ***Noncompliance** only applies if required members are not present.*				**Approve unless required members (Individual, guardian, authorized representative, SC, provider representative) were not present**
II. INTEGRATED ASSESSMENT (Sections I-IV)	**Comp**	**Partial**	**Non-Comp**	**Approval Instructions**
a. **Demographics sheet is completed (Information about living setting, mobility skills, providers, and diagnoses should be consistent with SIS/LAPlus)** • **Personal information (i.e., address, ethnicity, gender, date of birth, etc) must be correct and consistent across documents** • **Primary and secondary diagnoses should make sense compared to other assessments** • **MR/adaptive level must be noted and consistent with assessments** • **Individual's ability to respond to emergencies must be consistent with the SIS/LAPlus** • **Living situation must be accurate** *Rating Instructions:* ***Compliance** ratings apply to plans with all required information present and accurate* ***Partial Compliance** should be scored some of the information is present and accurate.*				**Approve unless checked partial or noncompliance**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

Noncompliance *only applies if no demographic sheet is completed or all information is inaccurate.*				
b. **If the individual's legal status is interdicted, continuing tutorship, or power attorney then a copy of the legal document denoting status is required.** *Rating Instructions:* ***Compliance*** *ratings apply if the legal documentation is present or is not required (i.e., competent major)* ***Partial Compliance*** *does not apply to this item.* ***Noncompliance*** *only applies if the documentation is not present or legal status is inaccurate.*				**Approve unless checked partial or noncompliance**
c. **Emergency information is completed** • **Emergency contacts are identified with accompanying addresses and phone numbers** • **Emergency information, plans, equipment have noted locations within the home** • **Providers are identified with phone numbers and specialties noted consistent with the assessments (or a note about reason for inconsistency is provided).** *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate* ***Partial Compliance*** *should be scored when some of the information is present and accurate* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				**Approve unless checked partial or noncompliance**
d. The health status section is completed fully for each person. • The "Physical" section must include a description of the person's current health status, communication abilities, mobility skills, and nutritional status (Consistent with SIS/LAPlus). It must include **assistive devices or equipment** needed. • **Allergies** must be noted including a description of what the allergic reaction looks like • All **current diagnoses are listed and consistent with the 90-L, SIS/LAPlus and other assessments.** • **Current treatment is noted for each diagnosis along with information about if the treatment is working or not.** • Provider, type, and date of last consult are noted for each diagnosis including if continued consultation/services will be needed in the coming year. Providers identified on the **SIS/LAPlus** must be included here even if they are newly identified providers. • Additional supports needed that are not currently provided should be noted. • A description of the person's behavioral concerns and mental health diagnoses is provided if applicable. Current treatment is noted along with information about if the treatment is working or not. **Must be present for all individuals assigned to level 4 or 6 prior to approval.** • If the person scores a 4 or greater on the behavioral scale of the LAPlus or behaviors warrant support, yes must be checked for behavior support plan. The plan must be attached and the section should provide a brief summary of planned services. **Must be present for all individuals assigned to level 6 prior to approval; for individuals assigned to level 4 a determination will be made on an individual basis following review of information – a 90 day interim approval may be granted for some individuals assigned level 4**				**Approve unless checked partial or noncompliance**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

• The number of incident reports and a summary of concerns related to the incidents must be provided. *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate* ***Partial Compliance*** *should be scored when some of the information is present and accurate (Note: 90 day interim approval may be granted is all items in red are included)* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				
e. **Medication name, dose, and frequency are provided consistent with 90-L and SIS/LAPlus.** • **The diagnosis/purpose for each medication is listed. (New diagnoses should not show up here for the first time. E.g., if the person receives medication for high blood pressure, then high blood pressure should be listed in the summary of my health as well.) (SIS/LAPlus)** • **Route of administration should be noted** • **Prescribing physician and person administering the medication is listed for each medication.** • **Clear guidelines are provided for PRN medications if used** • **If medications are administered by the DSS, a physician's delegation is included for all medications including PRNs.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate (NOTE: If current list is inconsistent with other documents but determined to be correct as of the date of the plan, this should be stated)* ***Partial Compliance*** *should be scored when some of the information is present and accurate (may note inconsistencies across documents with no explanation)* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				**Approve unless checked partial or noncompliance**
f. **Treatment name and frequency are provided consistent with 90-L and SIS/LAPlus.** • **The diagnosis/purpose for each treatment is listed. (New diagnoses should not show up here for the first time. E.g., if the person receives medication for high blood pressure, then high blood pressure should be listed in the summary of my health as well.) (SIS/LAPlus)** • **Procedures to complete treatment should be noted.** • **Prescribing physician and person administering the treatment is listed for each.** • **Clear guidelines are provided for PRN treatment if used** • **If treatments are administered by the DSS, a physician's delegation is included.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate* ***Partial Compliance*** *should be scored when some of the information is present and accurate* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				**Approve unless checked partial or noncompliance**
g. Section III.A. (historical information) should demonstrate clear understanding of who the person is. It must include the following: • The person's educational history (school(s) attended; if the person quit/graduated/ received certificate of achievement; performance/progress in school; a statement of				Approve unless checked noncompliance

Attachment 7.4.1 Individual Supports Review (ISR)

missing information if these specifics are not available) • The person's vocational history (Previous jobs held or day program attended; job skills; barriers to employment) • The person's achievements (Goals accomplished by the individual) • How the person learns best (Describe strategies that work for learning new skills; discuss what makes for a successful learning experience and what makes for a negative learning experience) • Important life events that continue to impact the person and his/her support needs • Nature and cause of the person's disability (including age of onset). *Rating Instructions:* ***Compliance** ratings apply to plans with all required information present and accurate(NOTE: If there are questions about investigating other possible important life events and this is the only question, it should not affect the compliance rating)* ***Partial Compliance** should be scored when some of the information is present and accurate* ***Noncompliance** only applies if no information is provided or all information is inaccurate.*				
h. Section III.B. (current living situation) should describe the person's social network and life situation with particular emphasis on available natural supports. It should include the following: • The person's strengths, skills, and abilities • Current issues that may present as barriers to the individual's goals including accessibility of resources • Where and with whom the individual lives (consistent with SIS/LAPlus) • Current and needed home modifications (consistent with LAPlus) • All individuals important to the person are noted including their relationship to the individual and what supports they provide • Financial and work information including the person's current work status • Information about the stability and consistency of the person's current living situation and support network. *Rating Instructions:* ***Compliance** ratings apply to plans with all required information present and accurate* ***Partial Compliance** should be scored when some of the information is present and accurate* ***Noncompliance** only applies if no information is provided or all information is inaccurate.*				Approve unless checked noncompliance
i. Section III.C. (current community supports and other agency involvement) should describe the person's community network and involvement. It should include the following: • Specific/favorite places or activities are noted (consistent with SIS/LAPlus "important to" information.) • Support needs are identified specific to the activities and are consistent with the SIS/LAPlus assessment • Current community supports and resources being utilized are noted • Other agencies involved in the person's support network are noted with supports provided described.				Approve unless checked noncompliance

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

Rating Instructions: ***Compliance*** *ratings apply to plans with all required information present and accurate* ***Partial Compliance*** *should be scored when some of the information is present and accurate* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				
j. Section IV (Things you need to know to support me) should provide support staff with the information needed to assist the person to achieve his or her goals. • It should be written from the person's perspective and should clearly define things based on what is important to the person • Information from the personal outcomes and SIS/LAPlus should inform section. • Gifts, and talents (A.) should describe from the person's perspective what he or she is especially good or skilled at (i.e., artist, great writer, computer wiz, very social and makes friends easily, etc.) • Communication (B.) should include a statement of communication method and a list of nonverbal communication strategies with meaning in the table. NOTE: even folks who are verbal can and most often do have some nonverbal communication techniques. • Item D should focus on support areas most important to the person. • Item G should be consistent with important to items from the SIS/LAPlus and the POA. *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate(NOTE: If only minor recommendations for consideration are made with no significant impact on the person's support needs and interests, then compliance should be rated.)* ***Partial Compliance*** *should be scored when some of the information is present and accurate* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				Approve unless checked noncompliance
k. All supports identified by the SIS/LAPlus as needed and important to or for the individual are included for each section. • Identified areas of importance from the SIS/LAPlus important to items must be included in appropriate sections of the plan (This does not mean a running list of every item checked important to) • Identified areas that are important for the participant should be addressed in the plan. • **Identified medical/mental health/behavioral items must be included and addressed in appropriate sections of the plan.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate (NOTE: this requirement is not meant to imply that each important to or for item requires its own statement in the plan. Rather, a summary of areas with sufficient information to address the area is required.)* ***Partial Compliance*** *should be scored when some of the information is present and accurate* ***Noncompliance*** *only applies if no information is provided or all information is inaccurate.*				**Approve unless checked partial or noncompliance**
l. Information from Assessments (medical assessment, psychological, therapy, etc. as determined by individual needs) reviewed is included in the appropriate sections of the plan. • **Identified medical/mental health/behavioral items must be included and addressed in appropriate sections of the plan.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with all required information present and accurate*				**Approve unless checked noncompliance**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

Partial Compliance should be scored when some of the information is present and accurate *Noncompliance* only applies if no information is provided or all information is inaccurate.				
III. PERSONAL OUTCOMES & PLANNING (Section V-IX.)	**Comp**	**Partial**	**Non-Comp**	**Approval Instructions**
a. A vision statement describing how the person sees his or her life in the next 3-5 years is noted prior to the Personal Outcomes Table. *Rating Instructions:* ***Compliance*** *ratings apply to plans with a vision statement that represents a broad description of how the person sees his or her life* ***Partial Compliance*** *should be scored when a vision statement is present but is either a) a simple list of goals, b) do not reflect the person's perspective, or c) reflects only maintenance of the current status* ***Noncompliance*** *only applies if no vision is present*				Approve unless checked noncompliance
b. Personal Outcomes are clearly linked to what matters to the person (focused on what the person wants) OR addressing significant support needs barriers • Each goal that is identified within the assessment(s) should be represented with a personal outcomes statement in the table • **Each identified health, mental health, behavioral issue must be addressed with a noted goal in column one** • Personal outcomes/goals should be as specific as possible such that the team is able to measure/assess whether it is accomplished as actions are implemented *Rating Instructions:* ***Compliance*** *ratings apply to plans with personal outcomes/goal statements that address each identified goal and all significant barriers with specificity that allows measurements of progress* ***Partial Compliance*** *should be scored when goals are vague, only some goals are present, or do not follow from the vision and assessments.* ***Noncompliance*** *only applies if no outcomes/goals are addressed or if those noted are all not applicable to the individual*				**Approve unless checked partial or noncompliance**
c. Support strategies are clearly linked to achieving the identified goals or removing the barrier. • Steps are sequential and likely to move the person closer to his/her goal or remove the challenge. • Steps/actions should say who will do what to move toward achieving the noted goal/remove the barrier – They should be action statements • Steps/actions should be included no matter who is the identified responsible person (i.e., even if family will address) • For personal goals, steps/actions must include planning activities needed, steps to accomplish the goal, and guidance regarding needed assistance/prompting for the individual • **For medical/mental health/behavioral concerns, steps/actions must address medications and treatments received, lab work needed, doctors/professionals seen, signs/symptoms for staff to observe, brief statement of response to signs/symptoms** *Rating Instructions:*				**Approve unless checked partial or noncompliance**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

Compliance *ratings apply to plans with sequential steps/actions for each outcome/goal (including barriers)that meet the requirements above.* ***Partial Compliance*** *should be scored when steps/actions are only present consistent with the criteria for some items or attempts to determine steps/actions are made for each outcome/goal but do not meet the criteria above* ***Noncompliance*** *only applies if no steps/actions are noted for all outcomes/goals.*				
d. Support strategies and frequencies are consistent with information from the SIS/LAPlus, discipline assessments, and the other plan information. • Column 3 should state how often each action step will occur • The frequencies should not be inconsistent with expectations based upon the SIS/LAPlus assessment of support needs • Strategies/assistance noted in column 2 should be consistent with SIS/LAPlus noted type of support *Rating Instructions:* ***Compliance*** *ratings apply to plans with frequencies noted for each action step consistent with assessments and normal daily activity expectations and assistance required consistent with type of support needed from assessments* ***Partial Compliance*** *should be scored when frequencies and strategies are noted but not all are consistent with assessments and/or normal daily activity expectations* ***Noncompliance*** *only applies if no frequencies/strategies are included or all frequencies/strategies are inconsistent with assessment results and normal daily activity expectations*				**Approve unless checked partial or noncompliance**
e. Support strategies are functionally linked to increased independence, autonomy, and achievement of desired outcomes. • Strategies should not focus on ongoing assistance from staff/family or others always doing for the person unless the person is physically unable to learn to perform the task(s) more independently. • Strategies should note methods for teaching the individual and increasing his/her ability to do things without waiting or depending on others to do it *Rating Instructions:* ***Compliance*** *ratings apply to plans with strategies focused on increasing independence and decreasing reliance on others for all appropriate outcomes/goals.* ***Partial Compliance*** *should be scored when there is some presence of efforts to increase independence, but clear missed opportunities within the current plan.* ***Noncompliance*** *only applies if no efforts to address independence are evident in the plan when there are clear opportunities for doing so.*				Provide recommendations – Do not hold up approval
f. Support strategies provide opportunities for work and other daily activities within the local community • When the person does not live or work in a community setting, support strategies are designed to maximize the individual's ability to live and work (if desired) in a community setting consistent with the individual's expressed preferences. • The plan should focus on assisting the person in having a full array of activities in his or her life. *Rating Instructions:* ***Compliance*** *ratings apply to plans with actions addressing greater involvement within the local community, working/volunteering/etc consistent with the person's expressed preferences, and provision or exploration of a variety of activities (NOTE: If the person clearly expresses that he or she does not wish to do these things, it should*				Provide recommendations – Do not hold up approval

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be clearly noted within the appropriate sections of the plan and a compliance rating should apply). ***Partial Compliance** should be scored when there is some presence of efforts to increase community involvement, work, etc but some preferences are not addressed.* ***Noncompliance** only applies if no efforts to address community involvement or work and the person has not clearly expressed disinterest.*				
g. Support strategies assure ongoing connection to important family and friends • Family and friends are identified and included as appropriate in the plan • For those for whom the individual has expressed clear preference for continued relationships that they are unable to maintain without assistance, there are strategies in the plan to address this ongoing connection *Rating Instructions:* ***Compliance** ratings apply to plans with strategies focused on maintaining connections where these are identified and assistance is needed.* ***Partial Compliance** should be scored when there is missing information/opportunities or the plan only addresses some issues regarding relationships.* ***Noncompliance** only applies if no efforts to address relationships/connections are included and there is evidence that this is important to the person.*				Provide recommendations – Do not hold up approval
h. Support strategies incorporates and respects individual choice • Statements of choice are honored and addressed in the plan even when barriers (including family differences) are present *Rating Instructions:* ***Compliance** ratings apply to plans that clearly are driven by the person (and his/her interests/preferences).* ***Partial Compliance** should be scored when there is some focus on the person's interests, but also instances in which choice is not honored and addressed or the family/provider is driving the planning* ***Noncompliance** only applies if no efforts to address choice are included or there is clear evidence that the person's choices/interests are disregarded.*				Provide recommendations – Do not hold up approval
i. **Support strategies include actions/supports to assure completion of routine and emergency visits/ consultations with noted medical providers.** *Rating Instructions:* ***Compliance** ratings apply to plans with strategies that note required appointments and assistance needed to complete routine and emergency visits.* ***Partial Compliance** should be scored when strategies address only some needed consultations* ***Noncompliance** only applies if routine and emergency consultations are not included in the plan.*				**Approve unless checked partial or noncompliance**
j. For individuals with behavioral challenges who require behavioral support strategies, the Behavioral plan is included in this section. The plan is attached and must include: • Actions designed to prevent the behavioral challenges • Actions required to intervene when the challenges occur • Skills that the person will learn to reduce need for the behavioral challenges • Expected intensity and frequency of needed intervention **Must be included with all requirements as written by an appropriate professional for individuals assigned to level 6. For individuals assigned to level 4 there must be inclusion of signs/symptoms of behavioral problems/mental health condition and effective strategies for preventing and responding. Requirement of a formal plan by a professional prior to any approval will be determined on an individual basis for**				**Approve unless checked partial or noncompliance**

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individuals in level 4. 90-day approval may be given in some instances. *Rating Instructions:* ***Compliance*** *ratings apply to plans including behavioral plans/strategies when identified as needed.* ***Partial Compliance*** *should be scored when there is some effort to address identified issues but the strategies are inadequate.* ***Noncompliance*** *only applies if no efforts to address identified behavioral concerns are included in the plan.*				
k. Each strategy must include appropriate methods to measure progress (as indicated). • Column 4 should include identification of a documentation method for each action. • The identified method should allow for measuring progress over time for the action step (i.e., is it completed, has improvement occurred, etc.) *Rating Instructions:* ***Compliance*** *ratings apply to plans with strategies identified measurement methods that allow for assessing progress over time.* ***Partial Compliance*** *should be scored when there are measurement methods noted for some but not all actions or the methods are not appropriate to allow for assessing progress over time.* ***Noncompliance*** *only applies if no measurement methods are identified.*				**Approve unless checked partial or noncompliance**
l. The plan identifies natural supports identified in the relationships section. • If not, are there plans to develop natural supports? • If yes, are they used in the plan? *Rating Instructions:* ***Compliance*** *ratings apply to plans with strategies that use natural supports within the plan (ie., natural supports are identified in some instances as responsible for actions) and paid supports are not taking the place of naturally occurring and available supports. NOTE: if no natural supports exist, compliance may be rated if actions in the plan focus on improving connections for the person which may build natural supports over time.* ***Partial Compliance*** *should be scored when there is some presence of natural supports in the plan, but there are clearly identified areas where natural supports are available and should be used but are not.* ***Noncompliance*** *only applies if there is no inclusion of natural supports that are available.*				Provide recommendations – Do not hold up approval
m. The plan uses general community resources or technological supports that allow more independence if applicable. • Community transportation options should be considered • Use of community offered classes/workshops/etc should be considered • Use of computer technology should be considered • Consideration of technology as options to increase independence should be considered *Rating Instructions:* ***Compliance*** *ratings apply to plans with inclusion of community/technological supports in appropriately identified areas. NOTE: if no appropriate opportunities exist and no community/technological supports are included, compliance should be rated.* ***Partial Compliance*** *should be scored when there is some use of community/technological supports but other opportunities are missed.* ***Noncompliance*** *only applies if no efforts to include community/technological supports in the presence of clear opportunities to do so.*				Provide recommendations – Do not hold up approval
n. The plan uses shared supports. If not, one of the following is true: • Opportunities are identified plans made to develop them				Provide recommendations – Do not hold up

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• Plans are made to develop opportunities to meet people and explore interests • The person lives at home and natural supports are being used when IFS hours are not • The person is able to be along/independent with the allotted IFS hours and not sharing • There is a contraindication for sharing *Rating Instructions:* ***Compliance*** *ratings apply to plans with shared supports included, plans to move toward shared supports, or rationale for not sharing supports (including notes that the person is able to be supported without sharing)* ***Partial Compliance*** *should be scored when there is identification of opportunities to share but no clear plan to move toward sharing.* ***Noncompliance*** *only applies if no efforts to address sharing are included and the person would need to and could share.*				approval
o. If the person has limited relationships, roles, and/or community experiences, steps are included to explore these areas and increase the person's options. (This would include when specific preferences are identified but not currently available and when the person has limited expressed preferences associated with limited opportunities and experiences.) *Rating Instructions:* ***Compliance*** *ratings apply to plans with strategies to address limited roles/relationships or the person does not have limitations in this area.* ***Partial Compliance*** *should be scored when there is some efforts to address this issue, but additional opportunities are clearly identified.* ***Noncompliance*** *only applies if no efforts to address limitations in these areas are included and limitations are identified.*				Provide recommendations – Do not hold up approval
p. For each support, the target date for completion/review is identified (column 4). *Rating Instructions:* ***Compliance*** *ratings apply to plans with target/review dates for each action.* ***Partial Compliance*** *should be scored when there are target/review dates for some but not all actions* ***Noncompliance*** *only applies if no target/review dates*				**Approve unless checked partial or noncompliance**
q. **A schedule is completed for each person based upon the Personal Outcomes section. The schedule should reflect employment, transportation, school, shared support hours, routine support hours, and any other relevant supports provided.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with a schedule based upon the assessment and planning efforts and hours in the schedule are justified by the assessment results and plan requirements.* ***Partial Compliance*** *should be scored when there is a schedule that is a) incomplete or b) not consistent with the assessment and planning identified needs.* ***Noncompliance*** *only applies if there is no schedule.*				**Approve unless checked partial or noncompliance**
r. **An alternate schedule should be completed for holidays, weekends, vacations, etc.** *Rating Instructions:* ***Compliance*** *ratings apply to plans with alternate schedules based upon individually identified planned deviations within each quarter or no alternate schedule is needed.* ***Partial Compliance*** *should be scored when there is an alternate schedule but it is not based upon individually identified planned deviations within each quarter.* ***Noncompliance*** *only applies if no alternate plan and one is needed.*				**Approve unless checked partial or noncompliance**
s. There is a plan attached that identified backup staff in the event the daily DSP is not available. The plan is individualized and detailed enough to implement. **A back-up plan**				**Approve unless checked partial or**

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

must be present for approval. *Rating Instructions:* ***Compliance*** *ratings apply to backup staff plans that are individual to the person's needs.* ***Partial Compliance*** *should be scored when there is a back-up plan that is not individualized or will not meet the person's needs* ***Noncompliance*** *only applies if no back-up plan.*				**noncompliance**
t. There is an individualized evacuation plan attached that addresses different reasons for evacuation including the need to relocate. It should identify responsibilities for transportation, supplies and direct support and should cover all settings in which the individual receives services. **An evacuation plan must be present for approval.** *Rating Instructions:* ***Compliance*** *ratings apply to evacuation plans that are individual to the person's needs.* ***Partial Compliance*** *should be scored when there is an evacuation plan that is not individualized or will not meet the person's needs* ***Noncompliance*** *only applies if no evacuation plan.*				**Approve unless checked partial or noncompliance**
u. There is an individualized set of provider guidelines (plan) with instructions on implementing the outcomes/goals in the person's support plan. **Provider guidelines (plan) must be present for approval.** *Rating Instructions:* ***Compliance*** *ratings apply to provider guidelines that are individual to the person's needs.* ***Partial Compliance*** *should be scored when there are provider guidelines that are not individualized or will not meet the person's needs* ***Noncompliance*** *only applies if no provider guidelines.*				

INDIVIDUAL SUPPORTS REVIEW CHECKLIST

PROCESS SCORING				
PROCESS AREAS	**YES TOTAL**	**÷**	**YES + NO TOTAL**	**PERCENT COMPLIANCE**
TIMELINES		÷	5	
INTEGRATED ASSESSMENT		÷	12	
PERSONAL OUTCOMES & PLANNING		÷	21	
OVERALL Compliance (80% or above)		÷	38	
Overall Partial Compliance		÷	38	
Overall Non-Compliance		÷	38	
Required Items (must be 100%): Section I items a-c, e Section II items a-f, k Section III items a-c, i-k, p-u		÷	23	
90-day approval items (all bolded items addressed as described)		÷	20	

Support Coordinator Supervisor Signature: _____ Date: _____
Print Name: _____
Regional Office Approval Signature: _____ Date: _____
Print Name: _____
Extra Care & Cost Review Chair/Central Office Rep. Signature (if applicable): _____ Date: _____
Print name: _____

8

IMPLEMENTING THE PARTICIPANT'S SUPPORT PLAN

8.1 Support Plan Approval: Activities for Implementation

8.2 Providing Training to Family and Staff

8.3 Identifying and Securing Needed Resources

8.4 Documentation of Implementation and Collecting Data/Information

8.5 Family Members as Staff

8.6 Attachments

- 8.6.1 Support Plan Revision Request Form
- 8.6.2 Provider Guidelines
- 8.6.3 Instruction Sheets
- 8.6.4 Skills Training Data Sheet
- 8.6.5 Seizure Report
- 8.6.6 Weight Log
- 8.6.7 Meal/Fluid Log
- 8.6.8 Bowel Log
- 8.6.9 Medication Side Effects Assessment
- 8.6.10 Psychiatric Symptoms Assessment
- 8.6.11 Menstrual Chart
- 8.6.12 Sleep Log
- 8.6.13 Challenging Behavior Chart

8.6.14 Behavioral Incident Report (ABC)

8.6.15 Graphic Schedule

IMPLEMENTING THE PARTICIPANT'S SUPPORT PLAN

The support team should leave the planning meeting with a clear agreement of who is responsible for completing which actions (or providing which supports) at what frequency (or within what timeframe).

The responsible people and frequencies for each action step and support should be noted in the support plan document as appropriate.

This document then becomes the basis for implementation of the plan.

8.1 SUPPORT PLAN APPROVAL: ACTIVITES FOR IMPLEMENTATION

A. After the initial support plan is approved, the OCDD Regional Waiver Office submits the cover page, budget pages, approval signature page, Form 18-W, and Form 51-NH to the DHH data contractor for prior authorization. The OCDD Regional Waiver Office submits the complete support plan to the support coordinator.

   1. After the annual support plan is approved, the OCDD Regional Waiver Office submits the cover page, budget pages, and approval signature page to the DHH data contractor for prior authorization and the complete support plan to the support coordinator.

   2. After a revision is approved, the OCDD Regional Waiver Office submits the budget sheets to the DHH data contractor and the complete revision form to the support coordinator. The revision form is located in *Attachment 8.6.1*.

B. After the support plan\revision is approved by the OCDD Regional Waiver Office, the support coordinator has two (2) calendar days or the next business day to forward the support plan\revision to the provider and the participant.

C. The support coordinator contacts the participant and/or his/her authorized representative within ten (10) days following the approval of an initial support plan to assure the adequateness and appropriateness of services.

8.2 PROVIDING TRAINING TO FAMILY AND STAFF

A. Each participant's support plan includes multiple strategies and actions to achieve his/her life vision and goals while addressing key support needs.

B. The support team identifies training the participant's family or staff may need in order to implement actions and strategies described in the plan.

C. The support team determines who will provide any needed training. The training may be specialized in nature and require an outside source. If specialized training is needed, an assigned team member is charged with securing a training source and monitoring that the training is completed.

1. Support teams should encourage people with disabilities to develop self-advocacy skills. Self-advocacy skills are an important component of participating actively in the community, achieving personal goals, establishing meaningful relationships, and recognizing and confronting discrimination. Developing self advocacy skills may require specialized training. There are several state organizations available to assist with empowering people with disabilities to advocate for themselves and their peers: People First has several local chapters located throughout the state. The Arc of Louisiana, 606 Colonial Drive, Baton Rouge, LA 70806, (225) 383-1033, can assist people with locating local chapters of People First. Other organizations that can also provide support in self-advocacy skills include Families Helping Families (see www.fhfla.org to find a local chapter) and the Advocacy Center of Louisiana (see www.advocacyla.org.)

D. Training is competency-based. Competency-based training provides needed information, knowledge or skills to the trainee and then "assesses" if the information, knowledge or skills can be demonstrated by the trainee.

1. Training focused on providing assistance is followed by observing the trainee complete the assistance for the participant.

2. Training focused on learning specific signs/symptoms/triggers of a specific problems or condition is followed by asking the trainee to repeat the information provided.

3. Training focused on steps to teach a particular skill/activity is followed by demonstration of the particular skill or activity.

E. Staff must receive any necessary training within 10 calendar days following plan approval

1. Staff acting as direct service workers must meet requirements established by Louisiana Medicaid in rule published as LAC 48:I.Chapter 92 and authorized by R.S. 40:2179-2179.1.

2. Residential services providers must provide an in-service consistent with item 8.2.D above to direct service workers for each participant the direct service worker will support. This includes shared supports pairings. The in-service focal areas should include, at a minimum, the participant's plan goals requiring implementation during the shift, supports requirements, preferences, and interests.

8.3 IDENTIFYING AND SECURING NEEDED RESOURCES

A. The support team identifies resources needed by the participant's family or staff to implement actions and strategies.

B. The support team determines who will provide or acquire anything needed for implementation.

C. The support team and the IFS provider agency provide tools to support caregivers and staff. Tools are focused on successful plan implementation. These include, at a minimum, Provider Guidelines (*Attachment 8.6.2*) and Instruction Sheets (*Attachment 8.6.3*) for complex need areas, a schedule, and agreed upon documentation sheets. A visual or graphic schedule may be helpful in assisting participants and families to manage a routine (see *Attachment 8.6.15).*

8.4 DOCUMENTATION OF IMPLEMENTATION AND COLLECTING DATA/INFORMATION

A. For each strategy and action, the support team has identified a method for measuring progress. This method specifies the means of documenting provision of the support or completion of the action.

B. Support coordination agencies and direct service providers are responsible for documenting activities during the delivery of services. There are recommended documentation formats provided in this document; however, providers may substitute their own format as long as it includes essential elements of the required documentation. All documentation content and schedule requirements must be met by both support coordination agencies and direct service providers.

C. A Service Log is a document which contains a chronological listing of contacts and services provided to a participant, as authorized in the approved plan of care, which serves as justification for service authorization.

1. Federal requirements for documenting service claims require the following information be included on the service log:
   - Name of participant,
   - Name of service provider and employee providing the service,
   - Service provider agency contact telephone number,
   - Date of service contact,
   - Start and end time of service contact,
   - Place of service contact,
   - Purpose of service contact,
   - Other issues addressed, and
   - Content and outcome of service contact.

2. Support coordinators must record the chronology of events and contacts, which support justification of critical support coordination elements, in the Case Management Information System (CMIS). Each service contact is to be

defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note.

3. Direct service providers must complete a narrative which reflects each entry into the payroll sheet and elaborates on the activity of the contact.

4. Service logs must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

D. Progress Notes are notes completed by a provider at the time of each activity or service which summarize the participant's day-to-day activities and progress toward achieving his/her personal outcomes as identified in the approved plan of care.

1. Progress notes must be completed by both support coordinators and direct service providers for each contact and service provided and documented in the service log or as a separate document.

2. Progress notes must be of sufficient content:
   - To reflect descriptions of activities, procedures, and incidents,
   - To give a picture of the service provided to the participant,
   - To show progress towards the participant's personal outcomes,
   - To record any changes in the participant's medical condition, behavior, or home situation which may indicate a need for reassessment and plan of care change,
   - To record any changes or deviations from the typical weekly schedule in the participant's approved plan of care, and
   - To reflect each entry in the service log and/or timesheet.

3. All progress note entries must be legible, written in ink, and must include:
   - The name of the person making the entry,
   - The title of the person making the entry,
   - A legible signature of the person making the entry, and
   - The full date of documentation.

4. The following are examples of general terms, which when used alone, are **not** sufficient and do not reflect adequate content for progress notes:

    - "Supported _____"
    - "Assisted _____"
    - "____ is doing fine"
    - "____ had a good day"
    - "Prepared meals"

5. Checklists alone are not adequate documentation for progress notes.

6. For those who are receiving formal training to learn a specific skill, progress notes must be paired with a skills training data sheet (*Attachment 8.6.4)*. Progress notes are written daily to document that skills training occurred. The progress note should serve as a pointer to data collection mechanisms used. In the example provided in *Attachment 8.6.4*, one time weekly, a formal data point is placed on the skills training data sheet and paired with the daily progress note. The team uses the trend of the documented data points to determine level of advancement in the goal area over time. A "completed independently" rating of 5 consecutive data points may be used as an indicator of independence for a particular skill and necessitate the development of a new skills training area.

7. Progress notes must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

E. A Progress Summary is a summary that includes a synthesis of all activities for a specified period which address significant activities, progress toward the participant's desired personal outcomes, and changes in the participant's social history. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the participant's current plan of care,

sufficient information for use by other support coordinators, direct service workers, or their supervisors, and evaluation of activities by program monitors.

1. Support coordinators and direct service providers may include the progress summary in the service log for this documentation requirement.

2. A progress summary must be completed at least every quarter.

F. A Discharge Summary for Transfers and Closures is a summary of the participant's progress prior to a transfer or closure.

1. Support coordinators and direct service providers may include the discharge summary in the service log for this documentation requirement.

2. The discharge summary must be completed within fourteen (14) days of discharge.

G. Direct service providers, who provide both waiver and state plan services, must provide separate documentation for these services.

Required Documentation and Schedule

SUPPORT COORDINATORS & SERVICE PROVIDERS				
WAIVER	**SERVICE LOG/PAYROLL SHEET**	**PROGRESS NOTES**	**PROGRESS SUMMARY**	**CASE CLOSURE/ TRANSFER**
NOW	At time of every activity	At time of every activity	At least every quarter	Within 14 days of discharge

H. The support team assures that other documentation and data collection methods other than progress notes, progress summary, and discharge summary are considered so that appropriate measures are used to track progress on plan goals and objectives.

I. For persons with behavioral, psychiatric, or medical risk factors, individualized documentation must be utilized as a means of tracking each key area of risk. This documentation is not required for those whom do not have identified risk factors. Risk factors requiring individualized documentation include, but are not limited to:

1. Having a **seizure disorder** and/or receiving seizure medication - Data forms used to track this information must include seizure reports *(Attachment 8.6.5)*. The team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis.

2. Having a **medical issue which is significantly affected by or has a significant effect upon one's weight -** Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition through g-tube, peg-tube, etc. Data forms used to track this information must include weight logs *(Attachment 8.6.6)*. The team may also need to consider tracking meal/fluid intake with a daily meal/fluid log *(Attachment 8.6.7)*, tracking frequency/consistency of bowel movements with a daily bowel log *(Attachment 8.6.8)*, and assessing for the presence of medication side-effects *(Attachment 8.6.9)*.

3. **Receiving certain medications which can have severe side effects or potentially cause death if medication management protocols are not strictly adhered to -** Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis *(Attachment 8.6.9)*. The team may also need to consider tracking meal/fluid intake with a daily meal/fluid log *(Attachment 8.6.7)*, and tracking frequency/consistency of bowel movements with a daily bowel log *(Attachment 8.6.8)*.

4. Having a **psychiatric diagnosis and/or receiving psychotropic medication -** Data forms used to track this information must include a psychiatric symptoms assessment *(Attachment 8.6.10)*. Based on the person's presenting symptoms,

antecedents, and psychotropic medication guidelines, the team may also need to consider tracking meal/fluid intake with a daily meal/fluid log *(Attachment 8.6.7)*, tracking frequency/consistency of bowel movements with a daily bowel log *(Attachment 8.6.8)*, tracking frequency of menstrual cycles with a menstrual chart *(Attachment 8.6.11)*, tracking sleep patterns with a sleep log *(Attachment 8.6.12)*, tracking frequency/intensity of challenging behaviors with a challenging behavior chart *(Attachment 8.6.13)*, and assessing for the presence of medication side-effects *(Attachment 8.6.9)*.

5. Having **challenging behaviors which are severe or disruptive enough to warrant a behavioral treatment plan -** Data forms used to track this information must include behavioral incident reports *(Attachment 8.6.14)*. The team may also need to consider tracking frequency/intensity of psychiatric symptoms with a psychiatric symptoms assessment *(Attachment 8.6.10)*, tracking frequency/consistency of bowel movements with a daily bowel log *(Attachment 8.6.8)*, tracking frequency of menstrual cycles with a menstrual chart *(Attachment 8.6.11)*, tracking sleep patterns with a sleep log *(Attachment 8.6.12)*, and assessing for the presence of medication side-effects *(Attachment 8.6.9)*.

Examples can be seen in Section 8.6. These are not mandated forms, but are intended as models of appropriate tools for data collection.

J. Documentation collected by IFS providers related to items in Section 8.4, I. must be organized and made available to professionals, nursing, and medical personnel providing services to the participant in order to facilitate quality of care.

K. For all documentation and data collection specified in the support plan related to items noted in Sections 8.4.D.6 and I. (above), the data collection mechanism (e.g., the form or other collection method) must be submitted with the support plan and, if altered, with any succeeding revisions.

1. The OCDD may request a revision of the data collection mechanism or may suggest an alternative mechanism that may better assist in the required monitoring.

2. Technical assistance is available through the OCDD Regional Waiver Office for implementation of the data collection mechanism.

L. Documentation and data collection as specified in the plan must be accurate. This serves as a basis for assessing progress toward the individual's goals and making necessary changes to the plan.

8.5 FAMILY MEMBERS AS STAFF

A. **New Opportunities Waiver Rules Regarding Use of Family Members as Paid Direct Support** (Louisiana Register, Vol. 30, No. 6, June 20, 2004 §13901 Individualized and Family Support and §13907 Residential Habilitation – Supported Independent Living)

1. For Individual & Family Support (IFS) services - Reimbursement will not be paid for direct support services furnished by a legally responsible relative. A legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the recipient's spouse.

2. For Supported Living (SL) services - Family members who are not legally responsible relatives as defined in §13901.D.1, can be SL workers provided they meet the same qualifications as any other SL worker. Legally responsible relatives may not be SL providers. Payment for SL does not include payments made directly or indirectly to members of the individual's immediate family. Minors living in their guardian's home are presumed not to need SL services. If SL services are needed, they must be requested with justification.

3. For Substitute Family Care (SFC) services - Immediate family members (mother, father, brother and/or sister) cannot be substitute family care parents.

B. **Act No. 333 (2008) and Limitations on Family Members as Paid Direct Support**

1. In the Regular Session, 2008, of the Louisiana Legislature, Act No. 333 was passed. This act requires the state Department of Health & Hospitals (DHH) to develop criteria regarding any parent, stepparent, grandparent, son, daughter, brother, sister, aunt, or uncle of a participant serving as a direct support worker. Act No. 333 (2008) Online document link:

   http://legis.state.la.us/billdata/streamdocument.asp?did=499966

2. The Act asserts that general state policy is to <u>not allow</u> family to serve as a paid direct service worker unless the relative meets the criteria established by the rule and has received a waiver issued by the secretary of DHH or his designee. The waiver must state that the relative is the best available appropriate direct service worker for the person using services. Family members who have acted as paid direct service workers prior to July 1, 2008 are grandfathered in and allowed to continue working as paid direct service workers.

3. As of June 2009, Act No. 333 is not yet in effect. DHH is still working on developing the criteria for family members as direct support and the process to apply for and get a waiver. Before these changes can be enacted, they must be posted in rule format, according to state regulations, and also receive approval at the federal level from the Centers for Medicare & Medicaid Services.

C. Support Team Discussion of Using Family Members as Paid Direct Support

1. Support teams should anticipate implementation of Act No. 333 by regularly discussing any use of family as paid direct service workers and by actively considering alternatives. In accordance with the act requirements, DHH will establish regulations for requests of waivers to enable family members to act as paid direct service workers. The following provides guidance for team discussion and consideration in preparation for a waiver request:

   a. Is the use of a family member age and developmentally appropriate?

      i. The team needs to consider the day from the person's perspective. Sometime having family around may be fine. Other times may not be. Does a 30 year-old generally have his mom accompany him to evenings out with friends? Not usually. Support teams must look at ways of using family as paid direct service workers in situationally appropriate times that are consistent with meeting the person's support needs.

      ii. If using family as a paid direct service worker for some times makes sense, then consider including non-family members for shifts involving planned socializing and peer interaction.

b. Will using family members as paid direct service workers enable the person to learn and to adapt to different people and also to form new relationships?

   i. The support team must build in opportunities to meet different people and form relationships, including making choices about selection of different direct support workers.

   ii. The support team must discuss any barriers to increased community integration or friendship development presented by use of family as paid direct service workers and how to address these barriers.

c. Is the person learning flexibility and skills for increased independence?

   i. The support team and IFS provider must reinforce with the family member that he/she is not in a "caretaking" role, but rather in a supportive role that is intended to encourage autonomy and skills building for independence in community living. The support team must ensure that the family member providing direct support approaches the job as such and does not present barriers to individual goals and treatment objectives.

      a. Support teams should approach with considerable caution use of family as paid direct support for persons with significant behavioral challenges due to requirements of treatment plans and treatment objectives.

d. What happens when the family caregiver is gone? Who else is prepared to step in and provide support?

e. Is this in the best interest of the person in the long-term?

i. Is this something that is sustainable for the long-term? Continuity of care in provision of direct services is an important aspect of achieving personal outcomes, including goals, wellness, and progression of skills.

f. Is this about the person's wishes, desires, needs, or about supplementing a family member's income?

i. Support teams must consider the motive and level of commitment of a family member requesting to act as a paid direct service worker. Protecting against exploitation is key. In the end, if a family member is only focused on money, the quality of care will be low, and the person will be put at risk.

2. Support teams should consider paying a family member in the following situations:

a. Staff supports are required at difficult times of the day to get or schedule employees;

b. The participant lives in a rural or isolated area;

c. The family member may work on a temporary basis while other staffing options are explored;

d. When having a family member as staff:

i. Truly reflects the person's wishes and desires,

ii. Increases the person's quality of life in measurable ways,

iii. Increases the person's level of independence,

iv. Increases the person's choices, and

v. Increases access to the amount of service hours for needed supports;

3. Holding regular team discussions and considering all of the above factors will assist in the preparation of waiver requests once Act No. 333 goes into effect.

8.6 ATTACHMENTS

Attachment 8.6.1 Support Plan Revision Request Form

DHH-OCDD Revision Request Form -- New Opportunity Waiver

☐ Attached Supporting Documentation as Needed ☐ Urgent

Revision #: _____ ☐ Shared Support

Participant's Name: _____ Last 4 Digits of SS#: _____

Medicaid #: _____ CPOC Begin Date _____

Requested Start Date: _____ CPOC End Date _____

Justification for Revision: _____

I have reviewed the Revision Request Budget Sheet and I am in agreement with services as outlined below:

Participant/Authorized Representative Signature: _____ Date: _____

Service Provider's Signature: _____ Date: _____

Service Provider's Signature: _____ Date: _____

Case Manager's Signature: _____ Agency: _____ Date: _____

1	2	3	4	5		6		7		8
Provider Name	Service Provider #	Service Description	Service Procedure Code(s)	Modifier 1	Modifier 2	Total # of Revision Units (+ or -)	X	Cost/ Rate Per Unit	=	Total Revision Cost Per Service (+ or -)
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00
							X		=	$0.00

Total Cost of Revision $0.00

For BCSS Use Only Approved: _____ Denied: _____ Effective Date: _____

BCSS Approval Signature: _____ Initials: _____ Date: _____

Comments/Notes _____

Issued March 25, 2009
Obsoletes BCSS-PF-04-010

OCDDWSS-PF-09-001
Page 1 of 3

Attachment 8.6.1 Support Plan Revision Request Form

Revision # _____

Schedule Page

DHH-BCSS Revision Request Form
for New Opportunity Waiver

Participant's Name: _____

Last 4 Digits of SS#: _____

Weekly Schedule Changes

Provider Name	Service Procedure Code(s)	Modifier 1	Modifier 2	A MON [# of Units (+ or -)]	B TUE [# of Units (+ or -)]	C WED [# of Units (+ or -)]	D THU [# of Units (+ or -)]	E FRI [# of Units (+ or -)]	F SAT [# of Units (+ or -)]	G SUN [# of Units (+ or -)]	H Total # of Units Per Week	I # of Weeks in Revision	J "H" X "I"	K + Partial Week Units (+ or -)	L Total ("J" + "K")
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0
											0		0		0

Alternate Schedule Changes
(All Other Changes)

Provider Name	Service Procedure Code(s)	Modifier 1	Modifier 2	A CPOC _____ Beginning Quarter Total # of Units (+ or -)	B Mth/Yr _____ 2nd Full Quarter Total # of Units (+ or -)	C Mth/Yr _____ 3rd Full Quarter Total # of Units (+ or -)	D Mth/Yr _____ 4th Full Quarter Total # of Units (+ or -)	E CPOC End _____ Ending Quarter Total # of Units (+ or -)	Total A Thru E (= or -)
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0

Issued March 25, 2009
Obsoletes BCSS-PF-04-010

OCDDWSS-PF-09-001
Page 2 of 3

NOW CPOC Revision Request Form

Instructions

Purpose

The purpose of this form is to document revisions to the budgeted waiver services as the needs of the individual participant change during the CPOC year. Support Coordinators shall submit revision requests in accordance with the policies and procedures as outlined in the NOW manual, the Case Management manual, the Guidelines for Planning Manual and as updated by written notification from the OCDD Program Offices.

Revision Request Form - Page 1 (Budget Page)

Page 1 of the Revision Request form indicates: (1) waiver participant identifying information, (2) requested time line for the revision changes, (3) justification for the revision request, (4) signatures of all parties affected by the revision, including the transferring provider if any (5) identification of the waiver service provider's Medicaid vendor number (provider #), (6) a summation of all CPOC cost changes effected by the revision, (7)OCDD' designation of the effective start date, and (8)OCDD' approval signature of the revision request.

Revision #

From the CPOC start date, each revision submitted to OCDD must be numbered consecutively for each CPOC year. Enter on this line the number of this revision request.

Attached Supporting Documentation as Needed

If the waiver participant/authorized representative is requesting changes for the remainder of the CPOC year, the change(s) **SHALL** be documented in the body of the CPOC and attached to the revision form. These changes shall be reflected in accordance with how the participant defines or prioritizes his/her personal outcomes/goals and/or service needs, and be submitted with the revision form. This request form does not change the annual CPOC dates.

Examples of attachments may include:

- Documented changes in the body of the CPOC
- Environmental modification and/or assistive device forms, including bids and diagrams
- Physician approved delegation of medication administration forms
- Service provider Freedom of Choice (FOC) Forms
- Home Health Plan of Care (POC)
- Hospice POC

Recipient Name

The participant's full legal name must be on the CPOC revision form. Please enter last name - comma - first name. If the individual prefers to use a nick name, this may be entered in brackets after the first name.

Medicaid I.D. Number

Enter the Participant's 13-digit Medicaid Identification (ID) Number. Please do not enter a Control Card Number (e.g. 7770000.....).

Last 4 Digits of Social Security No.

The number entered on this line is the last four digits of the individual's Social Security Number.

Requested Start Date

Enter the requested start date for service changes to begin. *(NOTE: The requested start date may be different from the approved effective date as in cases of emergency submission.)*

Justification for Revision

Enter a detailed explanation for the needed change in authorized waiver services. If this is an urgent revision the justification should also address why this is an urgent situation.

Attachment 8.6.1 Support Plan Revision Request Form

Routine Revisions

Whenever possible, additional service needs should be anticipated and planned for in the original CPOC. When an unanticipated need is identified 10 or more business days prior to the change, a CPOC Revision Request should be submitted and will be processed within 10 business days. If an unanticipated need is identified after the 10th business day the CPOC Revision Request must be identified as "Urgent", and the additional responsibilities for Provider and Support Coordinator must be assumed (see below).

Urgent

This box should be checked if the revision is an urgent request. An urgent need exists when there is an unplanned/unpredictable event which requires urgent changes(s) to waiver services and/or changes in the service provider. Urgent changes are changes that must begin less than 10 business days from receipt by the OCDD Regional Waiver Office.

If a revision meets the above criteria for urgent:

a. It is the responsibility of the waiver service provider to contact the Support Coordinator about the situation.

b. It is the responsibility of the Support Coordinator to telephone the OCDD Regional Waiver Office and inform OCDD that there is an urgent request for Prior Authorization (P.A.). The Support Coordinator then must submit to the OCDD Regional Waiver Office a revision request as soon as possible on the date of notice.

c. When the Support Coordinator telephones the OCDD office about the urgent request, the incoming call from the Support Coordinator will be directed to the staff person who will handle the revision. All urgent calls for emergency revisions will be rotated to an OCDD staff member according to the Region's policy.

d. The Support Coordinator must be available to the OCDD staff member who will be handling the emergency request. This is necessary in the event additional information is needed to justify approval of the revision, or in the event there are corrections needed. If the Support Coordinator will not be available arrangements should be made for a Support Coordination Supervisor to be available to handle immediate requests for information or corrections.

e. If an urgent service need occurs during non-business hours, Emergency changes must be submitted within 24 hours or by the close of the next working day. It is also the responsibility of the Support Coordinator to call, to ensure that the request has been received and is being processed.

f. Whenever possible the urgent revision request should have the participant/authorized representative and the service providers' signatures on the completed revision form. When it is not possible to obtain all signatures, the incomplete revision request form should be sent to OCDD according to the instructions above, and a fully signed copy must be sent to OCDD by the fifth working day. If a fully signed copy is not received by the fifth working day, the revision request will be forwarded to the Support Coordination Program Manager with the recommendations by the OCDD Regional Waiver Office (services can not continue without a CPOC verified by the participant/authorized representative and service provider).

g. When an urgent CPOC revision request is approved, the OCDD Regional Waiver Office staff will call Statistical Resources, Incorporated (SRI) to notify them that an urgent request for PA is being faxed. OCDD will request that the PA be issued promptly. OCDD will also provide a copy of the approvals to SRI and the Support Coordinator.

h. <u>It is the responsibility of the provider to have prior authorization for all services.</u> In the case of an urgent need after hours, the prior authorization must be obtained by the close of the following business day. If the Support Coordinator cannot be contacted, the Support Coordination Supervisor should be contacted. If results are still not obtained, the Health Standards complaint line should be called.

Attachment 8.6.1 Support Plan Revision Request Form

Shared Support

Check this box if the individual is receiving shared supports and submit with the CPOC revision for the other person/person sharing supports.

CPOC: BEGIN DATE

Enter the approved begin date of the current full CPOC.

CPOC: END DATE

Enter the traditional annual ending date of the CPOC year. This date does not change.

Signature Box

AFTER the form is completed, it shall be signed to indicate agreement with the requested changes entered on pages 1 and 2 of this revision request form.

- Recipient/Authorized Representative signs and enters the date they signed.
- Waiver Service Provider signs and enters the date they signed.
- Support Coordinator signs and enters the date they signed.

The Support Coordinator is to also enter the full name of their Support Coordination Agency.

CPOC Revision Budget Table (page 1)

This table will contain a summation of all costs and PA changes entered on the Weekly Schedule Changes Table and the Alternate Schedule Changes Table on Page 2.

Column 1 -Service Provider Name

Enter the name of the Waiver Service Provider which will provide the listed service and to which SRI will issue the change(s) in PAs. *(Note: All service providers affected by the change must be listed – this includes a service provider who will stop providing services).*

Column 2 - Service Provider No.

Enter the Service Provider's Medicaid Vendor Number for the listed service. Be sure to enter the correct number for the correct service.

Column 3 - Service Description

Enter an abbreviated description of the type of waiver service (e.g. ACS, CC, PER).

Column 4 - Service Procedure Code

This is the billing code assigned to the specific service. (Refer to the most recently issued service/procedure code/rate document).

Column 5 - Modifier

Enter the billing code modifier assigned to the service. (Refer to the most recently issued service/procedure code/rate document).

Column 6 - Total # of Revision Units (+ or -)

Enter the cumulative total of changes (+ and/or -) entered in the Weekly Schedule Changes Table and the Alternate Schedule Changes Table (Page 2), for the same service provider and the same service type.

Column 7 - Cost/Rate Per Unit

Enter the assigned cost per service unit. (Refer to the most recently issued service/procedure code/rate document).

Column 8 - Total Revision Cost Per Service (+ or -)

Enter the number arrived at (+ and/or -) when the number in Column 6 is multiplied by the number in column 7. (Column 8 = Column 6 x Column 7).

Attachment 8.6.1 Support Plan Revision Request Form

TOTAL COST OF REVISION

Enter the sum of all figures in Column 8. (This figure (+ and/or -) reflects the change in the CPOC year costs as a result of this revision request).

OCDD USE ONLY

Upon review and approval of the CPOC revision request, an OCDD Certification Specialist shall assign an effective date for the revision to begin. The OCDD Certification Specialist will also sign, initial, and enter the date of signature.

Instructions for Schedule Page – Page 2

Revision #

Enter the same revision number (#) that was entered on page 1 of this Revision Request Form. It is very important that this number be entered correctly as it is the entry that identifies this page as part of the current revision request.

Recipient's Name

The participant's full legal name must be on this page 2 of the CPOC Revision Form. Please enter last name - comma - first name. If the individual prefers to use a nick name, this may be entered in brackets after the first name.

Last 4 Digits of the Social Security Number

The number entered on this line is the last four digits of the individual's Social Security Number.

Weekly Schedule Changes

Enter on this table changes (+ or -) that are consistent from week to week and extend through the end of the CPOC year. Intermittent changes to service units are not entered in this schedule. A separate line entry is to be completed for each provider and for each service type.

Column 1 -Service Provider Name

Enter the name of the Waiver Service Provider which will provide the listed service and to which SRI will issue the change(s) in PAs. *(Note: All service providers affected by the change must be listed – this includes a service provider who will stop providing services).*

Column 2 - Service Procedure Code

This is the billing code assigned to the specific service. (Refer to the most recently issued service/procedure code/rate document).

Column 3 - Modifier

Enter the billing code modifier assigned to service. (Refer to the most recently issued service/procedure code/rate document).

Columns A through G

Enter the number of units to be changed (+ or -), for each day of the week.

Column H

Enter the sum (+ or -) of Columns A through G.

Column I

Enter the total number of full weeks (Monday through Sunday), that are included in the time range from the requested date of the revision through the end date of the CPOC year.

Column J

Enter the total of the number in column H multiplied by the number in column I. (J= H x I)

Column K

Enter the partial week units (+ or -) in this column. Determine the number of units in partial week(s) (less than Monday through Sunday), included in the requested time range at the beginning and/or end of this CPOC revision time range. (This time range is from the requested start date through the end of the CPOC year.

Column L

Enter the sum of columns J and K. (L = J + K)

Alternate Schedule Changes

Enter changes in service units or providers that are not consistent from week to week and/or do not extend through the remainder of the CPOC year.

Attachment 8.6.1 Support Plan Revision Request Form

Column 1 -Service Provider Name

Enter the name of the Waiver Service Provider which will provide the listed service and to which SRI will issue the change(s) in PA's.

Column 2 - Service Procedure Code

This is the billing code assigned to the specific service. (Refer to the most recently issued service/procedure code/rate document).

Column 3 - Modifier

Enter the billing code modifier assigned to service. (Refer to the most recently issued service/procedure code/rate document).

Column A

At the top of the column enter the current CPOC begin date. If the CPOC begin date is not the first date of a fiscal year quarter, Column A will identify a partial quarter at the beginning of the CPOC year. This column will contain changes that occur from the Begin date of the CPOC to (not through) the start date of the next consecutive fiscal year quarter. (April 1st, July 1st, October 1st, or January 1st).

If alternate changes occur during this partial quarter enter the following information

If there are any service unit or provider changes that occur during this partial quarter, enter the number of service unit changes (+ or).

Columns B, C and D

At the top of each of these columns enter the month and year of each of the next three consecutive fiscal year quarters. Dates at the top of this column should be 01/YR, 04/YR, 07/YR, or 10/YR (not necessarily starting in that order as the CPOC start date may have been later in the fiscal year.)

If alternate changes occur during these full fiscal year quarters enter the following information:

If there are any service unit or provider changes that occur during these full fiscal year quarters, enter the number of service unit changes (+ or -).

Column E

Enter the current CPOC end date. If the CPOC end date is not the last date of a fiscal year quarter, Column E will identify a partial quarter at the end of the CPOC year.

This column will contain changes that occur from the beginning of this consecutive (to Column D) fiscal year quarter (January 1st, April 1st, July 1st, or October 1st) through the CPOC end date.

If alternate changes occur during this partial quarter enter the following information

If there are any service unit or provider changes that occur during this partial quarter, enter the number of service unit changes (+ or).

Column F

Enter the sum of service unit changes (+ or -) that were entered in columns A through E.

(F = A + B + C + D + E)

The summation of changes entered in the Weekly Schedule Change Table and the Alternate Schedule Change Table must also be included on page 1 in the BUDGET Change Table.

DIRECT SUPPORT PROVIDER GUIDELINES

There are several phases associated with the ISP process and the following are the expectations and guidelines that Providers are required to follow throughout the process.

1. **Discovery**-The SIS/ LA PLUS and Personal Outcomes Assessment are included in this phase. Provider is required to attend and actively participate in all meeting(s) and interviews during this phase of the process.

    a. Appropriate Staff (Direct Support Professionals/Residential Support Staff and QMRP) and other people that know the person well should be present for these meetings and available to interview. If staff is unavailable for meeting, then QMRP is responsible for interviewing them to gather pertinent information prior to planning meeting.

    b. Relevant documentation pertaining to the person's wants and needs (assessments, records, etc) should be provided to Support Coordinator to prepare for planning meeting.

    c. Prior to the planning meeting, provider will be given information by Support Coordinator that has been gathered during the discovery process. Provider is responsible for reviewing this information and adequately preparing for the planning meeting.

    d. When shared supports are indicated, provider will use information gathered during the discovery process to begin locating compatible sharing partners that the participant may share supports consistent with the participant's preferences and interests, support needs, and risk mitigation requirements.

    e. SIL providers are to assist recipients that they serve in obtaining an annual 90-L prior to the planning meeting.

2. **Planning**

    a. Provider will be notified by the Support Coordinator 30 days in advance of an annual/initial planning meeting in writing, followed by a 2 weeks in advance notice by fax, email, or telephone.

b. Appropriate Staff (Direct Support Professional/Residential Support Staff and QMRP) need to attend this meeting. A decision-making authority from the Provider must be present to negotiate service provision requirements.

c. Provider is required to attend and actively participate in the planning meeting. This includes assisting the individual with developing their vision and establishing goals that will achieve their vision.

d. Following the planning meeting, the provider will begin to develop the service plan, back-up plan, and emergency evacuation plan based upon the consensus reached at the planning meeting. The provider will receive the finalized support plan from the Support Coordinator within 7 calendar days of the planning meeting

e. Upon receipt of the finalized support plan, the provider representative will have 5 calendar days to review the plan with budget sheets, sign the documents, and return the plan and budget sheets along with the finalized provider service plan, back-up plan, and emergency evacuation plan to the Support Coordinator.

---

3. **Implementation of Plan**

   a. Provider must ensure that staff are adequately trained to implement the plan. Staff training must be completed within 10 days of plan approval.

   b. Provider will complete instructional sheets (*Attachment 8.6.*3 provides an example template for instructional sheets) which will be kept in the in-home binder that can be quickly and easily accessed by staff.

   c. Provider will develop appropriate documentation (Templates) as per agreement in the plan (action steps and sustained supports; critical incident reporting; major life changes).

   d. Provider will track utilization of IFS hours, including flexible hours, per approved plan. Provider will work with person to manage approved hours effectively. Provider will notify Support Coordinator of anticipated need of additional hours request/plan revision in advance and in a timely fashion for the Support Coordinator to complete and submit the revision request.

4. **Evaluation/Review**

   a. During planning meeting, specific persons and timelines have been established to complete action steps. Provider's supervisory staff is required to monitor/follow up to insure that tasks are being completed by assigned persons when they are scheduled to be completed.

   b. Supervisory Staff/QMRP are responsible for reviewing plan and implementation at least quarterly, but may review more frequently. This review includes monitoring of plan implementation to determine if outcomes are being met and to modify objectives as needed as well as reviewing direct support staff documentation. Individual's satisfaction with life situation should be assessed.

   c. Provider Quarterly Review must be completed and submitted to Support Coordinator at the quarterly review meeting.

Individual Support Plan (Staff Instruction)

Name:	**ISP Date:**	**Revised:**
Contacts: (Team and Family Contact Numbers)	**Preferred places/activities**	
Include family members and others individual requests be involved include some of persons located in the meaningful relationships of ISP (Section III).	*Information from Community Life section of ISP (Section V). This section may include information relating to rituals non-negotiables specific to the individual (Section I)*	
Lifestyle/environmental preferences:	**Personal Goals:**	
Information from Community Life section of ISP (Section V). This section may include information relating to rituals non-negotiables specific to the person (Section I)	*Information from Profile of Supports section of ISP(Section XV)*	
Legal Status	**Assistance/Supervision**	
This information can be found on the Rights Page (Section VII)	*Examples of this might be: Person needs constant monitoring while in the community, level of assistance required when evacuating in an emergency, etc.*	

Behavioral/Psychiatric Supports (Summary of Supports) ***The information in this section does not replace the formal Behavior Plan. It is a summary of the recommendations made by ….. Please review plan for more information/detail.***

Name:	**ISP Date:**	**Revised:**
Behavioral Challenges and Psychiatric Symptoms:	**Prevention Strategies (environmental changes)**	
Information from Behavior Plan, behavioral assessments, and Behavioral/Mental Health section of ISP(Section VIII and XV)		
Replacement Behaviors:	**Intervention Strategies:**	

Nursing/Medical Supports

Name:	**ISP Date:**	**Revised:**
Signs/Symptoms: The following symptoms should be reported to a nurse or the person's physician:		
This section will include pertinent health information as noted in ISP (Sections VIII, IX, and XV). Examples of information to include in these sections are: seizure activity, diabetes, aspiration problems, skin breakdown, risk for constipation, etc. You will describe signs and symptoms that should be reported to nurse or physician in the top 2 sections.		
Staff Instructions: Staff are to use the following guidelines each day in supporting this person		
This section will include instruction to staff on how to support person in areas that are noted above (Sections VIII, IX, and XV)		

Nutritional/Physical Supports

Name:	**ISP Date:**	**Revised:**
Nutritional Outcomes:		
In this section you will want to include information about eating status (by mouth), food texture (puree), liquid consistency (Regular), medication administration (crushed and given in apple sauce), adaptive equipment needed (special plate), specific positioning required (upright after meal for 45 mins), and note special diet (diabetic, low sodium, low cholesterol, etc). [Located in Sections VIII, XI, X and XV of ISP]	**Guidelines/Techniques:** *In this section you will need note type of assistance person needs and special techniques that staff should follow such as, does the person want you to sit with them when they eat, do you need to remind them to eat slowly, do they need to be reminded to chew food thoroughly, does staff need to check mouth to insure person swallowed prior to giving more food, instruction as to what should happen prior to meal (thicken watery foods, etc). [Located in Sections VIII, XI, X and XV of ISP]*	
Physical Outcomes:		
In these sections instructions to include are: Mobility (does the person need wheelchair, walker, etc.), how should staff transfer position this person, adaptive equipment person uses (tilting wheelchair, padded bedrails), how person communicates (gestures, sentences), ADL's person needs assistance with (bathing, dressing, grooming, toileting, etc). [Located in Section II and IV of ISP]		

Attachment 8.6.4 Skills Training Data Sheet

Skill Training Data

Name: **Date implemented:**

Personal Outcome/Goal:

Skill:

Steps: Please attach additional pages if more than 7 steps are needed, and enter "More steps are attached " at step 7).

1)
2)
3)
4)
5)
6)
7)

Teaching times:

Reinforcement:

What kind of assistance did person generally need with this skill (for most of the steps)?
0 = no opportunity / refused
1 = physical prompt (hands-on, using physical assistance to guide person's movements)
2 = modeling (showing person how to complete the skill)
3 = verbal/gestural prompt (telling person how to complete the skill, pointing/gesturing to direct person's attention to something)
4 = no assistance needed

	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
1	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
2	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
3	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
4	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
5	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
6	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
7	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
8	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
9	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
10	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
11	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
12	Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		Date: Initials:		=
															Quarter total=

8.6.4 Skill Training Data Sheet

"Guidelines for Support Planning" v. 2, is. June 30, 2009
Office for Citizens with Developmental Disabilities

Attachment 8.6.4 Skills Training Data Sheet

Skill Training Data Form
Instructions

To prepare the form for individualized use:

1) In box entitled "**Name**" at top left corner of form: enter in person's name

2) In box entitled "**Personal Outcome/Goal**" on left side of form: enter in the personal outcome or goal that is the reason or the motivating factor for the particular skill being taught. For example, some personal outcomes or general goals may be to increase independence in housekeeping skills, to become more independent in community settings, or to save money to buy a house. *Note: Personal Outcomes/Goals are identified in Section V (Personal Outcomes) of the CPOC.*

3) In box entitled "**Skill**" on left side of form: enter in the specific skill being taught. The skill being taught should directly relate to a particular personal outcome or goal so that accomplishment of the particular skill will assist the person in fulfilling his/her personal outcome or goal. For example:

   a. Personal goal: increase independence in housekeeping skills → Skill: washing clothing
   b. Personal goal: become more independent in community settings → Skill: using public transportation
   c. Personal goal: save money to buy a house → Skill: paying bills on time each month to avoid late fees

4) In box entitled "**Steps**" on left side of form: enter in the specific steps that person must complete in order to complete the skill. Make sure the steps are short, not too detailed, and easy to understand. They should be written in the order in which they should naturally occur. For example:

   Skill: washing clothing

   Steps:
   1) Bring dirty clothing to laundry room
   2) Place dirty clothing in washing machine
   3) Add detergent to washing machine
   4) Turn washing machine on

   Note: The Skill Training Data Form has space available for up to 7 steps. If the skill being taught has fewer than 7 steps, place an "X" next to the numbered steps not being used. If the skill being taught has more than 7 steps, enter in the name of the skill in the "Skill" space, but leave the "Steps" spaces blank on the form. Write the name of the skill along with all steps on a separate page and attach it to the Skill Training Data Form.

5) In box entitled "**Teaching times**" on left side of form: enter in the days, and/or times during which it is appropriate or natural for the particular skill to occur. Specific days or times do not have to be entered. Skills can be taught as little as "once per week" (i.e., washing clothing) or as frequently as "twice a day" (i.e., brushing teeth) depending upon when the skill should be used.

Attachment 8.6.4 Skills Training Data Sheet

6) In box entitled "**Reinforcement**" on left side of form: enter in the type of reinforcement or reward that should be used to encourage the person to complete the skill again. The type of reinforcement used should be a word, an item, or an activity (or a combination) that is individualized and based upon personal motivations for a person. Different reinforcements work for different people. Also, some reinforcements are appropriate to give after completion of each step, while some are more appropriately given after completion of the entire skill. The type of reinforcement provided should be consistent with personal preferences and the health and safety elements of the person's support plan. Using money as a reinforcement is not recommended.

   - *Example:* Reinforcement: Carrie responds best to verbal praise and visual tracking of progress. Reinforce her with verbal praise after each step, and adding a star sticker to her calendar each time she completes the skill.

7) In box entitled "**Date Implemented**" at top right corner of form: enter in the date that the skill was or will be implemented (the date that the teaching begins).

To record data on the form:

The Skill Training Data form is designed so that staff can record approximately three months of data on one form. The table at the bottom of the form has 12 rows, one for each week, which amounts to 12 weeks. The team should determine how frequently documentation must occur. For example, some skills may be *taught* twice per day (i.e., brushing teeth), however the team may choose to *record* one's progress on the skill only one day per week. This is because not all skills show distinctive improvement in a short period of time (day to day).

Scoring a data point

8) To determine the score for a data point, staff should rate the person's completion of the skill according to how much assistance the person required (see rating scale on form). A rating of 1 indicates that a person needs physical prompts or assistance to complete all or most of the steps of the skill. A rating of 3 indicates that a person needs verbal prompts to complete all or most of the steps of the skill.

   - *Rate the completion of the skill as 4 only if the person is able to complete all steps of the skill independently (with no assistance).*
   - *Rate the completion of the skill as 0 only if the teaching opportunity did not occur as planned or the person did not wish perform the steps of the skill.*

9) Write the score into the box that corresponds to the appropriate day of the week that the teaching occurred. The "score" box is the small box that is to the right of the "date" and "initials" box. Start with row 1, or week 1, (even if it is not the first week of the month) and continue documentation through the rest of the 12 weeks.

10) Write the date that the teaching occurred next to the space that reads "**Date**:"

11) Write the initials of the staff providing the teaching next to the space that reads "**Initials:**"

12) At the end of the week, add up the daily scores received and place the total in the box in the far right column of the table. This makes it possible to assess progress from one week to the next.

13) The weekly totals (the numbers in the far right column) can be added and the total placed in the "**Quarter totals**" box at the bottom right corner of the form. This makes it possible to assess progress from one quarter to the next.

14) Once the form is full, replace it with another "blank" one (with top portion completed) and resume documentation of progress. Teams may consider adding more complex steps to the regimen if people master the basics. For example, once a person shows progress in washing her clothing, steps may be added to the skills so that she is taught to sort clothing into lights and darks prior to washing her clothing.

Attachment 8.6.5 Seizure Report

Seizure Report

Name: **Date:** _____

Seizure started: _____**am/pm** *(leave blank if this is unknown)* **Seizure ended:** _____**am/pm**

Seizure lasted: _____**min** _____**sec** *(give approximate time even if start time is unknown)*

The person was observed: ____ from start to end of seizure
____ after the seizure began

What was the person doing before the seizure:
___ walking
___ sitting
___ lying in bed
___ other: _____
___ not known

Description of seizure activity: place a number beside each symptom in order that it occurred

Body movements:
___ Eyes Staring
___ Eyes Moved to Left / Right (circle)
___ Lip Smacking/Chewing
___ Jaw Clenched
___ Became Limp
___ Fell

Skin Changes:
___ flushed (red/purple)
___ turned blue/gray
___ excessive sweating
___ skin cool,clammy
___ other_____

Tonic (muscle spasm/rigid):
___left arm
___left leg
___right arm
___right leg
___ trunk / torso

Did person become incontinent? Yes / No.
If yes, did they: urinate / defecate?

Clonic (jerky, rhythmic movement):
___left arm
___left leg
___right arm
___right leg
___ trunk / torso

Other unusual behavior: _____
_____
_____

Level of consciousness:
___ lost contact/awareness of surroundings (won't respond to stimulation or named when called)
___ unconsciousness (passed out)
___ no change in level of consciousness
If lost contact or become unconscious, how long did it last? _____min _____sec

What happened after the seizure?
___ person became alert : How long after seizure? ____min____sec
___ person resumed his/her prior activities
___ person seemed confused
___ person seemed agitated
___ person was drowsy/fell asleep

Injuries:
Any injuries received? Yes / No
If yes, described the injury: _____
_____
Was an incident report completed? Yes / No
Did the person go to the hospital? Yes / No

Name of witness/person completing seizure report: _____

8.6.5 Seizure Report

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Attachment 8.6.6 Weight Log

Height and Weight Record

Name:

DOB:

Recommended weight range:

Year =									
Height =	Date height measured: _____ _____			Date height measured: _____ _____			Date height measured: _____ _____		
	Date:	*Weight:*	*initials*	*Date:*	*Weight:*	*initials*	*Date:*	*Weight:*	*initials*
January									
February									
March									
April									
May									
June									
July									
August									
September									
October									
November									
December									

8.6.6 Weight Log

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Attachment 8.6.7 Meal/Fluid Log

Meal/Fluid Log

Name:

Date:

Prescribed Diet (Check all that apply. Write in "other"):

- ☐ Low sodium
- ☐ Low fat
- ☐ Low protein
- ☐ High fiber
- ☐ Renal (low in phosphorous, potassium, sodium, fluids)
- ☐ Cardiac (low fat, low cholesterol)
- ☐ Diabetic (low sugar, low fat)
- ☐ Other: _____

Targeted Intake (check N/A or write in "measure"):

Food: ☐ N/A or measure- _____(calories)

Fluids: ☐ N/A or measure-_____ (cc's)

Breakfast:

Food (type and amount) offered: _____

Food eaten: _____

Fluids offered: _____

Fluids drank: _____

initials: _____

Lunch:

Food (type and amount) offered: _____

Food eaten: _____

Fluids offered: _____

Fluids drank: _____

initials: _____

Supper:

Food (type and amount) offered: _____

Food eaten: _____

Fluids offered: _____

Fluids drank: _____

initials: _____

Snacks:

Food/fluids offered: _____

Food/fluids eaten: _____

initials: _____

Attachment 8.6.8 Bowel Log

Bowel Log

Name:

Month: **Year:**

Instructions:

1) Indicate type of bowel movement that occurred by placing an R, L, H, or S in the box corresponding to the appropriate day of the month (left column) and time of day (top row). See key below for description of types of bowel movements.

2) If person does not have a bowel movement on a particular day or a particular time, leave box blank

Type of bowel movement:

R = regular

L = loose

H = hard

S = soft

	12:00am-3:00am	3:00am-6:00am	6:00am-9:00am	9:00am-12:00pm	12:00pm-3:00pm	3:00pm-6:00pm	6:00pm-9:00pm	9:00pm-12:00am
1								
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8.6.8 Bowel Log

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Attachment 8.6.9 Medication Side Effects Assessment

Medication Side-Effects Assessment

Name:
Month:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Medication: Date begun:
Side effects:

Side effects	Frequency / Severity 0 = none / not a problem 1 = happens very little / is a little problem 2 = happens sometimes / is a moderate problem 3 = happens very often / is a big problem	Was Frequency/Severity more or less compared to last month?
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	
	0 1 2 3	

Attachment 8.6.9 Medication Side Effects Assessment

Medication Side-Effects Assessment
Instructions

To prepare the form for individualized use:

Form is best completed by a QMRP, nurse, or professional/paraprofessional

1) In box entitled "**Name**" at top left corner of form: enter in person's name

2) In box entitled "**Month**" on left side of form: enter in month (and year) of the assessment. The assessment should occur at least once per month, preferably the same day each month. However for certain medications (as determined by the physician), the assessment may need to occur more frequently.

3) List all medications prescribed to the person, including temporary medications (i.e., two weeks of antibiotics for ear infection).

   a) Next to "**Medication:**" write the name of the medication as it appears on person's prescription bottle.

   b) Next to "**Date begun**:" write the date that the person began taking the medication. For long-term prescriptions (i.e., prescribed for last 10 years), the actual beginning date may not be known. The year that the medication was prescribed may suffice. *Note: For medications which are often prescribed in varying dosages, the current prescribed dosage may need to be included next to* "**Date begun:**" *as well.*

   c) Next to "**Side effects:**" list all known side effects of the medication. This information can be obtained from a physician or pharmacist or by looking at the pharmacy insert when the medication is filled.

4) Identify the side effects that are the most commonly occurring symptoms and/or the most severe symptoms among all of the medications. List these identified symptoms in the "**Side Effects**" column on the left side of the table at the bottom of the form. Many of the medications may have the same or similar side effects. Some common examples include: Drowsiness, nausea, vomiting, diarrhea, seizures, etc.

To record data on the form:

5) Using the "**Frequency/Severity**" rating scale (the middle column of the table), determine the frequency and severity of each side effect listed in the left column. Circle the corresponding number for each side effect. *Note: The frequency/severity of a side effect can be determined by speaking with the person and asking him/her questions about how he/she feels (i.e., drowsiness) or observing for outward signs of a side effect (i.e., nausea).*

6) Review the Medication Side-Effects Assessment from the previous month. Look at the frequency/severity ratings for each side effect from the previous month and compare those ratings to the current month. Indicate whether each side effect is currently **more or less frequent/severe** compared to the previous month by writing "more", "less", or "same" in the right column. *Note: For the first month that the form is completed, this item cannot be completed as there is no data available for comparison.*

Attachment 8.6.10 Psychiatric Symptoms Assessment

Psychiatric Symptoms Assessment:

Name:
Focus of Treatment (diagnosis):
Medication(s)/Date:

Instructions: Below are symptoms of the person's disorder/diagnosis. To determine if his/her psychotropic medication is helping, please do the following:

1) Rate each symptom according to how often it has occurred during the past week. Refer to the "Frequency" key on the form which provides rating descriptors. Circle the corresponding number in the **Frequency** column.
2) Rate each symptom according to its intensity (how disruptive it is to person and/or others). Refer to the "Intensity" key on the form which provides rating descriptors. Circle the corresponding number in the **Intensity** column
3) Use the Frequency/Intensity grid below to determine the overall index score for each symptom (*Example: frequency of 2 and intensity of 1 = overall index score of 5*).
4) The overall index score for each symptom should be placed in the "**Index Score**" box.
5) "In "**Initials**" box, staff completing the assessment should sign their initials.

Symptom	Frequency	Intensity	Index Score	
	0 1 2 3	0 1 2		Initials:
	0 1 2 3	0 1 2		Initials:
	0 1 2 3	0 1 2		Initials:

Frequency	Intensity
Happens rarely, seldom (0) Happens occasionally (1) Happens a lot (2) Happens almost constantly (3)	Not disruptive or dangerous (0) A little disruptive, but can be stopped or redirected (1) Disruptive, dangerous, very difficult to stop or redirect (2)

Frequency

Intensity	1	2	3
0	1	2	3
1	4	5	6
2	7	8	9

Attachment 8.6.10 Psychiatric Symptoms Assessment

Psychiatric Symptoms Assessment
Instructions

To prepare the form for individualized use:

Form is best completed by a QMRP, nurse, or professional/paraprofessional

1) In box entitled "**Name**" at top left corner of form: enter in person's name.

2) In box entitled "**Focus of Treatment (diagnosis)**": enter in the person's formal psychiatric diagnosis that will be assessed for presence of symptoms. This diagnosis is given by the psychologist, psychiatrist, or physician. For those with more than one psychiatric diagnosis, a separate form will need to be completed for each diagnosis.

3) In box entitled "**Medication(s)/Date**": enter in the medication or medications currently prescribed to treat the formal psychiatric diagnosis listed. Next to each medication, enter in the date that the medication was prescribed.

4) In the table in the middle of the form, in the left-hand column entitled "**Symptom**" list 2 or 3 of the most prominent symptoms related to the person's psychiatric diagnosis. This information can be provided by the psychologist, psychiatrist, or physician. Provide a brief, but detailed description of the symptom.

   - Example: Diagnosis = Depression
     Symptoms:
     1. loss of energy: seems tired, sluggish, sits and watches television a lot
     2. loss of pleasure: does not seem to enjoy things she used to, doesn't show any interest or excitement in favorite activities
     3. sleep disturbance: sleeping too much, sleeping too little

To record data on the form:

Data can be recorded by a QMRP, nurse, or direct service worker

5) Rate each symptom according to how often it has occurred during the past week. Refer to the "Frequency" key on the form which provides rating descriptors. Circle the corresponding number in the **Frequency** column. *Note: The frequency of a symptom can be determined by speaking with the person and asking him/her questions about how he/she feels (i.e., loss of pleasure) or observing for outward signs of a symptom (i.e., sleep disturbance).*

6) Rate each symptom according to its intensity (how disruptive it is to person and/or others). Refer to the "Intensity" key on the form which provides rating descriptors. Circle the corresponding number in the **Intensity** column.

7) In "**Initials**" box, staff completing the assessment should sign their initials

<u>Scoring the symptoms (Index Score)</u>

8) Use the frequency/intensity grid on the bottom of the form to determine the overall score for each symptom.
   - Example: frequency of <u>2</u> (move down) and intensity of <u>1</u> (move right)= overall index score of <u>5</u>

9) In the "**Index Score**" boxes in the right-hand column, write in the overall index score corresponding to each symptom.

Attachment 8.6.11 Menstrual Chart

Menstrual Chart

Name:

Year:

Instructions:

1. Indicate type of menstrual flow by placing an S, L, M, or H in the box corresponding to the appropriate month and days (see key below)
2. If person does not have menstrual flow during a particular month or on a particular day, leave box blank

Type of Menstrual flow:

S = spotting

L = light

M = moderate

H = heavy

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1												
2												
3												
4												
5												
6												
7												
8												
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8.6.11 Menstrual Chart

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Attachment 8.6.12 Sleep Log

SLEEP CHART

Name:

Date:

Instructions:

1) For each hour, place check mark in either "awake" or "asleep" box. For best use, record the observation at the same time for each hour (e.g., record at 8:15, 9:15, 10:15, etc.)

2) If the "awake" box is checked, note what the person was doing while awake. Provide *brief* description in the "activity" box

3) Place initials of staff name recording the observation in "initials" box

TIME	AWAKE	ASLEEP	ACTIVITY (if awake)	Initials
12:00 am				
1:00 am				
2:00 am				
3:00 am				
4:00 am				
5:00 am				
6:00 am				
7:00 am				
8:00 am				
9:00 am				
10:00 am				
11:00 am				
12:00 pm				
1:00 pm				
2:00 pm				
3:00 pm				
4:00 pm				
5:00 pm				
6:00 pm				
7:00 pm				
8:00 pm				
9:00 pm				
10:00 pm				
11:00 pm				

8.6.12 Sleep Log

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Attachment 8.6.13 Challenging Behavior Chart

Challenging Behavior Chart

Name:

Challenging Behavior(s):
1.
2.
3.

Date:	Time:	Location:	Behavior:	How did staff deal with the behavior according to the Behavior Treatment Plan?	Was an incident report completed? (Y or N/A)	Staff initial

8.6.13 Challenging Behavior Chart

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Attachment 8.6.13 Challenging Behavior Chart

Challenging Behavior Chart
Instructions

This form is used to track the occurrences of *specific challenging behaviors* that are being addressed ("targeted") in a formal behavioral treatment plan designed by a professional such as a psychologist or therapist. This form is not used to track the occurrences of *general challenging behaviors* where no behavioral treatment plan is present (see form entitled "*ABC Chart*").

To prepare the form for individualized use:

Form is best completed by QMRP

1) In box entitled "**Name**" at top left corner of form: enter in person's name

2) In boxes entitled "**Challenging Behavior(s):**" list all challenging behaviors targeted in the behavioral treatment plan. *Note: If more than three behaviors are being targeted, an additional form* needs *to be completed.* Next to each challenging behavior, provide a brief, but detailed description of the behavior. The description should describe a specific behavior that can be observed by anyone.

   - *Examples*:
     a. Stealing – taking items from others' homes and/or stores, placing them in his pants pockets, and hiding them in his closet
     b. Tantrum behavior – screaming and cursing at others, and kicking the wall with his feet
     c. Physical aggression – shoving or pushing others (usually in the chest)

3) Staff should be inserviced on the behavioral treatment plan and data collection using this form.

To record data on the form:

When the challenging behavior occurs, the staff observing the behavior must document the occurrence of the behavior.

4) In the "**Date**" box, note date that the behavior occurred.

5) In the "**Time**" box, note time that the behavior occurred. Depending upon the type of behavior being targeted, this information may be noted as a specific point in time (i.e., 3:15 p.m.) or an episode of time (i.e., 3:15 p.m. – 3:25 p.m.)

6) In the "**Location**" box, note location that the behavior occurred (i.e., bedroom, kitchen, movie theater, park, etc.)

7) In the "**Behavior**" box, note the specific behavior that occurred. Staff may write in the corresponding number to the targeted behavior, rather than writing out the behavior each time.

8) In the large box entitled, "**How did staff deal with the behavior…**" list or describe what steps staff took to address the behavior as directed in the behavioral treatment plan.

9) In the box entitled, "**Was an incident report completed?**" note whether the behavior resulted in an injury or other event which required completion of an incident report.

10) In the "**Staff Initial**" box, staff observing the behavior should sign their initials.

Attachment 8.6.14 Behavioral Incident Report (ABC)

Behavioral Incident Report (ABC)

Name:

Date	Time	A-Antecedent What specific activity or event occurred before the challenging behavior?	B-Behavior What specifically did the person do or say?	C-Consequence What happened after or as a result of the challenging behavior?	Initials

8.6.14 Behavioral Incident Report (ABC)

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Attachment 8.6.15 Graphic Schedule

Name: **Plan Date:**

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12:00 a.m.							
1:00 a.m.							
2:00 a.m.							
3:00 a.m.							
4:00 a.m.							
5:00 a.m.							
6:00 a.m.							
7:00 a.m.							
8:00 a.m.							
9:00 a.m.							
10:00 a.m.							
11:00 a.m.							
12:00 p.m.							
1:00 p.m.							
2:00 p.m.							
3:00 p.m.							
4:00 p.m.							
5:00 p.m.							
6:00 p.m.							
7:00 p.m.							
8:00 p.m.							
9:00 p.m.							
10:00 p.m.							
11:00 p.m.							

Key

	Night 1:1		Day 1:1		Day Shared 3:1
	Intermittent Night 1:1		Intermittent Day 1:1		School
	Night Shared 2:1		Day Shared 2:1		Work
	Night Shared 3:1		Unsupported/ Alone Time Day		Unsupported/ Alone Time Night
	Unpaid Community Support		Unpaid Family Home Visit or Vacation		Unpaid Family/ Friend Natural Support

shaded boxes = paid hours / white boxes = unpaid hours

Attachment 8.6.15 Graphic Schedule

Graphic Schedule
Instructions
(For use with Windows Vista, Office 2007)

The purpose of the Graphic Schedule is to provide a visual representation of the person's typical weekly schedule. The typical schedule in the CPOC may not be easy for consumers and families to understand. The Graphic Schedule allows use of everyday symbols to show ways of using IFS and unpaid supports.

The Graphic Schedule should be opened in the Microsoft Office Excel program. The program icon looks like

EXCEL.EXE

The Excel program uses a spreadsheet format based on a table grid. Each box of the table grid is called a "cell." Each cell functions independently. Thus, you will enter into each cell the distinct item that you wish to appear.

What you see when you first open the Graphic Schedule is an example. You will want to customize the schedule to match each person's individualized typical weekly schedule.

A. Individualizing the schedule:

1) In the yellow cell at the top of the page to the right of "**Name,**" enter the person's name.
   a) Click (single left click) in the yellow cell area of B.1. The yellow cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
   b) Type in the person's name.
   c) When you are finished typing the name, press "TAB" on your keyboard 2 times [left side of the keyboard]. This will place you in the yellow cell for the next step.

2) In the yellow cell at the top of the page to the right of "**Date of Plan,**" enter in the CPOC annual start date:
   a) If the cell is not already highlighted, click (single left click) in the yellow cell area of G.1. The yellow cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
   b) Type in the person's CPOC annual start date in the format: Month Day, Year (e.g. May 12, 2009).

B. About the Graphic Schedule Set-Up:

- The days of the schedule begin with Sunday and end with Saturday (see Row 2 going across). The times of the schedule begin with 12:00 a.m. and end with 11:00 p.m. (see Column A going down). Each cell represents one hour. **Do not alter the day and time cells.**
- In the NOW service, nighttime hours begin at 10:00 p.m. and extend until 6:00 a.m. These hours are designated by a moon symbol on the left-hand side of each cell and darker cell shading. Daytime hours begin at 6:00 a.m. and extend until 10:00 p.m. Daytime cells do not have a moon symbol.
- Paid supports = gray shading. Night paid supports are darker than daytime paid supports.

Attachment 8.6.15 Graphic Schedule

For use with Windows Vista, Office 2007

- Unpaid supports or alone time = white background. This means that no paid staff are present and offering supports.
- Paid supports may not always be provided for a full one-hour time period. Paid supports that are only provided for 30 minutes out of an hour are represented in the symbol key by a diagonal line across the cell. These are referred to as "intermittent supports" since the person is receiving supports on an intermittent and not continuous basis.
- The key at the bottom of the schedule provides symbols that represent different uses of the IFS service, as well as different types of unpaid supports.

C. Using the Key to Customize the Day/Time Elements of the Graphic Schedule:

You can customize the graphic schedule by pasting in graphic elements from the Key [at the bottom of the Excel page] into specific day/time cells to reflect the person's individualized routine.

1) Click (single left click) on the graphic in the Key that you wish to use. (e.g.) The cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
2) Go to the top of the computer screen to the menu bar. Click on the HOME tab.
3) Look for the CLIPBOARD menu.
4) Click (single left click) on the COPY icon (looks like two pieces of paper).
5) The cell border will activate.
6) Click (single left click) on the cell in the schedule that reflects the day and time you wish to insert the graphic you have chosen [e.g. Monday at 9 AM]. The cell area will show a heavy outline. This means you have selected the cell for typing or pasting. The cell in the Key that you selected earlier should continue as active.
7) Go to the top of the computer screen back to the CLIPBOARD menu.
8) Click (single left click) on the PASTE icon (looks like clipboard with paper).
9) The graphic that you chose in the Key will appear in the schedule.
10) If you make a mistake, go to the top of the screen just below the menu bar. Click (single left click) on the UNDO icon (blue arrow curving downward).
11) Fill in the entire schedule using the copy and paste function. Copy items from cells in the Key and paste them into the schedule.
12) Make sure to re-check the schedule when you are done. Do not leave elements from the example in your newly individualized schedule.
    a. NOTE: If a person has unsupported hours, make sure to follow steps 1-9 to select, copy, and paste into the cells the type of unsupported hours the person is using. Do not leave the cell blank.

D. Pasting in multiple cells in a row (top to bottom, side to side)

Notice in the Graphic Schedule example that a person may use two, three, or more hours in a row of the same type of service. There is a shortcut you may use to quickly enter in the exact same Key graphic in cells that are next to each other.

Example of when you would want to use this function:
If a person uses 2:1 daytime supports every morning Monday thru Friday from 6-9 AM. You can use this shortcut to paste in the exact same Key graphic cells in Monday thru Friday.

1) Follow the instructions to place the correct Key graphic in the first cell you plan to copy. See above part C, steps 1-12.
2) Click (single left click) on the cell in the Schedule containing the symbol you wish to copy to other cells in the row (side to side) or column (up and down). A white border will appear around the chosen cell.
3) At the bottom right-hand corner of this white border is a small "+"sign. Click directly on the "+" sign and **hold your mouse button down** (do not raise your finger up after clicking).

Attachment 8.6.15 Graphic Schedule

For use with Windows Vista, Office 2007

4) While holding down on the click button, drag the mouse over to the nearby cells you wish to change. The click-and-drag motion will create borders around and "highlight" the other chosen cells.
5) When you release the click button, the highlighted cells will change to show the new symbol.

E. To shade/un-shade or change the color of a cell:

The shading in the cells indicates an unpaid (white) versus a paid (gray) hour. Paid (gray) hours are further distinguished by night (darker) and day (lighter) hours.
If you use part C, steps 1-12, pasting in items from the Key will automatically change the cell color to match the Key item. **It is recommended that you use the steps in part C to manage cell shading.**

However, there may be other times that you wish to change the shading or color of a cell, especially if you are using a color printer. Changing this takes a few steps.

1) Click (single left click) on the cell in the Schedule you wish to change.
2) Go to the top of the computer screen to the menu bar. Click on the HOME tab.
3) Look for the CELLS menu.
4) Select FORMAT. A drop-down menu will appear with a variety of options.
5) Select FORMAT CELLS. A dialogue box will appear with a variety of options.
6) Click on the FILL tab at the top of the dialogue box.
7) A variety of "background colors" are offered. Choose the one you want by clicking on the color. Cell patterns are also available in the drop down menu.
8) Click on the background color or pattern you wish to use. Your selection will appear in the "Sample" area.
9) Once your choice is made, click OK at the bottom of the dialogue box.
10) The FORMAT CELLS dialogue box will disappear, and the cell will become the chosen color.

F. Showing paid supports for 30 minutes (not a full hour):

Partial hour 1:1 night and 1:1 day options are available in the Key. Copy and paste these into the appropriate cell of the Schedule using instructions in part C, steps 1-11. **It is recommended that you use the Key and steps in part C to show 1:1 supports.**

Less than one hour coverage is shown with a slash (or diagonal line) through the middle of the cell. You may wish to show supports offered in less than an hour for 2 person or 3 person options. This graphic is not provided in the Key for 2 and 3 person shared supports, so you will need to create the cell design by following these steps:

1) Follow the instructions in part C, steps 1-12 for copying and pasting into the appropriate cell of the Schedule the number of people sharing and day/night support being used.
2) Click (single left click) on the cell in the Schedule you wish to change.
3) Go to the top of the computer screen to the menu bar. Select the HOME tab.
4) Look for the CELLS menu.
5) Select FORMAT. A drop-down menu will appear with a variety of options.
6) Select FORMAT CELLS. A dialogue box will appear with a variety of options.
7) Click on the BORDER tab at the top of the dialogue box. A variety of borders are offered.
8) Select the slash (or diagonal line) through the middle of the cell located in the BOTTOM RIGHT by clicking on the option.
9) An example of what the slash will look like will be shown in the middle of the dialogue box. Look at the example and make sure that you have turned on the slash.
10) Click OK at the bottom of the dialogue box.
11) The FORMAT CELLS dialogue box will disappear, and the cell will show the slash line.

Attachment 8.6.15 Graphic Schedule

Graphic Schedule
Instructions
(For use with Windows 98 through XP, Office 98-2006)

The purpose of the Graphic Schedule is to provide a visual representation of the person's typical weekly schedule. The typical schedule in the CPOC may not be easy for consumers and families to understand. The Graphic Schedule allows use of everyday symbols to show ways of using IFS and unpaid supports.

The Graphic Schedule should be opened in the Microsoft Office Excel program. The program icon looks like

The Excel program uses a spreadsheet format based on a table grid. Each box of the table grid is called a "cell." Each cell functions independently. Thus, you will enter into each cell the distinct item that you wish to appear.

What you see when you first open the Graphic Schedule is an example. You will want to customize the schedule to match each person's individualized typical weekly schedule.

A. Individualizing the schedule:

1) In the yellow cell at the top of the page to the right of "**Name,**" enter the person's name.
   a) Click (single left click) in the yellow cell area of B.1. The yellow cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
   b) Type in the person's name.
   c) When you are finished typing the name, press "TAB" on your keyboard 2 times [left side of the keyboard]. This will place you in the yellow cell for the next step.

2) In the yellow cell at the top of the page to the right of "**Date of Plan,**" enter in the CPOC annual start date:
   a) If the cell is not already highlighted, click (single left click) in the yellow cell area of G.1. The yellow cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
   b) Type in the person's CPOC annual start date in the format: Month Day, Year (e.g. May 12, 2009).

B. About the Graphic Schedule Set-Up:

- The days of the schedule begin with Sunday and end with Saturday (see Row 2 going across). The times of the schedule begin with 12:00 a.m. and end with 11:00 p.m. (see Column A going down). Each cell represents one hour. **Do not alter the day and time cells.**
- In the NOW service, nighttime hours begin at 10:00 p.m. and extend until 6:00 a.m. These hours are designated by a moon symbol on the left-hand side of each cell and darker cell shading. Daytime hours begin at 6:00 a.m. and extend until 10:00 p.m. Daytime cells do not have a moon symbol.
- Paid supports = gray shading. Night paid supports are darker than daytime paid supports.

Attachment 8.6.15 Graphic Schedule

For use with Windows 98 through XP, Office 98-2006

- Unpaid supports or alone time = white background. This means that no paid staff are present and offering supports.
- Paid supports may not always be provided for a full one-hour time period. Paid supports that are only provided for 30 minutes out of an hour are represented in the symbol key by a diagonal line across the cell. These are referred to as "intermittent supports" since the person is receiving supports on an intermittent and not continuous basis.
- The key at the bottom of the schedule provides symbols that represent different uses of the IFS service, as well as different types of unpaid supports.

C. Using the Key to Customize the Day/Time Elements of the Graphic Schedule:

You can customize the graphic schedule by pasting in graphic elements from the Key [at the bottom of the Excel page] into specific day/time cells to reflect the person's individualized routine.

1) Click (single left click) on the graphic in the Key that you wish to use. (e.g.) The cell area will show a heavy outline. This means you have selected the cell for typing or pasting.
2) Go to the top of the computer screen to the menu bar. Select EDIT.
3) In the EDIT menu, select COPY.
4) The cell border will activate.
5) Click (single left click) on the cell in the schedule that reflects the day and time you wish to insert the graphic you have chosen [e.g. Monday at 9 AM]. The cell area will show a heavy outline. This means you have selected the cell for typing or pasting. The cell in the Key that you selected earlier should continue as active.
6) Go to the top of the computer screen to the menu bar. Select EDIT.
7) In the EDIT menu, select PASTE.
8) The graphic that you chose in the Key will appear in the schedule.
9) If you make a mistake, go to the top of the screen to the menu bar. Select EDIT. In the EDIT menu, select UNDO. The program will tell you if it cannot undo.
10) Fill in the entire schedule using the copy and paste function. Copy items from cells in the Key and paste them into the schedule.
11) Make sure to re-check the schedule when you are done. Do not leave elements from the example in your newly individualized schedule.
    a. NOTE: If a person has unsupported hours, make sure to follow steps 1-8 to select, copy, and paste into the cells the type of unsupported hours the person is using. Do not leave the cell blank.

D. Pasting in multiple cells in a row (top to bottom, side to side)

Notice in the Graphic Schedule example that a person may use two, three, or more hours in a row of the same type of service. There is a shortcut you may use to quickly enter in the exact same Key graphic in cells that are next to each other.

Example of when you would want to use this function:
If a person uses 2:1 daytime supports every morning Monday thru Friday from 6-9 AM. You can use this shortcut to paste in the exact same Key graphic cells in Monday thru Friday.

1) Follow the instructions to place the correct Key graphic in the first cell you plan to copy. See above part C, steps 1-11.
2) Click (single left click) on the cell in the Schedule containing the symbol you wish to copy to other cells in the row (side to side) or column (up and down). A white border will appear around the chosen cell.
3) At the bottom right-hand corner of this white border is a small "+"sign. Click directly on the "+" sign and **hold your mouse button down** (do not raise your finger up after clicking).

Attachment 8.6.15 Graphic Schedule

For use with Windows 98 through XP, Office 98-2006

4) While holding down on the click button, drag the mouse over to the nearby cells you wish to change. The click-and-drag motion will create borders around and "highlight" the other chosen cells.
5) When you release the click button, the highlighted cells will change to show the new symbol.

E. To shade/un-shade or change the color of a cell:

The shading in the cells indicates an unpaid (white) versus a paid (gray) hour. Paid (gray) hours are further distinguished by night (darker) and day (lighter) hours.
If you use part C, steps 1-11, pasting in items from the Key will automatically change the cell color to match the Key item. **It is recommended that you use the steps in part C to manage cell shading.**

However, there may be other times that you wish to change the shading or color of a cell, especially if you are using a color printer. Changing this takes a few steps.

1) Click (single left click) on the cell in the Schedule you wish to change.
2) Go to the top of the computer screen to the menu bar. Select FORMAT.
3) Select CELLS. A dialogue box will appear with a variety of options.
4) Click on the PATTERNS tab.
5) A variety of "background colors" are offered. Choose the one you want by clicking on the color. Cell patterns are also available in the drop down menu.
6) Click on the background color or pattern you wish to use. Your selection will appear in the "Sample" area.
7) Once your choice is made, click OK at the bottom of the dialogue box.
8) The "*Format Cells*" dialogue box will disappear, and the cell will become the chosen color.

F. Showing paid supports for 30 minutes (not a full hour):

Partial hour 1:1 night and 1:1 day options are available in the Key. Copy and paste these into the appropriate cell of the Schedule using instructions in part C, steps 1-11. **It is recommended that you use the Key and steps in part C to show 1:1 supports.**

Less than one hour coverage is shown with a slash (or diagonal line) through the middle of the cell. You may wish to show supports offered in less than an hour for 2 person or 3 person options. This graphic is not provided in the Key for 2 and 3 person shared supports, so you will need to create the cell design by following these steps:

1) Follow the instructions in part C, steps 1-11 for copying and pasting into the appropriate cell of the Schedule the number of people sharing and day/night support being used.
2) Click (single left click) on the cell in the Schedule you wish to change.
3) Go to the top of the computer screen to the menu bar. Select FORMAT.
4) Select CELLS. A dialogue box will appear with a variety of options.
5) Click on the BORDER tab. A variety of borders are offered
6) Select the slash (or diagonal line) through the middle of the cell located in the BOTTOM RIGHT by clicking on the option.
7) An example of what the slash will look like will be shown in the middle of the dialogue box. Look at the example and make sure that you have turned on the slash.
8) Click OK at the bottom of the dialogue box.
9) The "*Format Cells*" dialogue box will disappear, and the cell will show the slash line.

9

REVIEW AND MODIFICATION OF THE PARTICIPANT'S SUPPORT PLAN

9.1 Purpose of Monthly Calls in the Plan Review Process

9.2 Preparing for the Quarterly Review

9.3 Completing the Quarterly Review

9.4 Using the Quarterly Quality Review to Document Progress

9.5 Using the Quarterly Review for Annual Planning

9.6 Urgent Meetings to Address Crisis Issues

9.7 Attachments

9.7.1 Quarterly Quality Review

REVIEW AND MODIFICATION OF THE PARTICIPANT'S SUPPORT PLAN

Support plan review is completed by the support team for each individual quarterly. Support plan review may occur more frequently based on the person's request or presence of need(s).

The support plan review provides a structured setting for the team to discuss monitoring of the implementation of planned services within the home and other applicable settings, such as work or school.

The team should:

1. Discuss action steps in the support plan document,

2. Discuss supports delivery according to the support plan document,

3. Evaluate the individual's progress/status in meeting set outcomes,

4. Determine when and if changes need to be made to the support plan, and

5. Designate who is responsible for making the needed modifications to the plan.

9.1 PURPOSE OF MONTHLY CALLS IN THE PLAN REVIEW PROCESS

A. Each support coordinator is required to complete at least a monthly phone call to each participant and discuss the items in Section 9.4.B (below).

B. The monthly phone call is part of the required monitoring of each participant's support plan. During the call the support coordinator reviews the following information. Follow-up probes may be needed for each item to acquire meaningful information.

1. Satisfaction with supports,

2. Implementation of plan actions and supports,

3. Identification of any barriers existing, and

4. Identification of any new interests/goals/needs.

C. Documentation of the monthly phone call must indicate responses to the items outlined in Section 9.4.B.1-4. Documentation must show:

1. Participant spoken with (or about),

2. Family member spoken with,

3. Date and time of contact, and

4. Responses to each item.

D. With the participant's agreement, the support coordinator speaks to provider staff and family members, if the participant lives with family, to determine if the plan is being implemented and is working for the participant.

1. In exercising his/her mutual responsibility with providers, the support coordinator is responsible for verifying, via communication with the provider, that the participant's IFS hours authorized for the quarter are sufficient to meet the participant's needs.

E. New barriers, concerns or needs that cannot wait for the quarterly review are addressed as needed, including revision to the plan as needed.

1. In exercising his/her mutual responsibility with providers, the support coordinator must work with the participant and provider to determine the need for a revision request for additional hours or an alteration of the typical schedule. Requests for additional hours in a quarter should be made proactively (anticipating the need), rather than as a last-minute emergency request. Regular communication between the support coordinator and provider as described in item 9.1.D above will facilitate identification of needed changes to a participant's plan.

2. As described in Section 6.6.H, the IFS provider has an ongoing responsibility to monitor the use of and assist persons with the management of their allocation of IFS hours, including IFS flexible hours and alternate schedule hours.

F. The provider must receive written notification of any changes within three (3) working days of approval.

9.2 PREPARING FOR THE QUARTERLY REVIEW

A. The review meeting is facilitated by the support coordinator in conjunction with the individual. At a minimum, the support coordinator, provider staff, individual, and his/her family and friends (as invited by the individual) should be present. Participation of the vocational provider is required if the participant receives vocational/day services.

B. If a support team member is unavailable to attend the meeting and has crucial information for the review process, the support coordinator contacts that person prior to the meeting to assure that the recommendations from that member are clear and can be conveyed during the meeting.

   1. Following the meeting, the support coordinator completes further follow-up to assure agreement of the absent team member with the resulting plan.

   2. Team members anticipating an absence should be offered the opportunity to participate by phone. The support coordinator should inquire about the team member's availability by phone for incidental questions that may come up during the meeting time and secure contact information.

C. The support coordinator works with the individual (as with the initial/annual meeting) to determine a time, date and location. The support coordinator provides written notification to all members of the time, date, and location of the quarterly review at least two weeks prior to the meeting. OCDD recommends that the quarterly schedule be developed during the annual planning meeting. This helps to assure attendance and assist in maintaining the two week's notice requirement. A phone call reminder will occur 1 week prior to the scheduled meeting.

D. If the fourth quarterly is being used as the annual planning meeting, a 30 day written notice must be provided (time, date, and location). A two week prior follow-up notice is sent as required in Section 9.2.C (above).

E. In preparation for each quarterly meeting, the support coordinator must observe services within the home setting (and other applicable settings) and must also review the provider's documentation. This activity may occur on the same day as the scheduled meeting, but the meeting may not substitute for the observation and review.

9.3 COMPLETING THE QUARTERLY REVIEW

A. During the meeting, the support coordinator facilitates a discussion about the status of supports, the prospect for sustained supports, and progress on action steps.

B. The support team discusses and reaches consensus about any recommended/ requested changes in the plan. Discussions should consider whether the plan is working in assisting the individual to meet his/her set outcomes (and work toward his/her vision).

C. The individual (or those who know him/her best) is given an opportunity to modify his/her vision or outcomes.

D. The support team makes and plans for any needed changes.

E. The support coordinator ensures that prior to leaving the meeting, all changes have an assigned responsible person, date, and data sources (full plan) for the actions required.

9.4 USING THE QUARTERLY QUALITY REVIEW TO DOCUMENT PROGRESS

A. At the end of the quarterly meeting, the support coordinator facilitates discussion to answer the questions posed on the Quarterly Quality Review (*Attachment 9.7.1).*

B. For quarters 1, 2, and 3, the review is focused on the quarter as it compares to the previous quarter in determining progress.

C. For the last quarter, the review focuses on the entire year to determine progress since implementation of that annual plan. The third quarter meeting includes all Discovery activities necessary for annual planning meeting.

D. The support coordinator keeps documentation of the Quarterly Quality Review and submits the final Quarterly Quality Review with the newly proposed plan for the participant as part of the annual process.

9.5 USING THE QUARTERLY REVIEW FOR ANNUAL PLANNING

A. The appropriate quarterly review is to be used as the annual planning meeting. The support coordinator must provide a 30 day written notice (time, date, and location) to members of the support team prior to the annual planning meeting date. Two week prior follow-up phone notice must be sent according to Section 9.1.C.

B. The support coordinator must send the participant the 90-L with accompanying instructions at least 90 days prior to the support plan expiration date.

C. The SIS and LA PLUS assessment must not be completed more than 90 days prior to the expiration of the participant's support plan. If the participant has had a re-assessment completed within the past six (6) months, the support coordinator must review the assessment and conclude that the assessment is an accurate indication of the individual's current support needs. If an accurate assessment of current need, then the SIS and LA PLUS completed within the past six (6) months may be used.

D. Other Discovery activities must also be completed with the participant. This includes updating the participant's Personal Outcomes Assessment. Each quarterly may be used to update the Personal Outcomes information with formal updating of the worksheets and verification of accuracy of information occurring at the third quarterly.

E. The support coordinator shares information with support team members **one week prior to the planning meeting by email or fax** by circulating to the support team a rough draft of the support plan document that includes key information from Discovery, the Personal Outcomes Assessment, and results of the SIS/ LA PLUS. The SIS in its entirety is not sent to team members. It is important that support team members have all of the information that has been gathered, along with the vision and outcomes which have been identified by the person, available to them in the plan format for review before the meeting. This allows time for the team to prepare for the meeting, including bringing any concerns and proposed strategies to address these concerns to the planning meeting for optimal team discussion.

1. The support plan rough draft does not need to be written to the quality and volume of content required in the final planning document; it is a draft. However, the support coordinator must include information in all plan sections that can be filled in with Discovery information.

a. This includes information pertaining to criteria for shared supports.

b. Support coordinators are not to complete the Personal Outcomes Table (Section 5 of the CPOC) other than the person's Vision.

2. In order to include shared supports information for roommates, the support coordinator and IFS provider must have held the roommate risk/benefit discussion prior to sending out the draft document (see Section 6.4).

3. **The support coordinator is responsible for assuring that the person understands that this information will be shared.**

F. The planning meeting must be held no less than 55 days prior to the expiration of the support plan.

G. Following the planning meeting, the support coordinator must develop the support plan. The IFS provider must concurrently develop the participant's individualized service plan, back-up plan, and emergency evacuation plan.

H. The support coordinator monitors the completion of the 90-L.

I. Within (7) calendar days following the planning meeting, the support coordinator sends the support plan to the participant and the support team for review and agreement.

J. The provider and other support team members have five (5) calendar days to review the support plan and return the signed support plan to the support coordinator. The provider must also include the individualized service plan, back-up plan, and emergency evacuation plan to the support coordinator.

K. The support coordinator then submits the signed support plan to the support coordinator supervisor. The support coordinator supervisor has seven (7) calendar days to review, require any necessary revisions, and complete submission to the OCDD Regional Waiver Office.

1. Within 35 days prior to the expiration of the support plan, support coordination supervisors must complete submission of the support plan, provider's individualized service plan, emergency evacuation plan, back-up plan, and 90-L to the OCDD Regional Waiver Office.

L. The OCDD Regional Waiver Office is responsible for reviewing and approving the support plan within ten (10) business days following receipt of the plan.

M. Once the support plan is approved, the support coordinator forwards the approved plan to the provider and the participant within two (2) calendar days or by the next business day.

9.6 URGENT MEETINGS TO ADDRESS CRISIS ISSUES

A. Team members aware of urgent and critical issues or concerns are responsible for notifying the support coordinator of the need for a meeting.

B. The support coordinator should not delay discussion until the next scheduled review, but should assure that items are addressed. Intervention may include development of a plan or course of action that may require revising the participant's support plan.

C. Issues that may require an urgent meeting and/or plan revision include, but are not limited to, the following:

   1. A risky or life-threatening critical incident,

   2. A trend of repeated critical incidents, or

   3. Risk of losing current living situation.

D. An urgent meeting may need to be held with little notice. Use of phone conferencing is appropriate to assure attendance by all support team members.

E. Written changes to the support plan must be sent to team members and submitted within three (3) working days.

Attachment 9.7.1 Quarterly Quality Review

Quality of Life Indicator	1 (Not at all/None)	2 (Some but not as planned)	3 (As desired/ needed)	If 1 or 2 is checked, code reason* (see codes below)	Is there a plan in the ISP to address this issue	Was the plan modified at this review?
1. The individual had contact with his or her family and friends (See Meaningful Relationships section in ISP)						
2. The individual has desired/needed supports for his or her home life (As defined in Home Life section in ISP & Home Maintenance and ADL sections in POS)						
3. The individual participates in the life of his or her community including going preferred (fun) places (As defined in Community Life section in ISP)						
4. The individual works/volunteers/has learning experiences consistent with his or her goals & desires (As defined in My Roles section in ISP)						
5. The individual's rights are protected and hs/she has opportunities, support & assistance for self-advocacy (See Rights/Self-Advocacy section in ISP for information & include any concerns or information about rights restrictions or abuse and neglect in consideration of rating in this area)						
6. The individual had choices within his or her day (See Important Things to Know About Me, What is most important to me, & preferences in each section of the ISP)						
7. The individual has learned new skills that increase his or her independence (See learning actions in POS)						
8. The individual is medically stable (See Summary of Health section and General Health sections on POS)						
9. The individual has no behavioral or psychiatric challenges or has experienced decreases in these (See Summary of my health section and Behavioral & Mental Health sections in POS)						
10. The individual has access to preferred (fun) items, activities, and people (as defined in the individual's ISP)						
11. All needs are being met based upon individual/family support and support team review (See POS from ISP). If not, specify unment need:						
12. The individual has made progress toward his/her personal goals or the individual or those who know him or her best report that QOL has improved (See Personal Goals sections in POS). Specify any goal for which the individual is not making progress:						

Reason Codes: Note if 5 is coded, specify reason	1(Access to supports)	2(Trans-portation)	3(No funding)	4(Not done as planned)	5(Other)	

10

APPEALING DENIALS OF SERVICES

10.1 Disenrollment, Decertification, and Discharge Procedures

10.2 Denial of IFS Hours

10.3 Attachments

10.3.1 Medicaid Fair Hearings Brochure

10.3.2 BHSF Form 142 Notice of Medical Certification

APPEALING DENIALS OF SERVICE

A fair hearing is an administrative procedure that affords participants the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter.

Participants have the opportunity to request a fair hearing/appeal when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service by the Department of Health and Hospitals (DHH). For further information on fair hearing and appeals, refer to the Medicaid Vendor Administration, Administrative Manual, Appeals. (Medicaid Vendor Administration, Administrative Manual, Appeals

http://10.12.8.169/administrativemanual/applicant-enrollee%20appeals.pdf.)

A brochure on Medicaid fair hearings is included as *Attachment 10.3.1.*

Fair hearing and appeals only as they apply to the New Opportunities Waiver (NOW) and recommended IFS hours are addressed in this Section.

The OCDD Regional Waiver Office issues a notice of adverse action in five circumstances:

1. The individual no longer meets the level of care requirements for NOW participation (90 L).

2. The individual can no longer be safely served under the NOW.

3. The individual violates waiver policies and responsibilities.

4. The individual requested and was denied additional IFS hours.

5. The individual does not receive a waiver services for more than 30 days.

The first three circumstances require that the individual be disenrolled from the NOW. The decertification and waiver discharge procedures in Section 10.1 apply in these cases. The procedures for denial of IFS hours are presented separately in Section 10.2 of the Guidelines.

10.1 DISENROLLMENT, DECERTIFICATION, AND DISCHARGE PROCEDURES

A. The following procedures are established if a participant meets any of the three criteria requiring disenrollment from the NOW.

1. The OCDD Regional Waiver Office issues a notice of adverse action. In the case where any individual no longer meets the level of care criteria or requires a higher level of care than available under the waiver a "Notice of Medical Certification" BHSF Form 142 (*Attachment 10.3.2)* with a cover letter to the participant, support coordinator, the Department of Health and Hospitals (DHH) data contractor, and Bureau of Health Services Financing (BHSF) is issued to discharge the participant from the waiver.

2. Services continue until the appeal is resolved, provided that the participant requests an appeal within ten (10) calendar days of the adverse action notice and requests the continuation of services. Participants must submit their appeal request in writing or verbally to the DHH Bureau of Appeals. The appeal request should specifically state the reason of disagreement with the decision. The OCDD Regional Waiver Office notifies the support coordinator, provider, DHH data contractor, and BHSF immediately by telephone or fax if an appeal is made within this timeframe.

3. If an appeal request is not received within ten (10) calendar days of the adverse action notice, then all services are stopped on the 11th calendar day (All prior authorizations are voided through the DHH data contractor on the eleventh (11) calendar day.).

4. If the participant appeals within 30 calendar days of the adverse action notice, the OCDD Regional Waiver Office completes a Summary of Evidence and prepares for the appeal.

5. If the appeal decision is in favor of the participant, the OCDD Regional Waiver Office takes steps to reinstate the participant's waiver certification and services.

B. Decertification or any other disenrollment of a waiver participant is subject to review by the State Office Review (SOR) panel prior to notification of appeal rights and subsequent termination of waiver services.

10.2 DENIAL OF IFS HOURS

A. The following processes apply to denials of requested IFS hours:

1. The Developmental Disabilities Regional Waiver Office issues a Notice of Adverse Action for IFS requests that are denied. This notice is sent to the participant and to the support coordinator. The notice includes a cover letter and formal notice of appeal and fair hearing rights.

    a. The Developmental Disabilities Regional Waiver Office notifies the OCDD data contractor (SRI) of any change in current authorizations.

2. If the individual is <u>not receiving IFS services</u>, he/she may appeal within 30 days of the notice of the adverse action. If the appeal decision is in favor of the individual, the OCDD initiates hours as appropriate.

3. If the individual is <u>currently receiving IFS hours</u> in excess of the recommended IFS hours and <u>wishes to continue current IFS hours service delivery during the appeals process</u>, he/she must file a request for appeal within ten (10) calendar days of the notice of adverse action. This request for appeal must also request continuation of services during the appeal period.

    a. The participant must submit his/her appeal request in writing or verbally to the DHH Bureau of Appeals. The appeal request should specifically state the reason for disagreement with the denial decision.

    b. The Developmental Disabilities Regional Waiver Office notifies the support coordinator, provider, OCDD data contractor, and BHSF immediately by telephone or fax if an appeal is made within the ten (10) day timeframe and also requests continuation of services. IFS hours will be continued at the higher level.

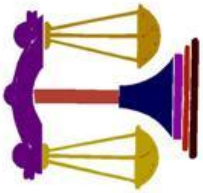
4. If the individual is currently receiving IFS hours in excess of the recommended IFS hours, he/she may appeal within 30 days of the notice of adverse action. Appeals not requesting continuation of services (described in #3 above) and appeals not occurring within ten (10) calendar days of the notice of adverse action (also described in Section 10.2.A.3 above) will result in IFS hours being delivered according to the approved support plan. This delivery may be a reduced number of IFS hours than what the participant is requesting in the appeal.

    a. The participants must submit his/her appeal request in writing or verbally to the DHH Bureau of Appeals. The appeal request should specifically state the reason for disagreement with the denial decision.

10.3 ATTACHMENTS

Attachment 10.3.1 Medicaid Fair Hearings Brochure

Medicaid Fair Hearings (Appeals)



When you **apply for** or **receive** Medicaid health coverage, you get certain rights and responsibilities. This includes the right to ask for a Fair Hearing if you don't agree with the action taken to deny, close, or reduce your Medicaid benefits.

This brochure will help you. . .

- **Understand** your Appeal rights
- **Decide** if you want to ask for a Fair Hearing
- **Prepare** for a Fair Hearing

Where do I go for the Fair Hearing meeting?

Fair Hearings are usually held at local Medicaid offices. You will get a letter from the Appeals Bureau that will give you the date, the time, and where you need to go for the hearing.

Will the hearing be face-to-face with an Administrative Law Judge?

Fair Hearings are usually done by telephone at the local Medicaid office. The hearing will be taped and a speaker phone will be used to talk to the Administrative Law Judge. You, those you choose to attend, and local Medicaid staff members will be at the meeting. If requested timely, a face-to-face hearing at the local Medicaid office may be granted.

Can I get free legal assistance?

You may be able to get free legal help from the legal assistance office nearest you. You can get the telephone number of the nearest legal assistance office from the local Medicaid office.

What happens during the hearing?

1) The Administrative Law Judge will preside over the hearing and may question those present at the hearing.
2) All persons present must be sworn in.
3) First, a Medicaid staff member will read the Summary of Evidence and explain the reason for the action. Witnesses may be called to give testimony and answer questions. You may question the Medicaid staff and the witnesses.
4) Next, you or your representative will explain why you feel the action should not be taken on your case. Witnesses may be called to give testimony and answer questions. Medicaid staff may question you, your representative, and witnesses.

What if I lose my case?

If you lose the appeal, you may be asked to pay the Medicaid Program for any Medicaid benefits you received while you were waiting for your Fair Hearing decision.

What if I do not agree with the decision?

If you do not agree with the decision, you may ask for a judicial review. You will have 30 calendar days from the date of the appeal decision notice to file the request in the parish where you live or in East Baton Rouge parish.

When can I re-apply for Medicaid?

You can **re-apply** for Medicaid benefits at any time. You do not have to wait until the Fair Hearing decision is made before re-applying.

This public document was printed as a cost of $4,500. Fifty thousand (50,000) copies were produced in this printing. This document was produced for Louisiana Department of Health & Hospitals, Office of Management & Finance, P.O. Box 91030, Baton Rouge, LA 70821-9030. This material was printed in accordance with the standards for printing by State Agencies established pursuant to R.S. 43:31.

LOUISIANA

Department of HEALTH and HOSPITALS

BHSF Flyer-Fair Hearings
Issued 09/01

What is a Fair Hearing?

If you think we have made a mistake on your Medicaid eligibility decision, you can ask for a meeting that is called a Fair Hearing. Sometimes it is called an **Appeal Hearing**.

Do I have a time limit to request a Fair Hearing?

Yes. You have 30 days from the date of the notice explaining the action taken on your case to ask for a Fair Hearing.

How do I ask for a Fair Hearing?

You may ask for a Fair Hearing through the Medicaid office in your area by telephone, in-person, or by mail. You may fill out the back of your notice or write a letter to ask for a Fair Hearing. The Medicaid office will send your request to the Appeals Bureau. If you like, you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183.

What if I am not sure I want a Fair Hearing?

You may ask to talk to a Supervisor in the local Medicaid office before the 30 days on your written notice ends. The Supervisor will review the decision made on your case. If the Supervisor agrees with the decision made on your case, you may be given other information about the reason we took the action.

Sometimes we make a mistake. If the Supervisor does not agree with the decision, you will get a new decision notice. You may wish to ask for a Fair Hearing after the supervisor has reviewed the action taken or proposed on your case.

How will I know that the Appeals Bureau received my request?

You will get a letter that tells you that your Fair Hearing request was received by the Appeals Bureau.

Will my medical coverage end if I ask for a Fair Hearing?

In most cases, if you are already certified for Medicaid or Medicaid-related coverage, we will not take action on your case if you ask for a Fair Hearing **within 10 days** of the notice. Your coverage will stay active or unchanged until the Appeals Bureau decision has been made. This will give you, or anyone you want to represent you, time to give us the information we need or time to discuss this decision with a supervisor in the Medicaid office.

May I ask for the hearing date to be delayed until later?

The Administrative Law Judge may grant a delay in cases of AGood Cause@ only.

Can I review my case file before the hearing?

Before the hearing you will get a copy of the report (Summary of Evidence) prepared by the local Medicaid office. The report will tell you why the agency decided to take the action on your case. It will include the forms, information, and policies used to make their decision. You may contact your local Medicaid office if you would like other information from your file.

Who will be the judge at the hearing?

An Administrative Law Judge from the DHH Appeals Bureau will be assigned to hear your case. The Administrative Law Judge will be fair. The Administrative Law Judge did not make the decision that will be reviewed in your hearing and does not work for the Medicaid Program.

How long does the hearing last?

The Fair Hearing usually lasts no longer than one hour.

How long will it take to get a decision?

In most cases a decision will be made within 90 days from the date you filed the request for a Fair Hearing, unless you asked for an extension.

What will the decision say?

You will get a written decision that will give a summary of the facts of your case and the rules and regulations that supported the decision. The decision will be based on the evidence presented at the Fair Hearing.

What if my situation changes before the hearing?

If your situation changes before the hearing, you should contact the local Medicaid office. You may be asked to bring new information to the hearing such as medical reports and information about income changes.

Do I have to be at the hearing?

No. If you do not want to be at the hearing, you may have a relative, friend, or other spokesperson represent you. Legal counsel may also represent you. Medicaid providers **cannot** serve as your representative.

Attachment 10.3.2 Form 142 Notice of Medical Certification

BHSF Form 142
Rev. 12/08
Prior Issue Obsolete

Louisiana Department of Health and Hospitals
Medicaid Program
Notice of Medical Certification

Primary Dx:_____ Secondary Dx: _____

SSN: _____ Date of Birth: _____ Medicaid No: _____

To: _____

Home Address: _____

Facility/Provider Name: _____ Vendor No: _____

Facility Address:_____ Parish: _____

(if Medicaid applicant in facility) _____

I. Nursing Facility or Intermediate Care Facility

- This decision is effective for 30 days prior to admission/application to a facility which provides NF/ICF services and 5 days prior to admission/application to a facility which provides SNF services.
- This decision may be reviewed periodically to determine continued need for medical services.
- This decision relates to medical eligibility only and is separate from a decision of financial eligibility for Medicaid.

☐ A. Approved for Medicaid medical eligibility services effective_____.

☐ B. Approved for Medicaid medical eligibility services for a temporary period effective_____through_____.

☐ C. Vendor payment to the Nursing Facility is approved effective_____.

☐ D. Facility is currently on Denial of Payment for new admissions effective_____.

☐ E. Not Approved – Unable to make a determination because complete admission packet was not received.

☐ F. Not Approved – Does not meet Medicaid medical eligibility requirement.

☐ G. Not Approved – Admission Denied by Level II Authority.

☐ H. No longer approved.
- Medicaid payment will continue for above type services through_____.
- This is not a notice of discharge. It relates only to medical benefits from Medicaid.

☐ I. Approved for_____services effective_____.

II. WAIVER/PACE

☐ A. Approved for Medicaid medical eligibility_____Waiver services effective_____.

☐ B. Not Approved - Does not meet Medicaid Medical eligibility.

☐ C. Date of Home Visit:_____

☐ D. Vendor Payment May Begin:_____ Date completed: _____

Agency Representative: _____Date: _____

OAAS or OCDD Regional Office: _____

OAAS or OCDD Regional Office Address: _____

CC: ☐ Facility/Provider ☐ Office of Mental Health ☐ OAAS ☐ OCDD
☐ Medicaid Long Term Care Unit (specify Parish): _____
☐ Other (specify): _____

11

TRAINING AND CERTIFICATION PROCESSES

11.1 Training for the SIS/LA PLUS Assessors

11.2 Certification in the use of the SIS/LA PLUS

11.3 Certification Step 1: Classroom Training for the "Guidelines for Support Planning"

11.4 Certification Step 2: Support Plan Completion Consistent with the "Guidelines for Support Planning"

11.5 Designation and Requirements of Master Trainers

11.6 Attachments

TRAINING AND CERTIFICATION PROCESSES

Realizing that good assessments and planning start with good assessors/facilitators, OCDD places a high priority on the training and certification of assessors and those developing and reviewing plans.

OCDD's objective is to ensure that assessments are accurate reflections of individuals and their needs and that they are used to develop quality plans to meet identified desires and needs.

11.1 TRAINING FOR THE SIS/LA PLUS ASSESSORS

A. The training and certification process for assessors involves a multiphase process.

B. The first phase includes classroom training (2.5 days - involving 2 days of classroom training and typically a ½ day videoconference). The classroom training is used to introduce both assessment tools. It covers the following information:

   1. Background in tool development,

   2. Uses of the tool, and

   3. Administration of the tools.

C. At the end of each day, trainees are expected to practice administration of the tools (SIS on day one and LA PLUS on day two). At the end of the second day, trainees are expected to pass a written competency test of material presented.

D. On the third day, a videoconference is used to present the electronic versions of both instruments and have trainees become familiar with the features found in the electronic versions of the SIS and LA PLUS.

   1. Particular emphasis is given to demonstrating the features of the electronic versions so that trainees can become knowledgeable of such.

   2. Trainees are then given electronic versions of both instruments and encouraged to familiarize themselves with them by engaging in practice manipulations.

   3. It is noted that the videoconference is the format utilized by SIS/LA PLUS Project Team. Regional Office Specialist staff and support coordinator agency

master trainers (defined in Section 11.5) may utilize an agency on-site training variation (i.e., may conduct training on-site at the particular agency where staff are being trained).

11.2 CERTIFICATION IN THE USE OF THE SIS/LA PLUS

A. The second phase of certification continues the practice involved in training and begins the competency process. The assessor trainees are required to schedule three assessments that are to be shadowed by a previously certified assessor ("rater") as the second level in the process.

B. The rater completes the SIS and LA PLUS for the same individual with the same information while the assessor trainee is conducting the assessment.

   1. If the trainee is a state Regional Office Specialist (ROS) or ROS back-up, the assessments are shadowed by a rater from the SIS/LA PLUS Project Team.

   2. If the trainee is a support coordinator agency master trainer, the assessment is shadowed by either the ROS or ROS back-up rater.

   3. If the trainee is a support coordinator, the assessment is shadowed by the support coordinator master trainer.

C. The rater compares the results of the assessment he/she completes with that of the assessor trainee. A formula (an inter-rater reliability formula established by a statistical consultant for OCDD) is used which allows the rater to help determine if an assessment was conducted reliably.

D. If after the first shadowed assessment (and any other subsequent assessments until certification is achieved) the rater determines that a reliable assessment was not performed, the rater offers pointers, training tips, etc. to better prepare the assessor trainee for the next scheduled assessment(s).

   1. Pointers, training tips, etc. are offered only after and between assessments.

2. A rater does not offer pointers, tips, etc while the assessment itself is conducted. This goes against protocol in the inter-rater reliability process.

E. When a minimum of three assessments are completed, both the trainee's assessments and the rater's shadowed assessments are forwarded to the SIS/LA PLUS Project Team for review.

1. It is important that the rater note the sequence of assessments as the SIS/LA PLUS Project Team looks for progressive improvement in trainee skill.

2. It is important that trainees be reminded that the shadowed assessments are used for training purposes only.

3. No assessments occurring during shadowing exercises can be used for planning purposes. (This applies to both the rater's and the trainee's.)

F. A review of all trainee assessments by the SIS/LA PLUS Project Team is the third level in the process. (This also would likely include consultation with ROS staff.) The SIS/LA PLUS Project Team reviews all submitted assessments by a trainee and the matching shadowed assessment by the rater.

G. The State SIS/LA PLUS Project Team uses the inter-rater reliability formula to determine if the trainee's assessments are within acceptable reliability guidelines. In addition, the trainee's assessments are reviewed to determine if there appears to be comprehension of assessment principles relevant to both tools (i.e., Did the assessor appear to grasp the concept of the "Important To" and "Important For"? Was documentation supplied which justifies the response and demonstrates comprehension of this assessment concept? In addition, did the assessor complete the assessment in entirety? Did the assessor make assessment errors that demonstrate a failure to grasp pertinent assessment rules?).

H. If the State SIS/LA PLUS Team determines that a trainee has mastered the assessment concepts and that the third assessment was within acceptable reliability guidelines, then certification is granted for one year.

I. If the trainee failed to demonstrate mastery of assessment principles and/or fell outside acceptable reliability guidelines, then a plan of remediation as determined by the SIS/LA PLUS Project Team is applied.

1. It is typical that a plan of remediation begins with a request that an additional assessment and shadowing experience occur.

2. Before an additional assessment occurs, the trainee and rater are notified of the deficiencies by e-mail.

3. SIS/LA PLUS Project Team members may also counsel the trainee by phone in an attempt to clarify any misunderstanding a trainee may have following the e-mail noting deficiency.

4. It is important that this counseling be individualized to the particular needs of the trainee and discusses areas of weakness.

5. Counseling is also used to increase skill proficiency.

6. After the additional assessment is completed, it is forwarded to the State SIS/LA PLUS Team for review.

7. If the additional assessment contains deficiencies, the trainee may be asked to submit revisions or may be asked to complete additional shadowed assessments.

8. Other remediation strategies include: having the trainee participate in additional classroom training, conducting additional phone or in-person counseling by a member of the SIS/LA PLUS Project Team, having the trainee observe a member of the SIS/LA PLUS Project Team or ROS staff conduct an

assessment and then conduct another shadowed assessment along with a rater, etc.).

J. After various attempts at remediation and the submission of five deficient assessments, a trainee is determined ineligible for certification for six months following the date of the last assessment submitted for review.

K. The SIS/LA PLUS Project Team issues the final determination of whether certification is granted or denied.

L. At any time after certification, the assessor trainee can begin conducting assessments independently.

M. If certification is denied, the trainee shall not conduct any additional assessments. Following a six month period subsequent to denial of certification, an individual may restart the assessor trainee process. The individual must complete the classroom training and complete a minimum of three (3) shadowed assessments that are submitted to the SIS/LA PLUS project team for review.

N. Certification is valid for up to one year. Before issuance of re-certification, a minimum of one shadowing experience must occur with the assessor demonstrating mastery standards.

O. To maintain integrity in the assessment process and for data collection purposes, all certified assessors are monitored. All certified assessors are defined as Region Office Specialists and back-ups, support coordination master trainers and back-ups, and support coordinators. Monitoring procedures include:

1. A minimum of one shadowing experience for all ROS and back-ups every quarter - The shadowing is to be conducted by a member of the SIS/LA PLUS Project Team. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated (either additional classroom training, observation of SIS staff conducting assessments, or additional shadowings of the ROS and back ups);

2. A minimum of one shadowing experience for all support coordination master trainers and back-ups every quarter - The shadowing is to be conducted by the ROS or ROS back-ups. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated (either additional classroom training, observation of ROS staff conducting assessments, or additional shadowings of the support coordination master trainer and back ups); and

3. A minimum of one shadowing experience for all support coordination agency support coordinators semi-annually - The shadowing is to be conducted by a support coordination master trainer or back-up. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated (either additional classroom training, observation of support coordination agency master trainers and/or back-ups conducting assessments, or additional shadowings of the support coordinator).

P. Should a certified assessor be unable to demonstrate reliability, the assessor is de-certified. The assessor and immediate supervisor, as well as the OCDD Executive Director of Community Services are notified of the decertification. The assessor is no longer permitted to conduct SIS and LA PLUS assessments independently. If the ROS staff are de-certified, they are no longer be able to train, shadow and perform other assessment and training duties relevant to the role of ROS.

Q. All certified assessors must attend and successfully complete a yearly classroom training that is offered by the SIS/LA PLUS Project Team. The purpose of the annual classroom training is to:

1. Present and train on any new assessment procedures (e.g., if additional data categories are added to the existing assessments),

2. Reinforce current skills,

3. Clarify questions, concerns or issues that may have emerged since last contact, and

4. Extend certification of the participant.

R. Manual checking of all assessments conducted occurs by SIS/LA PLUS Project Team before submission to the OCDD SIS/LA PLUS database. The purpose is to assure that assessments are complete and error free and to identify potential problem assessments.

(Note: This additional data monitoring step is proposed and is necessary until Information Technology is able to create the technological framework necessary that will render such manual checks obsolete.)

S. A SIS/LA PLUS users group meets with Regional Office Specialists and back-ups in quarterly phone conferences. The SIS/LA PLUS Project Team ask all ROS and back-ups to answer questions and/or clarify concerns which may present. This concept is repeated by ROS and back-ups in their own respective regions with support coordination master trainers and back-ups.

T. Finally, all data pertaining to training, shadowings, certification status and assessments are tracked by the SIS/LA PLUS Project Team. This data is monitored to determine compliance with OCDD policy and procedures.

11.3 CERTIFICATION STEP 1: CLASSROOM TRAINING FOR THE "GUIDELINES FOR SUPPORT PLANNING"

A. The training and certification process for support coordinators in the "Guidelines for Support Planning" is separate and distinct from SIS/LA PLUS training required for assessors.

B. The first step in certification for the "Guidelines for Support Planning" is completion of a multi-day classroom training that covers all key areas of the "Guidelines for Support Planning." During each day of training, trainees are expected to practice the various components of the planning process.

C. The number of days of required training is based upon the role of the support coordination agency personnel.

   1. Supervisors are required to attend two and one-half (2 ½) days of classroom training.

   2. Support coordinators are required to attend at least two (2) days of classroom training.

D. Following successful completion of classroom training, support coordinators and supervisors progress to the second step in certification, which is completion of support plans consistent with the principles in the "Guidelines for Support Planning."

11.4 CERTIFICATION STEP 2: SUPPORT PLAN COMPLETION CONSISTENT WITH THE "GUIDELINES FOR SUPPORT PLANNING"

A. In addition to classroom training, all support coordination supervisors and support coordinators must complete three (3) support plans that meet the requirements of the "Guidelines for Support Planning." This determination is made through application of the Individual Supports Review (ISR) by the support coordination agency supervisor (for support coordinators only), designated OCDD Regional Waiver Office staff, and Guidelines for Planning State Office Review Committee. (The detailed process is discussed in Sections 7.1, 7.2, and 7.3)

B. Trainees must complete Discovery activities, conduct a planning meeting, and develop a complete plan following the process described in "Guidelines for Support Planning" Sections 3 through 6. Trainees may be shadowed during planning meetings until two plans are approved.

C. When the plans are completed, the support coordination agency supervisor must complete the ISR according to protocol in Section 7.

    1. Both the trainee's plan and the support coordination agency supervisor's ISR are forwarded to the GPSORC Chair for review. (See Section 7.)

D. The GPSORC (or designees of the committee) reviews the three completed plans and ISRs. The review includes consultation with Region Office Specialist (ROS) staff. Plans are reviewed using the criteria in the ISR consistent with the review process in Section 7.

E. If after review it is determined that three of the trainee's initial submissions were within acceptable approval guidelines, then certification is granted for one year.

F. If the trainee fails to meet criteria and/or falls outside acceptable guidelines, then a plan of remediation as determined by the GPSORC (or designees of the committee) is applied.

1. The plan of remediation is developed by GPSORC (or designees of the committee).

    a. Typical remediation strategies begin with a request that additional planning meetings with shadowing experience occur.

    b. The ROS may also provide additional training in an attempt to clear any misunderstanding a trainee may have following the e-mail noting deficiency.

    c. It is important that any additional training be individualized to the particular needs of the trainee in order to address areas of weakness.

2. The trainee and supervisor are notified of the deficiencies and the remediation requirements by e-mail.

3. One or more additional plan(s) may be requested to demonstrate competency. After the additional plan(s) is completed, it is forwarded to the GPSORC Chair (or designee) for review.

4. Should the plan still contain deficiencies, the trainee may be asked to submit revisions or to complete additional shadowed plans.

5. Other remediation strategies include: having the trainee participate in additional classroom training, having the trainee observe a ROS staff conduct a planning meeting and complete a plan, having the trainee complete an additional shadowed plan post additional training or observation of ROS, etc.

G. After various attempts at remediation and submission of five deficient plans, a trainee is determined ineligible for certification for six months.

H. The GPSORC Chair issues the final determination of whether certification is granted or denied.

I. Should the trainee not be eligible for certification status, he/she must cease conducting any additional planning meetings or completing any additional plans.

J. Trainees who master the required skill level are issued a certificate that is valid for up to one year from the time of issuance.

K. In an effort to maintain integrity in the planning process, on-going reliability measures and monitoring of support coordinators is required. In addition to support coordinators, once certified, all ROS and back-ups and support coordinator master trainers and back-ups are also monitored on an on-going basis. Monitoring requirements of ROS, support coordinator master trainers, and support coordinators are described in the following paragraphs.

1. A minimum of one reliability review for all ROS and back-ups every quarter. The shadowing is to be conducted by a member of the GPSORC. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated.

2. A minimum of one reliability review for all support coordinator master trainers and back-ups every quarter. The shadowing is to be conducted by ROS or back-ups. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated.

3. A minimum of one shadowing experience for all support coordinators semi-annually in addition to regularly required supervisory review of plans. The shadowing is to be conducted by support coordination master trainers or back-ups and includes review of Discovery activities, observation of planning meeting and review of the support plan. If the shadowed individual fails to meet reliability criteria, then a remedial plan of action is initiated.

L. Should a certified support coordinator be unable to demonstrate an ability to maintain standards, the support coordinator is de-certified. The support coordinator and immediate supervisor, as well as the OCDD Executive Director of Community Services, are notified. The support coordinator is no longer able to conduct planning independently.

M. If an OCDD Regional Waiver Office staff person is unable to demonstrate an ability to maintain standards, that individual is no longer able to train, shadow, and perform other duties relevant to the role of ROS in support planning.

N. All individuals conducting support planning and/or those who train persons to conduct support planning are required to attend and successfully complete a yearly classroom training that is offered by the OCDD. The purposes of training attendance are to complete the following:

1. Reinforce current skills,

2. Clarify questions, concerns or issues that may have emerged since last contact, and

3. Extend certification of the participant.

O. Finally, all data pertaining to training completion, certification status, and support plan ratings (according to the ISR) are tracked by the GPSORC. This data is monitored to determine compliance with OCDD policy and procedures.

11.5 DESIGNATION AND REQUIREMENTS OF MASTER TRAINERS

A. The support coordinator master trainer is appointed by the support coordination agency.

B. The support coordinator master trainer serves as the lead agency trainer in assessment and the "Guidelines for Support Planning" training matters for the agency.

C. A back up is appointed for each agency.

D. The support coordinator master trainer (and back up) undergo additional OCDD sponsored trainings, certification, and monitoring as compared to other agency staff.

1. The support coordinator master trainer (and back up) attends an additional training session that focuses on preparing him/her to train other staff.

2. Information is disseminated to the support coordinator master trainer on how to properly conduct shadowing with trainees.

3. The Region Office Specialist (ROS) conducts routine reliability checks on the support coordinator master trainer. The reliability checks are used to determine maintenance of skill level and need for remediation.

4. The ROS attends the initial training offered by the support coordinator master trainer in order to assure that the training offered by the master trainer is in compliance with quality standards.

5. The support coordinator master trainer must circulate an evaluation form to all those that he/she trains to get participant feedback on his/her effectiveness in training on the material.

E. Support coordinator master trainers and back-ups are required to be certified in both the assessment of support needs (SIS and LA PLUS) and in the creation of support plans for individuals ("Guidelines for Support Planning").

F. If an agency designated master trainer or back-up does not initially meet full certification requirements, then the agency must designate another individual as the master trainer or back-up.

1. If an individual is not certified in SIS/LA PLUS, but does gain certification in the "Guidelines for Support Planning," he/she may develop support plans based on assessments conducted by certified assessors. But he/she may not independently conduct SIS/ LA PLUS assessments.

2. The individual is able to attempt certification again after the passing of six (6) months since last attempting certification.

3. Attempting certification again involves starting the training process over and includes going through classroom training (including SIS/LA PLUS, "Guidelines for Support Planning," and Train the Trainer) and a minimum of three (3) shadowed assessments and submission of three (3) plans that meet requirements of the "Guidelines for Support Planning."

4. If at that time the individual passes both certifications, the agency may designate that individual as a master trainer or back-up.

G. The above also applies to individuals who have been originally certified and failed at re-certification.

11.6 ATTACHMENTS

No attachments for Section 11.6

12

OCDD QUALITY MONITORING PROCESS

12.1 Relevant Policies and Requirements

12.2 Support Planning Quality Monitoring Process

12.3 Establishing and Monitoring Performance Indicators

12.4 Responsibilities for Assuring the Quality of Support Plans and Delivery of Services

12.5 Attachments

OCDD QUALITY MONITORING PROCESS

The Office for Citizens with Developmental Disabilities (OCDD) Quality Monitoring Process involves a coordinated effort among providers, support coordination agencies, Regional Developmental Disability Offices, and OCDD Central Office in obtaining and reviewing information and data in order to assure that:

1. Office programs are achieving outcomes important to people with developmental disabilities by meeting established performance criteria;

2. Individual situations that require remediation are addressed;

3. Data collected on specific performance indicators identifies trends, patterns, and opportunities for improvement and appropriate action for remediation; and

4. Data provides information on how well the service system is meeting the needs of individuals served, Department/Office goals and priorities, and the Centers for Medicare and Medicaid Services (CMS) assurance requirements.

12.1 RELEVANT POLICIES AND REQUIREMENTS

A. In accordance with the *OCDD Quality Enhancement Process Policy #603*, it is the policy of OCDD that quality assurance is the responsibility of every person at every level within the developmental disabilities services system and that quality assurance activities occur at provider, support coordination, regional, and statewide levels in order to provide quality services and to identify and respond to opportunities for improvement in the provision of supports and services to people with developmental activities.

B. Home and Community-Based Services Waiver Requirements

1. OCDD must demonstrate adherence to waiver assurances and other federal requirements as documented in each waiver application. OCDD's quality assurance program systematically collects and reviews data in order to assure the requirements are being met and engages in remediation actions when non-adherence is identified.

2. OCDD must adhere to six (6) major waiver assurances with one or more requirements (also known as subassurances) for each assurance. The six major assurances are:

   a. Level of care,

   b. Service plan,

   c. Qualified providers,

   d. Health and welfare,

   e. Financial accountability, and

f. Administrative authority.

3. The OCDD "Guidelines for Support Planning" process must adhere to service plan assurance by implementing processes that address the five (5) required subassurances.

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

   b. The state monitors service plan development in accordance with its policies and procedures.

   c. Service plans are updated and or revised at least annually or when warranted by changes in the waiver participant's needs.

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

   e. Participants are afforded choice between waiver services and institutional care and between/among waiver services and providers.

4. For each of the service plan subassurances, OCDD must specify within each waiver application:

   a. Performance indicators including methods used to obtain information about compliance and the frequency of and process for data review,

   b. Remediation activities followed to correct individual problems including data collection for remediation activities, and

c. The quality enhancement process including how data is aggregated, reviewed, and used to develop and implement quality improvement initiatives.

12.2 SUPPORT PLANNING QUALITY MONITORING PROCESSES

A. OCDD has developed several methods for obtaining information about the quality of support plans and the delivery of supports and services; thereby assuring that waiver participants' needs and preferences are identified, plans address assessed needs and preferences, and services are delivered as according to participants' plans.

B. People's needs and preferences are assessed through administration of the SIS/LA PLUS to individuals and through pre-planning Discovery activities to identify needs and personal goals. Quality management strategies to assure that needs and personal goals are comprehensively assessed include:

1. A certification process for the SIS/LA PLUS to assure that SIS/LA PLUS assessments are only conducted by support coordinators who have been determined to reliably administer the SIS/LA PLUS assessment and document assessment results. A description of the certification processes is described in Section 11, Training and Certification Process.

2. A certification process for "Guidelines for Support Planning" to assure that support coordinators identify participant's needs and personal goals during the pre-planning Discovery process. A Personal Outcomes Assessment is completed by the support coordinator each year as part of the planning process to identify the preferences and priorities of the individual as part of the planning process. [See Section 3.2, Completing Discovery (Using Personal Outcomes Interview/Mapping Strategies/Discovery Meeting) and Section 3.3, Developing a Personal Vision and Goals.]

3. Certification in the "Guidelines for Support Planning" that requires that support coordinators successfully complete a classroom training in which support coordinators learn Discovery activities to identify a participant's needs and preferences. Support Coordinators also received training in the use of the Discovery information during planning process to develop an individualized support plan for each participant. A description of the certification process is described in Section 11, Training and Certification Process. Spreadsheets for tracking Certification for the SIS/LA PLUS and "Guidelines for Support Planning" are maintained in both the OCDD Central Office and the Regional Developmental

Disability Offices database to assure that only certified people are performing the functions of SIS/LA PLUS administration and Support Coordination Supervisor reviews with the Individual.

C. Support Plans meet people's assessed needs and preferences. OCDD provides ongoing training and certification to support coordination agency supervisors and trainers and Regional Office Specialists and other staff on the use of the Individual Supports Review Protocol as a mechanism for determining that support plans meet participants' assessed needs, personal goals, and OCDD and CMS requirements. In order to assure that support plans address participants' needs and include strategies to help participants attain their personal goals, several quality management processes have been implemented, including:

1. Support coordinator supervisors and their subordinates are required to be certified in the "Guidelines for Support Planning." The certification includes classroom instruction and shadowing. Training competencies include:

    a. Understanding of OCDD planning values and assumptions,

    b. Purpose of person-centered planning and service delivery,

    c. Discovery process,

    d. Planning format,

    e. Planning meeting preparation,

    f. Planning meeting facilitation,

    g. Development of planning strategies,

h. Plan implementation, and

i. Plan review and revision.

2. The Support Coordination Supervisor is required to review 100% of the initial and annual support plans using the Individual Supports Review Protocol. (See Section 7, Support Plan Approval Process.) If the support coordination supervisor determines that a support plan does not meet criteria for approval, the supervisor must assure that the support plan is corrected. The Individual Supports Review Protocol must be submitted along with the participant's support plan to the Regional Developmental Disability Office Waiver Unit for approval once the support coordinator supervisor certifies the plan meets OCDD Protocol requirements.

3. Regional Developmental Disability Office staff is required to review 100% of the service plans using the Individual Supports Review Protocol. Regional Developmental Disability Office staff shall require revisions when criteria as established in the Individual Supports Review Protocol are not met. In addition, Regional Developmental Disability Office waiver staff is required to complete a reliability verification of the support coordination supervisor's Individual Supports Review Protocol and complete certification of the support coordination supervisor. Certification is verified by Central Office staff through a review of three qualifying Individual Supports Review Protocols from the support coordination supervisor and Regional Developmental Disability Office staff. Regional Developmental Disability Office staff also tracks plan approval in terms of timelines, approval status, and compliance with the "Guidelines for Support Planning" requirements by support coordination agency, support coordination supervisor, and support coordinator.

4. The OCDD Central Office receives data by agency from the Regional Developmental Disability Offices and reviews the data reports to identify agency, regional, and statewide trends with regard to this subassurance. This data is then used to determine Office initiatives inclusive of training efforts, remediation strategies, and other corrective measures. Central Office staff also review a random sample of all plans completed to assure quality and accuracy of the process.

D. Support coordinators are required to monitor participants' support plans to assure that the support plans continue to adequately meet participants' needs and help them accomplish their personal goals and that services are delivered as specified in the participants' support plans.

1. Support coordinator monitoring activities include:

   a. Monthly phone contacts,

   b. Quarterly in-person visits,

   c. Quarterly support team meetings to review the participant's support plan to assure that services are delivered according to the plan and that the plan continues to meet the needs and preferences of participants,

   d. Quarterly observation of services, and

   e. Annual update of the support plan.

2. Support coordinator documentation of support coordination monitoring results is maintained in the support coordinator's contact and progress notes/service logs and the data is entered into the Case Management Information System (CMIS).

   a. In conducting required monitoring, support coordinators monitor and observe any type of IFS used, including flexible hours. It is not necessary to conduct an additional observation to assure monitoring of a planned service.

3. Tracking of support coordination monitoring is maintained in CMIS and includes when the monitoring was done and what was observed.

4. The Quarterly Quality Review Tool is completed at each quarterly review for each participant by the support team led by the support coordinator. This information is used to assure that services are being provided and goals and needs are being met. This data is submitted with the annual plan review for the next planning cycle and is reviewed by the Regional Developmental Disability Office staff for compliance with monitoring practices and to assess outcomes for each participant. The information is entered into an OCDD database and reviewed for trends and patterns by agency, support coordination supervisor, and support coordinator.

5. OCDD Central Office receives data per agency from the Regional Developmental Disability Office and reviews it to track agency, regional, and statewide trends with regard to this subassurance. This data is then used to determine Office initiatives inclusive of training efforts, remediation strategies, and other appropriate corrective measures.

12.3 ESTABLISHING AND MONITORING PERFORMANCE INDICATORS

A. Establishing Performance Indicators

1. OCDD determines performance indicators related to the "Guidelines for Support Planning" through its annual strategic planning process.

2. Data for these indicators are reviewed at least quarterly to determine progress and identify any challenges or barriers. Trends and patterns are analyzed by support coordination agency, region, and statewide.

3. Indicators may be modified or added to based upon this quality review process.

B. Monitoring Performance Indicators

1. Reports with performance indicator data are generated as specified by frequency of review and presented to the OCDD Performance Review Committee. The committee determines if strategies need to be developed and implemented to improve performance.

2. The OCDD Performance Review Committee monitors implementation and effectiveness of strategies to improve performance.

12.4 RESPONSIBILITIES FOR ASSURING THE QUALITY OF SUPPORT PLANS AND DELIVERY OF SERVICES

A. Responsibilities of the Direct Service Provider Agency include:

1. Completing the provider responsibilities as a member of the support team as described in Section 3.4 (Establishing the Support Team),

2. Notifying the support coordinator if the participant's plan is not meeting the participant's needs or if the participant's needs and preferences change.

3. Tracking agency performance for plan implementation,

4. Reviewing data and implementing remediation and quality improvement strategies, as warranted [(See http://www.dhh.louisiana.gov/offices/publications.asp?ID=77&Detail=2312 for a copy of the Quality Enhancement Provider Handbook that was jointly developed by OCDD and the Office for Aging and Adult Services (OAAS).], and

5. Requesting technical assistance from the OCDD Regional Developmental Disability Offices, when needed.

B. Responsibilities of the support coordination agency include:

1. Maintaining sufficient numbers of support coordinators that are certified in administration of the SIS/LA PLUS and the "Guidelines for Support Planning,"

2. Maintaining a master trainer certified to train agency staff in the SIS/LA PLUS and Guideline for Planning,

3. Reviewing 100% of support coordinator's service plans with the Individual Supports Review Protocol by the support coordination supervisor and remediating any plan deficiencies prior to submission to the OCDD Regional Developmental Disability Offices.

4. Monitoring service plan implementation during monthly contacts and quarterly reviews and revising service plans, as needed,

5. Tracking compliance with time lines for service plan submission, percentage of plans that meet criteria identified in the Individual Support Review Protocol, and compliance with quarterly monitoring of plans to assure that services are delivered according to the plan and that the plan continues to meet participant's needs and preferences,

6. Reviewing data and implementing remediation and quality improvement strategies, as warranted, and

7. Requesting technical assistance from the Regional Developmental Disability Offices, when needed.

C. Responsibilities of the Regional Developmental Disability Offices include:

1. Maintaining a Regional Office Specialist and a back-up who are certified in the "Guidelines for Support Planning" and the SIS/LA PLUS,

2. Maintaining waiver staff who are certified in the "Guidelines for Support Planning,"

3. Providing training and technical assistance on the "Guidelines for Support Planning" to Regional Developmental Disability Office, support coordination agency, and direct service provider staff,

4. Following Office policy on reviewing and approving service plans, including conducting in-depth reviews on a representative sample of plans from each support coordination supervisor and on plans for participants at risk because of behavioral, medical, or environmental risk factors,

5. Tracking performance for timeliness of service plan submission, adequacy of plan to meet criteria identified in the Individual Support Review Protocol, and adequacy of monitoring of the plan to assure that services are delivered according to the plan and that the plan continues to meet participant's needs and preferences,

6. Reviewing data and implementing remediation and quality improvement strategies, as warranted, and

7. Requesting technical assistance from the OCDD Central Office, when needed.

D. Responsibilities of the OCDD Central Office include:

1. Assuring that policies and procedures are issued and updated, as needed,

2. Requiring and tracking any needed remediation,

3. Reviewing reports with aggregate data on performance indicators and remediation to identify trends and patterns,

4. Developing and implementing quality improvement strategies,

5. Tracking implementation of quality improvement strategies,

6. Evaluating effectiveness of quality improvement strategies, adjusting strategies as needed to improve quality of plans and services, and

7. Providing training and technical assistance, as needed.

12.5 ATTACHMENTS

For more details on OCDD's quality enhancement process, see the agency policy: Policy #603, *OCDD Quality Enhancement Process*, Adopted 11/20/07. This policy is available by request from the OCDD Central Office (telephone: 225-342-0095).

13

FREQUENTLY ASKED QUESTIONS

13.1 Assessments

13.2 Planning

13.3 Shared Supports

13.4 Resource Allocation

13.5 General Questions

FREQUENTLY ASKED QUESTIONS

13.1 ASSESSMENTS

A Where will the SIS/LA PLUS document be kept?

The SIS/LA PLUS is kept electronically by the support coordinator and in a centralized database at OCDD. A hard copy will be kept in the regional waiver office.

B. Will the level be re-evaluated every year?

The SIS/LA PLUS will be completed at least annually and the Resource Allocation System level reviewed/modified as needed based upon the updated results. It may also be completed following a significant change in status that may change the person's support needs.

C. Who will be sitting in for the assessments SIS/LA PLUS?

The following criteria are used to determine respondents for the SIS/LA PLUS:

- **Respondents should know the individual well across a variety of settings and activities;**
- **Minimal criteria for length of time respondent has known the individual is three months;**
- **Individual agrees for the person to participate as a respondent; and**
- **More than one respondent may be used if appropriate and agreeable to the participant.**

D, What is the timeframe for when levels are assigned by the SIS/LA PLUS Project team?

SIS/LA PLUS assessments are submitted to the SIS Project Director within three business days of the assessment. The SIS Project Team reviews all assessments within five business days of receipt of the assessment. At that time most assessments are accepted and level assignment occurs. If further information is needed or questions exist about the completeness of the assessment correction may be required. The support coordinator has three business days to complete and return corrections. The SIS/LA PLUS Project Team will respond in three working days.

13.2 PLANNING

A. Is the provider required to be at the support plan meeting or can the individual refuse to let the provider attend? Are providers required to participate in the Discovery process?

The direct service provider must be present at the support plan meeting. If an individual is requesting that the provider not attend, then the support coordinator should assess why he/she does not wish for the provider to attend and either work with the individual to resolve any real issues or to obtain another provider with whom he/she is comfortable. The direct service provider is also expected to participate in the Discovery process as requested by the support coordinator. If the individual receives vocational or day services, then the vocational/day service provider is expected to attend meeting as well. This will not be possible when an individual is newly receiving the NOW.

B. Will the support coordinator meet with the family initially and come up with goals and write the plan? At what point does the provider become involved in the process? Who writes the support plan? Will provider plans be turned in with support plan?

The support coordinator will meet with the individual/family/etc. based upon individual request to complete the SIS/LA PLUS and personal outcomes interview. A provider will be chosen prior to completion of the support plan. The provider should be present with other team members including the individual/guardian at the support plan meeting. The support coordinator will complete the support plan document based upon the planning meeting. The provider plan must be turned in with the support plan.

C. Once a goal in the support plan is attained, should it be taken off the support plan?

If a goal is attained and no longer requires maintenance actions or supports, then it can be removed as a personal outcome item in the table. If it represents a personal goal, then it should be noted as an accomplishment in the appropriate section of the support plan. If it is related to a medical or behavioral issue/barrier, then it should be discussed in terms of positive improvements in the appropriate section of the support plan. If the goal is attained and continues to require maintenance actions or supports, then it should continue to be noted in the personal outcomes table with the needed supports listed.

13.3 SHARED SUPPORTS

A. Can the participants attend each others meetings?

If they invite one another and wish to attend, then they may do so. Each participant's support coordinator must explain the person's rights in relation to protected health information and explain that such information may be discussed in the team meeting. The participant does not have to share protected health information with his/her roommate.

B. Do persons that share have to be of the same sex? If male and females do share supports, can a male staff member bathe a female participant? If a male staff cannot bathe a female, how can you make sure the female wants to bathe when there is a female staff available?

Persons do not have to be the same sex to share supports. It is common practice (and OCDD recommended practice) that male staff should not provide personal supports (bathing, dressing, completion of gender-specific ADLs related to hygiene) for a female participant. Each circumstance should be evaluated on case by case basis (Does the person require physical assistance to take a bath, or does he/she just need someone to verbally tell him/her to go and bathe?). OCDD recommends that male staff be used to provide personal supports for male individuals only. Female staff may provide personal supports to males or females.

C. Must participants be married in order to live with someone of the opposite gender?

OCDD does not have any requirements relative to persons being married. This is a personal choice. Support teams must hold a risk/benefit discussion, identify necessary and appropriate support areas, and address through each person's support plan goals and strategies to meet personal goals, provide needed supports, and assure health and safety. Support teams are responsible for assuring people are not exploited, abused, or neglected. Appropriate consent must be obtained, and the Documentation for Authorization of Shared Staff and Release of Information in New Opportunities Waiver must be signed by responsible parties.

D. What if two persons are sharing and shared monthly bills are put in one participant's name, such as the electric bill; what happens if sharing does not work or if one individual does not want to pay their share?

An IFS provider agency should have policies developed for these situations. It is the expectation that the two persons sharing would enter a contractual agreement and that both of their names would be listed on the lease and all bills.

E. Would there need to be a consent signed to introduce people when developing shared supports?

No, introductions should occur as they do in any instance in which someone meets someone new. No private information needs to be shared to introduce people. They should agree to meet and, if interdicted, their guardians should be informed about the process being used to explore the possibilities of sharing. Once the individuals decide to share supports as roommates, consent is required. Individuals' protected health information remains confidential, even with the consent present. This means that even if a person is interdicted, his/her family cannot learn private things about the roommate. If sharing in casual/everyday situations only (not as roommates), then no consent is required because names of persons will not be included in support plans.

13.4 RESOURCE ALLOCATION

A. How is allocating hours according to Resource Allocation Level System person-centered?

Each level sets a range with an upper limit of expected needed IFS hours. Members of the level will have different numbers of IFS hours used based upon individual support team determination of need. The level membership reflects general level of support needed across a variety of life areas. Members of the same group should generally require the same amount and type of support; thus, the level is used to determine range of needed IFS hours. The level does not determine where, with whom, or how the person spends his/her time. A personal outcomes assessment is completed prior to the planning meeting and used to develop a life vision and goals. The plan is then developed to assist the individual in achieving these goals and addressing other support needs required for maintenance of health and well-being. Each person's life vision, goals, support needs, and plan will be tailored based upon his/her interests, likes/dislikes/etc. and no two plans should look the same. However, individuals in the same level will generally have similar needs in terms of the amount of IFS hours and support needed. A process is also in place to request (based upon assessed need) additional hours above the level guidelines. A committee will review these need requests and where there is a justified need additional hours may be incorporated into the plan.

B. Why do the day program hours change from level to level in the chart?

With regard to Day Program/Activities hours, numbers in the Guidelines for Planning reflect anticipated use based on review of persons in each level. It reflects the assumed number of day program hours for individuals who are in that level.

In "Lives with Family" table, members of Level 1A are allocated fewer than 30 hours of Day Program hours. In our review of persons who are currently members of Level 1A, many people were competitively employed and were not using Day Program hours. The less than 30 hours reflects those observations, demonstrated diminished need of people who are actually in Level 1A.

Members of Level 5 and Level 6 are also allocated less than 30 hours in

the Guidelines. While one of the underlying principles of the model is that persons should have meaningful day activities, in looking at persons who are actual members of Level 5, many had medical support needs and medical conditions that prohibited full time day activity participation. When looking at actual current members of Level 6, many had behavior support needs and/or mental health conditions that limited ability to participate in day activities for 30 hours a week. The reduced hours allocated reflects what was observed in looking at these people, their needs, and capabilities.

Persons may freely access additional Day Activities hours (i.e., If member of Level 5 wants greater than 12 hours, he/she may access this. If member of Level 3 requires greater than 30 hours, he/she can access this).

Additional Day Activities hours can be freely accessed within the NOW service limits (Whereas additional IFS hours beyond the "Guidelines for Planning" must be requested through the Guidelines for Planning State Office Review Committee.).

C. Do conversions apply to all hours for initial planning? Can flexible hours be converted as well?

Conversion options apply to all hours for initial planning. See Section 5 of the Guidelines for specific information on conversion of hours to establish the typical weekly schedule (initial planning) and the different process of conversion of IFS hours for flexible hours (after a person has a prior approved plan).

D. Is this move comparable to what other states are doing with waivers?

Yes. Most others states are moving toward developing resource allocation models, and the most commonly used assessment in these efforts is the SIS. Most states are emphasizing natural supports, meaningful day activities, and shared supports. No other state to our knowledge has an uncapped waiver built on 24 hour 1-on-1 supports. Most other states have either capped waiver services or rely on shared supports (with the smallest setting typically being four individuals). The NOW allows up to three individuals to share supports.

GENERAL QUESTIONS

A. Can people retire and at what age?

People receiving NOW services can retire just as anyone can retire. The guideline for retirement age should be the typical social security retirement age, taking into account individual differences/choice/needs as appropriate. It is important to remember that retirement does not mean that the individual does not engage in meaningful activities during the day. For any individual who retires, the team will need to explore individual preferences in terms of retirement/senior activities, volunteer opportunities, hobbies, and other interests.

B. What is the timeframe for all these expectations to occur for a new participant; that is, once he/she receives the letter offering the waiver, how soon can services actually begin?

Each individual/family will receive a NOW offer letter explaining waiver services and the process for accessing the offer. The participant/family must return the Support Coordination Freedom of Choice form and Waiver Acceptance/Inactive/Declination form to SRI. At that time, SRI will link the participant to a support coordination agency. The participant must obtain a completed 90-L from his/her physician. The assigned support coordination agency will contact the participant within 3 days following linkage to begin the discovery assessment and planning process. The discovery assessment and planning process is expected to take approximately 60 days. Plans are generally approved within 10 days following submission to the OCDD Regional Waiver Office. Services may begin as early as the day following plan approval.

C. How will this process be monitored by the regions (quality enhancement)?

The quality monitoring process has several components:

- **The first one hundred plans and every plan a newly trained support coordinator completes will be reviewed by a joint**

committee from OCDD Central Office and OCDD Regional Waiver Office to determine certification of the support coordinator in the planning process. Re-certification will be completed on an annual basis.

- **For every plan completed, the support coordinator supervisor will complete a plan review using the Individual Supports Review document.**
- **The plan of care and the Individual Supports Review will be submitted to the OCDD Regional Waiver Office for review and approval.**
- **Once a plan is approved and implemented, regular required quarterly reviews will be completed with the support coordinator completing a Quarterly Quality Review to determine individual status and progress in targeted areas.**
- **Data will be reviewed by Central Office and OCDD Regional Waiver Office regarding plan certification (by region, by agency, by support coordinator) and each quality area (by region, by support coordination agency, by support coordinator, and by provider).**
- **This data will be used to determine areas in need of further training and technical assistance.**

D. Is there an age limit for individuals that are support workers?

Support workers must be at least 18 years old (Title 50 Chapter 1 Section 101.E.2.a of Standards of Payment).

E. Right now I have a lot of family support with my son; however, I am concerned about his care as I get older. What if I want to get the waiver later; can I do this?

If a person is on the Registry and is not interested in using NOW services immediately but would like to access the waiver later, he/she can request inactive status. Inactive status will hold the original protected request date. When the person is ready to request their NOW services, a written request should be submitted to the OCDD Regional Office/ Human Services District/ Authority asking for their waiver opportunity. The written request must include the person's original protected request date and state that he/she would like his/her name removed from Inactive status.

F. How will emergency situations be handled when a regularly scheduled natural support outing cannot occur?

If the person is receiving SIL services (SIL per diem), the SIL provider is responsible to provide back up support and emergency coverage.

Appendix

14

DEVELOPMENT OF LOUISIANA'S RESOURCE ALLOCATION SYSTEM

14.1 Selection and Testing of the Needs Assessment

14.2 Linking the Needs Assessment to Resource Use

14.3 Validation of the Model

14.4 Framework for Louisiana's Allocation of IFS Hours

14.5 Programmatic Assumptions for each of Seven Levels

14.6 IFS Hours Allocated to Each Level

14.7 Resource Allocation for Participants Under 16 Years of Age

14.8 Attachments

- 14.8.1 Recommended IFS and Day Program Hours by Level - Lives with Family
- 14.8.2 Recommended IFS and Day Program Hours by Level - Lives Independently
- 14.8.3 Conversion Table

DEVELOPMENT OF LOUISIANA'S RESOURCE ALLOCATION SYSTEM

The Louisiana Resource Allocation System has seven levels. The levels start at Level 1A, representing the lowest level of need, and extend to Level 6, representing the highest level of need.

The development of the Louisiana Resource Allocation System occurred over several years. There were two key components in the development of the process:

1. Selection and testing of the needs assessment
2. Linking the needs assessment to resource use.

Section 14.4 provides the framework underlying the system.

Section 14.5 provides the programmatic assumptions for each of the seven levels that guide planning.

Section 14.6 provides the IFS hours allocated to each level.

For participants sharing services, available IFS hours are greater than hours for one person alone.

The last subsection provides a conversion table for support coordinators that translate the IFS and Day Activity hours allocated to each level.

14.1 SELECTION AND TESTING OF THE NEEDS ASSESSMENT

A. The selection of the Supports Intensity Scale (SIS) and the LA PLUS as the needs assessment for the NOW resulted from several years of development during which OCDD:

1. Formed a Stakeholder Group with broad representation,

2. Conducted an extensive review of other states' instruments and processes,

3. Evaluated available instruments,

4. Selected the Supports Intensity Scale,

5. Developed a complementary tool – LA PLUS,

6. Over a two year period field-tested, modified, and refined the needs assessment process,

7. Completed SIS assessments on more than 2,000 people served under the NOW, private ICF/DD providers, and Public Supports and Service Centers (SSCs),

8. Conducted reliability testing,

9. Developed better descriptions for the tool, and

10. Developed training and certification requirements for support coordinators conducting the SIS/LA PLUS assessments.

B. The SIS assesses Advocacy, Medical Support, and Behavioral Support needs; and the SIS assesses six life activities based on 49 items:

1. Home Living,

2. Community Living,

3. Lifelong Learning,

4. Employment,

5. Health and Safety, and

6. Social Activities.

C. LA PLUS includes supplemental items in a number of areas:

1. Material supports (e.g., powered wheelchair, walker, vehicle modification, etc.),

2. Vision related supports,

3. Hearing related supports,

4. Supports for communicating needs,

5. Positive behavior supports,

6. Physician supports,

7. Professional supports (e.g., registered nurse, psychologists, occupational therapists, physical therapists, speech therapists, etc.),

8. Stress and risk factors,

9. Protective supervision,

10. Summoning help, and

11. Sharing supports.

D. The information on the SIS/LA PLUS is used both in determining the level membership in the Resource Allocation System and in developing support plans for each participant based upon their unique support needs.

E. Additional information on the SIS is available at the official web site http://www.siswebsite.org/.

14.2 LINKING THE NEEDS ASSESSMENT TO RESOURCE USE

A. Once the SIS/LA PLUS was selected as the needs assessment tool, the next step in development of the Louisiana Resource Allocation System was linking supports to those needs. During this process, OCDD:

1. Evaluated resource allocation processes in other states, including regression based models,

2. Conducted regression analyses on a statewide sample of assessments in Louisiana and examined the supports used by participants with different needs,

3. Established the need levels (originally six and expanded to seven) and SIS scoring that defines membership in each level,

4. Subjected data to different potential model configurations involving different covariations of general, medical, and behavioral supports to determine best fit with Louisiana citizens' needs profiles,

5. Analyzed the use and cost of all services for all participants in the NOW for Fiscal Year 2006 and Fiscal Year 2007,

6. Analyzed the use and cost of services for participants at each of the seven levels of supports (using two data samples – a statewide representative sample of approximately 400 and a capitol area sample of approximately 800),

7. Conducted a clinical validation of the model, and

8. Examined outlier cases.

B. The original proposal was for six levels of need. However, Level 1 was too large and contained people with a broad range of needs. Approximately half of the waiver population fell into Level 1. As a result, Level 1 was split into 1A and 1B to ensure the Levels contained people with comparable needs.

C. These steps resulted in a recommended maximum number of IFS hours for participants living with family and those living independently at each Level of need referred to as the Louisiana Resource Allocation System. The hours are a key component of the "Guidelines for Support Planning;" however, they are not a fixed cap. The hours for each participant is determined based upon individual circumstances and identified need. Additional hours may be requested with justification.

14.3 VALIDATION OF THE MODEL

A. The statistical analyses and model fitting of assessment data gathered during a sampling of NOW waiver participants in 2006 and 2007, and review of services and associated costs for FY 2006 and 2007 for these same participants produced a proposed model of resource allocation.

B. To guide the development of IFS hours allocated to each level and to evaluate the validity of the levels themselves, OCDD conducted a clinical validation study. The clinical validation of the system was designed to determine whether the levels meaningfully differentiated persons with lower and higher needs and resulted in *within-level* memberships of persons with generally comparable support needs.

C. The validation process began by selecting participants with both typical and atypical profiles that populated each of the proposed levels. Atypical profiles included persons within a level who had medical or behavioral support needs greater or less than the majority of other persons within that level or had scores that placed them near the boundary between two levels. The process resulted in the selection of nearly 100 (or approximately 25% of the total NOW statewide representative sample) participants for the validation study.

D. OCDD staff collected the plan of care, psychological evaluations, 90-L, medical notes and provider progress notes for each of the participants selected for the study. A team of experts from various backgrounds and experiences was assembled. Comprising the team were experts in needs-based assessment (the Supports Intensity Scale -SIS and LA PLUS), experts in support coordination, national experts in resource allocation methodology and those with a background in community-based direct service provision to those with intellectual and developmental disabilities.

E. The team conducted a detailed inspection and study of participants' completed SIS assessments, plans of care, psychological and medical reports, and progress notes. For each participant in the sample, waiver support needs were defined by the clinical expert based on all of the available assessment information independent of the supports historically used. Waiver support needs were defined using the structure below.

1. IFS Day Support Hours

2. IFS Night Support Hours

3. Unsupported Hours

4. Day Program Hours

5. Supported Employment Hours

6. One-Time Supports

7. Other Services

8. Shared Services

F. The clinical validation study found that persons with similar SIS scores have similar support needs and, in most comparisons, persons with the same Level membership have generally comparable support needs. Further, the IFS hours in the Louisiana Resource Allocation System are consistent with the clinical determination of support needs.

G. The clinical validation study underscored the need for mechanisms to allow additional hours for outlier cases. OCDD developed the process for approvals of additional IFS hours (Section 7.3).

H. In conducting the clinical validation, team members also examined the accuracy of the assessor in reflecting the participant's needs. Most SIS assessments had few

problems. The most frequent problem was underrating of the participant's medical support needs. To further guard against these errors, OCDD developed:

1. A formal training and certification protocol, and

2. A self-check protocol for assessors.

14.4. FRAMEWORK FOR LOUISIANA'S ALLOCATION OF IFS HOURS

A. In allocating IFS hours, OCDD adopted a framework consistent with the planning assumptions introduced in Section 1. The framework has the following principals:

1. People who live with family have different IFS needs than those who live independently and, therefore, IFS hours allocated differ by living situation.

2. Natural supports are to be used as appropriate and applicable in each person's living circumstances.

3. Age appropriate school/day programs/work activities are to be assumed in planning as a natural part of a weekly schedule. These hours may be converted to a proportionate number of IFS hours depending on individual need and choice.

4. IFS hours and IFS shared support hours may be converted one to another proportionately within allocated hours.

5. Participants who score less than 15 on the General Support factor of the SIS and have minimal or no behavioral or medical challenges are presumed not to need IFS hours. These participants may freely access all other services in the NOW through the planning process. Any proposed need for IFS hours by these participants has to be requested and is considered as an exception by the Guidelines for Planning State Office Review Committee.

6. Supportive Living services are available only by exception to participants living with their families. Participants who need this service may request it in the planning process. These requests are considered on an individual basis in the OCDD Regional Waiver Office. This service is not available for participants in self-directed services.

14.5 PROGRAMMATIC ASSUMPTIONS FOR EACH OF SEVEN LEVELS

A. The resource needs of participants falling into each of the seven levels differ both for participants living at home and participants living independently.

B. As a result, the programmatic assumptions for participants living at home and participants living independently at each level also differ. These differences in programmatic assumptions are a key component in planning for supports.

LEVEL 1A

Description:

Members of Level 1A, with regard to our citizens with developmental disabilities, require the least amount of supports. These participants have SIS scores below the 25th percentile indicating fewer General Support needs (Home Life, Community, Health and Safety Support Needs) than 75% of the population with developmental disabilities. Support needs tend to be minimal. Most members have mild intellectual disabilities. They are capable of managing many aspects of their lives independently. Teaching supports and monitoring, as well as supports of a more intermittent nature, are frequently what are requested by 1A members.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 1A **living at home** include that these participants: ■ Normally, do not require nighttime supports ■ Should participate in school, work, or other day activities that are personally meaningful and meet their needs ■ Generally benefit from participation in age-appropriate competitive employment activities ■ Can independently meet some or even many of their own needs and can have some or perhaps even a substantial number of unsupported hours	**Programmatic Assumptions** for Members of Level 1A **living independently** include that these participants: ■ Can share supports ■ Normally, do not require nighttime supports ■ Should participate in school, work, or other day activities that are personally meaningful and meet their goals ■ Generally benefit from participation in age-appropriate competitive employment activities ■ Can independently meet some or even many of their own needs and can have some or perhaps even a substantial number of unsupported hours

LEVEL 1B

Description:

Members of 1B have General Support Needs that fall from the 25th to 50th percentile, relative to our citizens with developmental disabilities. Many participants in 1B have mild intellectual disabilities, although broader ranges of intellectual disabilities do occur in this level. Level 1B is the largest level. While these participants require more support than members of Level 1A and may manage fewer personal needs independently, support needs still generally are minimal to limited in a number of life areas.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 1B **living at home** include that these participants: ■ Generally benefit from participation in school, work, or day activities ■ Normally do not require paid night time supports ■ In some instances could have unsupported hours	**Programmatic Assumptions** for Members of Level 1B **living independently** include that these participants: ■ Can share supports ■ Generally benefit from participation in school, work, or day activities ■ In many instances will not require night time supports. Some members with more significant intellectual disabilities may. ■ In some instances could have unsupported hours

Level 2

Description:
Members of Level 2 have General Support Needs that place them between the 50th and 75th percentile relative to other persons with developmental disabilities. These participants have significant support needs relative to tasks of daily living. Most participants in Level 2 have severe or profound intellectual disabilities. For most, behavior and medical support needs are minimal or nonexistent.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 2 **living at home** include that these participants: ■ Normally do not require paid nighttime supports given acuity level. Natural supports are appropriate options at night. ■ Generally benefit from participating in day activities ■ In most instances could not have unsupported hours ■ In the context of acuity of their needs, a balance of natural and paid supports, with some natural supports occurring during the day and natural supports occurring at night, will meet the needs of most participants and families	**Programmatic Assumptions** for Members of Level 2 **living independently** include that these participants: ■ Can share supports ■ Do require nighttime supports ■ Generally benefit from participating in day activities ■ In most instances could not have unsupported hours

Level 3

Description:

Members of Level 3 include citizens with the most significant General Support Needs in the absence of very extensive medical or behavioral support needs. These participants have greater General Support needs than 75% of the population with developmental disabilities. Most have some medical support needs, although these needs do not reach the significance of the needs of members of Level 5. Many participants in Level 3 have significant physical support needs. For example, many have Cerebral Palsy. Many require full physical supports. Most members have severe or profound intellectual disabilities, although some members may have mild intellectual disabilities with significant physical support needs.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 3 **living at home** include that these persons: ■ Normally do not require paid nighttime supports. Natural supports are appropriate options at night. ■ Generally benefit from participating in day activities that can accommodate physical support needs ■ Could not have unsupported hours ■ Intensity of support needs are such that during awake hours enough paid support hours should be available to exceed the number of natural support hours if participants and families need this.	**Programmatic Assumptions** for Members of Level 3 **living independently** include that these persons: ■ Can share supports. ■ Do require paid nighttime supports ■ Generally benefit from participating in day activities that can accommodate physical support needs ■ Could not have unsupported hours

Level 4

Description:

Members of Level 4 include persons who have significant behavior support needs but who do not meet the extensive behavior support requirements of participants in Level 6. Most have some level of aggressive behavior. Support profiles of members differ with intellectual disabilities ranging from mild to profound, although the majority of members have General Support Needs that fall below the 50th percentile. Some members have mental health challenges or concerns. Some members have autism with significant challenging behaviors. Most members of Level 4 do not have substantial medical support needs.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 4 **living at home** include that these participants: ■ Normally do not require paid nighttime supports. Natural supports are appropriate options at night. ■ Are generally good candidates for benefiting from day activities that can accommodate behavior and/or mental health support needs including school and vocational options ■ In some instances could have unsupported hours ■ Intensity of behavior support needs are such that during awake hours paid support hours may outnumber natural support hours for participants and families who need this.	**Programmatic Assumptions** for Members of Level 4 **living independently** include that these participants: ■ In most but not all cases can share supports ■ Do require paid nighttime supports ■ Are generally good candidates for benefiting from day activities that can accommodate behavior and/or mental health support needs including school and vocational options ■ In some instances could have unsupported hours

Level 5

Descriptions:
Members of Level 5 include persons with the most extensive Medical support needs. Extensive physical support needs, including lifting and positioning support needs, often associated with Cerebral Palsy, are typical. G-tube and other feeding support needs, oxygen therapy or breathing treatment, and/or suctioning are common as well. The need for full physical supports with regard to activities of daily living is common.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 5 **living at home** include that these persons: ■ In most instances, do not require paid nighttime supports, although some participants may. For most persons in Level 5, natural supports are appropriate options at night. ■ Should have access to personally meaningful day activities although medical issues may limit day activity attendance. Day activities will need to accommodate their significant medical support needs. ■ Could not have unsupported hours ■ Intensity of physical and medical support needs are such that during awake hours paid support hours should be available to provide significant assistance to persons and families and minimize the need for natural support hours for participants and families who require this.	**Programmatic Assumptions** for Members of Level 5 **living independently** include that these persons: ■ In most cases can share supports. For some participants, sharing supports might be difficult. For some participants, sharing supports with a ratio of two paid supports per three participants might be a more suitable option that a 1:2 ratio. ■ Require nighttime supports ■ Should have access to personally meaningful day activities although medical issues may limit day activity attendance. Day activities will need to accommodate their significant medical support needs. ■ Could not have unsupported hours

Level 6

Descriptions:

Members of Level 6 include persons with the most significant Behavior Support Needs. Many of these participants require one-to-one supervision. All members of Level 6 have multiple significant behaviors support needs. Mental health conditions with accompanying aggressive or self-injurious behavior are common. Some members may have high rates of challenging behavior in the absence of a mental health condition although this is less common. Some members would pose safety risks to the community or themselves without continuous supervision and support. Most Level 6 members do not have Medical Support Needs and General Support Needs typically fall below the 50th percentile.

LIVING AT HOME	LIVING INDEPENDENTLY
Programmatic Assumptions for Members of Level 6 **living at home** include that these persons: ■ In most instances, do not require paid nighttime supports. Natural supports are typically suitable options. ■ Behavior and mental health support needs pose challenges to identifying day activities. Personally meaningful day activities, particularly activities with mental health treatment components or that can at least support mental health needs, should be explored. These activities need to take into consideration the participant's ability to tolerate others, danger to others, and possible psychological fragility. ■ Could not have unsupported hours ■ Intensity of behavior support needs are such that during awake hours paid support hours should be available to provide significant assistance to persons and families,	**Programmatic Assumptions** for Members of Level 6 **living independently** include that these persons: ■ In most instances could not share supports although this should be explored on an individual basis. ■ Require paid nighttime supports. ■ Behavior and mental health support needs pose challenges to identifying day activities. Personally meaningful day activities, particularly activities with mental health treatment components or that can at least support mental health needs, should be explored. These activities need to take into consideration the participant's ability to tolerate others, danger to others, and possible psychological fragility. ■ Could not have unsupported hours

minimizing the need for natural support hours if participants and families require this.	

14.6 IFS HOURS ALLOCATED TO EACH LEVEL

A. *Attachment 14.8.1* and *Attachment 14.8.2* provide the weekly maximum IFS hours that may be accessed without additional approvals for each of the seven levels for participants living with family and participants living independently respectively as well as the expected day activity hours and natural support hours. The IFS hours for a participant at a given level should be included in the support plan unless an exception is approved consistent under Sections 5.7-9 and 7.3.

B. The seven levels appear across the columns of each table. The rows show day, night and shared IFS hours, total IFS hours highlighted and the assumptions for day programming and natural supports. The final row totals 168, the number of hours in a week (24 hours x 7 days). Consistent with OCDD's assumptions for planning, meaningful day activities and natural supports are a component of the weekly schedule and the allocated IFS hours. Natural supports may include hours when the participant is able to support themselves without assistance. For participants living independently, shared hours for both day and night are included reflecting OCDD's encouragement of shared services.

C. There are two adjustments to the hours appearing on *Attachment 14.8.1* (Lives with Family). If the participant is less than 18 years of age, maximum IFS hours are reduced by 7 hours for all seven levels. For example, for Level 1A, IFS hours are reduced from 25 to 18 to reflect age appropriate parental support. If the participant is older than 55 years of age, 7 hours are added to maximum IFS hours for each level to reflect additional needs of older participants. In Level 1A, for example, rather than 25 hours of IFS, hours would increase to 32.

D. For participants living independently, there is also an adjustment to Level 1A and 1B to add 7 hours for those older than 55 years of age. These additional hours reflect the added effort for older participants from natural supports. There is no adjustment to the other five levels for participants living independently because there are no natural support hours included in the weekly schedule.

E. To use the conversion table (*Attachment 14.8.3),* select the type of hours that must be converted to another type of hour. For example, use the first section to convert from an IFS Day 1 person hour to another type of hour. Using the row for Five IFS Day 1 Person hours and moving across the columns convert to 7 IFS Day 2 person

hours. Similarly, ten IFS Day 1 Person hours convert to 20 SE Mobile Crew hours shown in the last column.

F. If Employment Related Training/Day Habilitation hours need to be converted to IFS or SE Mobile Crew Hours, use the 5th section of the conversion table. Five ERT/Day Hab hours convert to 2 IFS Day 1 person hours.

14.7 RESOURCE ALLOCATION FOR PARTICIPANTS UNDER 16 YEARS OF AGE

A. The Louisiana Level System, which includes seven levels of Individual and Family Support hours associated with different volumes and types of support needs described in the "Guidelines for Support Planning," has undergone additional study since its initial development in 2008. Additional examination of the Levels relative to the support needs of participants provided further indications of the overall validity of the system and indicated applicability for participants under 16 years of age.

B. For youths under 16 years of age, the recommended number of IFS hours for planning is proposed based on a two step process.

1. First, the Supports Intensity Scale or SIS (minus items not relevant for youths) will be used as the needs-based assessment instrument with the agreement of AAIDD, the developers of the SIS. This adapted version of the SIS, which maintains items relevant to determining general, medical, and behavioral support needs and which does not assess items not relevant for youths (e.g., supports needed for Employment), is currently being used in some other states and has been used for some time pending development of a new youth version of the SIS which OCDD intends to adopt pending the completion of psychometric studies and final development of the new youth instrument. This adapted version of the SIS was also been used by OCDD to assess youths under 16. OCDD further validated the use of the SIS for assessing the need of children for IFS hours by comparing the actual use of IFS hours with the acuity level recommended by their SIS assessment. Both the SIS and LA PLUS will be used for support planning purposes.

2. Secondly, OCDD staff currently certified in both SIS and the OCDD Planning process and who currently serve as the quality monitoring entities for NOW CPOC's will review the SIS, intellectual, and adaptive assessment information and apply professional judgment and experience to assure that the assessment information meets the programmatic assumptions for the recommended level for the participant.

C. The participant's team in the planning process may request IFS hours beyond those recommended by the SIS assessment using the process outlined in Section 5.8 of the "Guidelines for Planning."

D. In addition, a participant retains the right to appeal any denial of requested IFS hours by following procedures outlined in Section 10.2 of the "Guidelines for Planning."

Attachment 14.8.1 Recommended IFS and Day Program Hours by Level - Lives with Family

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

GUIDELINES FOR PLANNING:

RECOMMENDED IFS AND DAY PROGRAM HOURS BY LEVEL

Lives with Family							
	1A	**1B**	**2**	**3**	**4**	**5**	**6**
IFS Day	25	32	46	56	62	62	82
IFS Day Shared	0	0	0	0	0	0	0
IFS Night	0	0	0	0	0	0	0
IFS Night Shared	0	0	0	0	0	0	0
Day Program Hours	20	30	30	30	30	30	12
Total Paid Hours	**45**	**62**	**76**	**86**	**92**	**92**	**94**
Natural Sup Hours	123	106	92	82	76	76	74
	168	**168**	**168**	**168**	**168**	**168**	**168**

Total Hours							
<18 years = -7 hrs IFS Day	-7	-7	-7	-7	-7	-7	-7
>55 years add = +7 hrs IFS Day	+7	+7	+7	+7	+7	+7	+7

Attachment 14.8.2 Recommended IFS and Day Program Hours by Level - Lives Independently

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

GUIDELINES FOR PLANNING:

RECOMMENDED IFS AND DAY PROGRAM HOURS BY LEVEL

Lives Independently							
	1A	**1B**	**2**	**3**	**4**	**5**	**6**
IFS Day	10	10	10	10	14	14	112
IFS Day Shared	35	40	72	72	68	86	0
IFS Night	0	0	0	0	0	0	56
IFS Night Shared	0	40	56	56	56	56	0
Day Program Hours	30	30	30	30	30	12	0
Total Paid Hours	**75**	**120**	**168**	**168**	**168**	**168**	**168**
Natural Sup Hours	93	48	0	0	0	0	0
Total Hours	**168**	**168**	**168**	**168**	**168**	**168**	**168**
>55 years add = +7 hrs IFS Day	+7	+7					

Attachment 14.8.3 Conversion Table

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
GUIDELINES FOR PLANNING SERVICE HOURS CONVERSION TABLE
EFFECTIVE 9/24/2008

IFS - DAY 1 PERSON	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	2	3	2	2
2	2	3	4	5	5	4
3	3	4	5	8	7	6
4	4	6	7	10	9	8
5	5	7	9	13	11	10
6	6	8	11	15	14	12
7	7	10	12	18	16	14
8	8	11	14	20	18	16
9	9	13	16	23	20	18
10	10	14	18	25	23	20

IFS - DAY 2 PERSONS	IFS DAY 2P CONVERSION	IFS DAY 1P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	1	2	2	1
2	2	1	3	4	3	3
3	3	2	4	6	5	4
4	4	3	5	7	7	6
5	5	4	6	9	8	7
6	6	4	8	11	10	9
7	7	5	9	13	11	10
8	8	6	10	15	13	12
9	9	6	12	17	15	13
10	10	7	13	18	16	14

IFS - NIGHT 1 PERSON	IFS NIGHT 1P CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	1	1	1	1	1
2	2	1	2	3	3	2
3	3	2	2	4	4	3
4	4	2	3	6	5	5
5	5	3	4	7	6	6
6	6	3	5	9	8	7
7	7	4	5	10	9	8
8	8	5	6	11	10	9
9	9	5	7	13	12	10
10	10	6	8	14	13	11

3/23/2009 OCDD

Attachment 14.8.3 Conversion Table

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
GUIDELINES FOR PLANNING SERVICE HOURS CONVERSION TABLE
EFFECTIVE 9/24/2008

IFS - NIGHT 2 PERSONS	IFS NIGHT 2P CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	ERT/DAY HAB CONVERSION	SE MOBILE CREW CONVERSION
1	1	0	1	1	1	1
2	2	1	1	1	2	2
3	3	1	2	2	3	2
4	4	2	2	3	4	3
5	5	2	3	3	4	4
6	6	2	3	4	5	5
7	7	3	4	5	6	5
8	8	3	4	6	7	6
9	9	4	5	6	8	7
10	10	4	5	7	9	8

ERT/DAY HAB	ERT/DAY HAB CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	SE MOBILE CREW CONVERSION
1	1	0	1	1	1	1
2	2	1	1	2	2	2
3	3	1	2	2	3	3
4	4	2	2	3	4	4
5	5	2	3	4	6	4
6	6	3	4	5	7	5
7	7	3	4	5	8	6
8	8	4	5	6	9	7
9	9	4	6	7	10	8
10	10	4	6	8	11	9

SE - MOBILE CREW	SE MOBILE CREW CONVERSION	IFS DAY 1P CONVERSION	IFS DAY 2P CONVERSION	IFS NIGHT 1P CONVERSION	IFS NIGHT 2P CONVERSION	ERT/DAY HAB CONVERSION
1	1	1	1	1	1	1
2	2	1	1	2	3	2
3	3	2	2	3	4	3
4	4	2	3	4	5	5
5	5	3	3	4	6	6
6	6	3	4	5	8	7
7	7	4	5	6	9	8
8	8	4	6	7	10	9
9	9	5	6	8	11	10
10	10	5	7	9	13	11

Appendix

15

EMERGENCY PROTOCOL FOR TRACKING LOCATION BEFORE, DURING, AND AFTER HURRICANES

Emergency Protocol for Tracking Location

Before, During, and After Hurricanes

When a hurricane threatens Louisiana, every effort will be made to assure to track the location of participants, and Direct Service Provider and Support Coordination Agencies will provide OCDD with contact information for the agency if phones are temporarily out-of-order or the agency needs to temporarily relocate the agency's office.

Location of Participants and Provision of Emergency Assistance will be tracked as follows:

1. As soon as it is likely that mandatory or voluntary evacuation may be required, the Support Coordinator will contract the participant, participant's family, and/or the provider to determine for each participant in their caseload: 1) the location to which the person will be evacuating and 2) contact information (phone number) to reach the participant. The support coordinator should also assure that the participant has whatever assistance he or she needs to prepare for the hurricane and evacuate, if necessary, including that the person's Take and Go Emergency Book is readily available. (A copy of The Take and Go Emergency Book is available athttp://www.dhh.louisiana.gov/offices/publications.asp?ID=77&Detail=1193).

2. The Support Coordination Agency must contract the Regional Developmental Disabilities Office prior to the hurricane to provide the office with evacuation information for the participants for which they provide services.

3. The Regional Developmental Disabilities Office will submit to the OCDD Central Office a list with the evacuation information for participants in the region in the format requested by the OCDD Central Office.

4. As soon as feasible after the hurricane, Support Coordinators will contact participants to assure that they are safe and that any emergency needs are being met. If the participant has evacuated, the Support Coordinator will work with the participant, family, Direct Service Provider, and Regional Developmental Disabilities Office to assure that any assistance needed by the participant is provided to come back home, repair their home, find a new home, and obtain needed services or emergency assistance.

Location and Contact Information for Direct Service Provider and Support Coordination Agencies:

1. Prior to a hurricane, Direct Service Provider and Support Coordination Agencies must notify the Regional Developmental Disabilities Office of a phone number that the agency can be reached at if their power goes off.

2. If the agency temporarily moves their office due to lack of power or damage to the office, the agency must immediately notify the Regional Developmental Disabilities Office.

Additional Resources:

1. Additional Resources are available at http://www.dhh.louisiana.gov/offices/publications.asp?ID=77&Detail=1193 including the Providers EP Best Practice Guidelines and Support Coordination EP Best Practice Guidelines.

2. Providers EP Best Practice Guidelines and Support Coordination EP Best Practice Guidelines.

Appendix

16

NOW Resource Allocation Phase-In Plan: Beginning July 1, 2009

NOW Resource Allocation Phase-In Plan

Participants currently receiving NOW services with plans due to the OCDD Regional Waiver Office 35 days after July 1, 2009 will be subject to the following planning and implementation of the recommended IFS hours detailed in the OCDD "Guidelines for Planning":

1. Sixty (60) days prior to the date the plan is due to the OCDD Regional Waiver Office, Support Coordination agencies will send by mail notices to participants and families to schedule the SIS and LAPLUS assessments and the participant's annual planning meeting. These notices by mail will be followed up as necessary by phone.

2. After completion of the SIS and LAPLUS and securing the recommended acuity level for the Person, the "Guidelines for Planning" will be used for all planning meetings.

For all continuing NOW participants:

   a. Planning teams are to use no more IFS hours than those recommended for the person's acuity level in the "Guidelines for Planning" or

   b. Plans are to be phased into compliance with the IFS hour recommendations according to the following schedule:

Percent Below Refers To IFS Hours

Fiscal Year 2009	>150%	>125% to <150%	>100% to <125%
1. Fiscal Year 2010	>125% to <150%	>100% to <125%	< or =100%
Fiscal Year 2011	>100% to <125%	< or = 100%	
Fiscal Year 2012	< or = 100%		

2. When the planning team determines that neither option a. nor b., shown above, fits the needs of the participant, then the team must request additional hours as detailed in Sections 5.7 and 5.8 of the "Guidelines for Planning."

For all new NOW participants:

a. Planning teams are to use no more IFS hours than those recommended for the person's acuity level in the "Guidelines for Planning"

b. If the planning team determines that the participant needs more IFS hours than recommended for the acuity level of the participant, the team may request additional hours as detailed in Sections 5.7 and 5.8 of the "Guidelines for Planning."