alliance services
FOR TBI, INC.

NURSING HOME TRANSITION & DIVERSION (NHTD)
&
TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAMS

TRAINING CURRICULUM

♦ ANNUAL TRAINING ♦
♦ BASIC ORIENTATION TRAINING ♦
♦ SERVICE SPECIFIC TRAINING ♦

Nursing Home Transition & Diversion (NHTD) and Traumatic Brain Injury (TBI)

Waiver Programs Overview

- By the end of the training, training participants will be able to:

  - Discuss the philosophy of the NHTD/TBI Waiver programs
  - Explain the difference between Medicaid State Plan services and waiver services
  - List the eligibility criteria for the NHTD/TBI Waiver programs
  - Identify the rights and responsibilities of waiver participants
  - Describe the organizational structure of the NHTD/TBI Waiver program
  - Describe the roles and responsibilities of the various contracted entities for the NHTD/TBI waiver program including: Regional Resource Development Specialist, Nurse Evaluator, and Quality Management Specialists
  - Describe the importance of the team approach to service provision
  - Identify record keeping requirements such as Detailed Plan, daily service notes and Individual Service Reports
  - Identify effective methods and interventions to provide support and supervision for waiver participants
  - Recognize the need for basic safety and emergency procedure including crisis intervention
  - Recognize the need for Incident Reporting

What is a Waiver Program?

- A Waiver Program is:
  - An agreement between NYS and Federal Government that the state can use Medicaid for services not covered under Medicaid State Plan.
  - Considered when informal supports, local, state and federally funded services, and Medicaid State Plan services are not sufficient
  - Allows Medicaid to pay for specialized services, through the Waiver
  - Can result in efficiencies to Medicaid program

The History of Waivers

- State legislation
- Advocates
- Need for additional Medicaid services
- People were not able to access existing programs

Purpose of Waivers

- Provide an alternative to institutionalization

- Must be cost neutral – doesn't cost more than institutionalization based on average cost of waiver vs. average cost of institutional care

Waiver Principles/ Characteristics

- Alternative to institution
- Targeted population
- In community setting
- Can only be on one waiver at a time
- Participant driven
- Participant choice
- Self-determination
- Assure health and welfare of participant
- Cost-neutrality
- Supporting informal caregivers

Waiver Philosophy

- Individual is the primary decision maker
- Dignity of risk and the right to fail
- Waiver services are provided based on participant's:
  - Unique strengths, needs, choices, goals
  - Health and welfare
- The individual planning with providers leads to:
  - Personal empowerment
  - Independence
  - Community inclusion
  - Self–reliance
  - Meaningful activities

Waiver Participants

- Participants are diverse:
  - Young to old
  - Male or female
  - May need increasing support over time
  - Is driving force of all services
  - Sets own personal goals
  - Develops the Service Plans with the Service Coordinator
  - Has freedom of choice, including choice of waiver services and providers

Waiver Participants

(continued)

- May have a:
  - Spinal cord injury
  - Stroke
  - A progressive disease such as Alzheimer's or MS
  - May be elderly and frail

- May Also have:
  - Cognitive issues *(challenges with thinking)*
  - Physical issues *(challenges with ADL/IADL)*
  - Behavioural issues *(challenges with acting)*

Waiver Participants
Rights and Responsibilities

- Rights for the participants

- Partnership between participants and providers means participants have Responsibilities

Waiver Eligibility

(continued)

- Need nursing home level of care
- In receipt of Medicaid for Community Based Long Term Care services
- At least 18 years of age
- Have safe adequate community housing
- Needs can be met under funds and services available in waiver and Medicaid
- Need at least one waiver service per month to assure health and welfarePart of an aggregate group
- Make a choice regarding living in the community
- Not participate in another HCBS waiver

Uniform Assessment System-New York (UAS-NY)

- The tool used to assess applicants for the program is the Uniform Assessment System – New York (UAS—NY)
  - UAS-NY must be completed within 90 days of enrollment
  - A new UAS-NY is required annually, or when a significant change occurs
- UAS-NY is completed by a Registered Nurse (RN) approved by NYSDOH
  - Other people involved in your care may contribute to the UAS-NY Assessments

Uniform Assessment System-New York (UAS-NY)

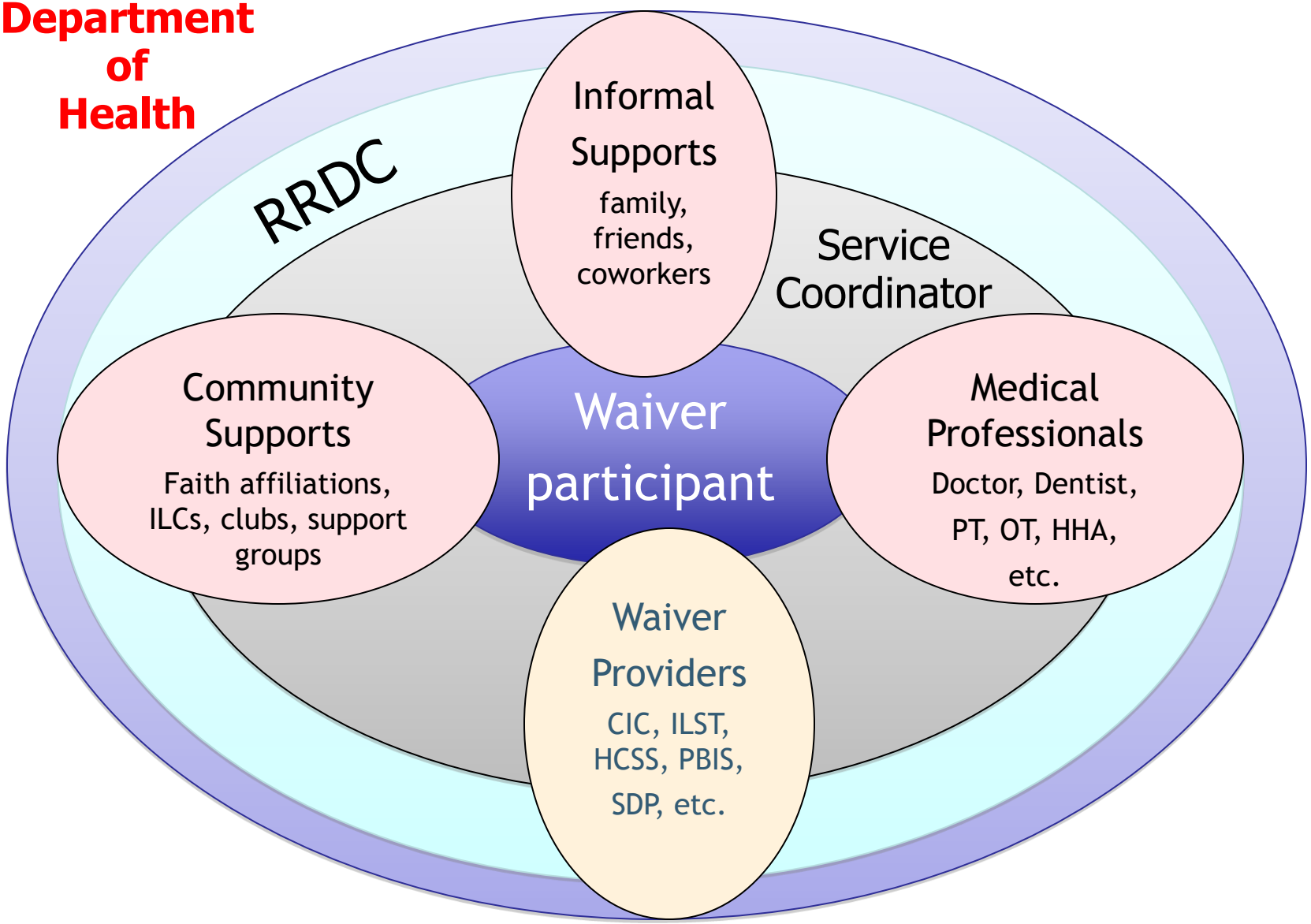
(continued)

- The PRI/SCREEN is used as the first assessment for people coming out of a nursing home or hospital.
- To be eligible for the TBI and NHTD Waivers, the individual's UAS-NY LOC score must be five (5) or greater.
- If the individual is assessed and does not score 5 or greater, a second UAS-NY will be done.
  - If the second UAS-NY does not result in a 5 or greater, the individual may request that a doctor perform an assessment to show the need for the NHTD or TBI Waiver service(s).
- NYSDOH staff reviews certain LOC or eligibility determinations before a Notice of Decision (NOD) is sent.

Alternate Route

- If the individual does not score a 5 or greater after two (2) UAS-NY assessments have been completed, a third assessment, called the Alternate Route, must be obtained.

Department of Health



Regional Resource Development Center (RRDC)

- Employs RRDS and Nurse Evaluator
- Is initial point of contact for applicants, their families, legal guardians and/or authorized representatives
- Administers day-to-day activities of waiver
- Develops and maintains waiver resources and supports

Regional Resource Development Center (RRDC)

(continued)

- Maintains ongoing, collaborative relationships with regionally based stakeholders
- Reduces the incidence of unnecessary institutionalization
- Makes recommendations to DOH for improvement to waiver

Regional Resource Development Specialist (RRDS)

- Encourage participant choice
- Ensure the delivery and assist in development of high quality waiver services
- Oversee cost-effectiveness
- Collaborate with LDSS, service providers and advocacy groups

Nurse Evaluator

- Assists the RRDS with medical issues
- Determines whether some applicants/participants can be safely served in the community
- Resolves issues with PRI/SCREENs

Nurse Evaluator

(continued)

- Provides technical assistance to Service Coordinator and RRDS

- Trains and educates providers at RRDS request

The Participant

- Is driving force of all services
- Sets own personal goals

- Develops the Service Plans with the Service Coordinator
- Has freedom of choice, including choice of waiver services and providers

Services Available Under The Waiver Program

TBI

- Service Coordination (SC)
- Independent Living Skills Training (ILST)
- Structured Day Program (SDP)
- Substance Abuse Program (SAP)
- Positive Behavioural Interventions and Supports (PBIS)
- Community Integration Counseling (CIC)
- Home and Community Support Services (HCSS)
- Respite Services
- Environmental Modifications Service (E-mods)
- E-mods for Vehicles
- Assistive Technology Services
- Waiver Transportation Community Transitional Services (CTS)

NHTD

- Service Coordination (SC)
- **Daily Living Services**
  - Home and Community Support Services (HCSS)
  - Independent Living Skills Training (ILST)
  - Positive Behavioural Interventions and Supports (PBIS)
  - Structured Day Program (SDP)
- **Environmental Adaptations**
  - Assistive Technology Services
  - Environmental Modifications Service (E-mods)
- **Relocation Services**
  - Community Transitional Services (CTS)
  - Moving Assistance
- **Adapting to the Community**
  - Community Integration Counseling (CIC)
  - Peer Mentoring
- **Keeping Well**
  - Congregate and Home Delivered Meals
  - Home Visits by Medial Personnel
  - Nutritional Counselling/Educational Services
  - Respiratory therapy
  - Wellness Counselling Service
- **Support Services**
  - Respite Services

Non-Waiver Services

- **SNAP**
  - The Supplemental Nutrition Assistance Program (SNAP) issues electronic benefits that can be used like cash to purchase food. SNAP helps low-income working people, senior citizens, the disabled and others feed their families.

- **HEAP**
  - The Home Energy Assistance Program (HEAP) helps low-income people pay the cost of heating their homes.
  - If you are eligible, you may receive one regular HEAP benefit per season and could also be eligible for an emergency HEAP benefit if you are in impending danger of running out of fuel or having your utility service shut off.

- **Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)**
  - Starts with the presumption that all individuals with disabilities can benefit from vocational rehabilitation services and should have opportunities to work in jobs integrated within their communities. Vocational Rehabilitation Counselors guide individuals through service programs they need to reach their employment goal

THERE ARE TWO TYPES OF WAIVER PROGRAMS:

NURSING HOME TRANSITION AND DIVERSION (NHTD)

TRAUMATIC BRAIN INJURY (TBI)

Nursing Home Transition And Diversion

(NHTD)

Nursing Home Transition And Diversion Waiver Program (NHTD)

- The Nursing Home Transition and Diversion (NHTD) Waiver Program is one of the options available to New Yorkers with disabilities and seniors so they may receive services in the community rather than in a Nursing Home.

Nursing Home Transition And Diversion Waiver Program (NHTD) (continued)…

- The NHTD program is targeted at individuals either already in nursing homes and wanting to return to their community, or those being considered for nursing home placement but who would prefer to avoid institutional care and remain in their own homes.

NHTD Service Philosophy

- Services are provided on an individual basis. A program participant may have one or all the outlined NHTD Waiver services, dependent on need and necessity at the time.

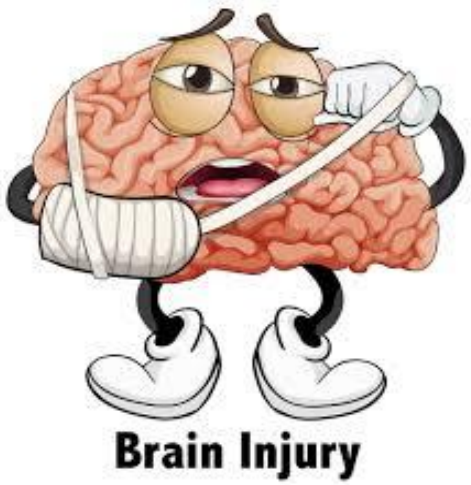
- Services are meant to be "fluid" and to flow with the program participant's life needs.

NHTD Eligibility

- Be capable of living in the community with needed assistance from available informal supports, non-Medicaid supports and/or Medicaid State Plan services and be in need of one or more waiver service
- Be eligible for nursing home level of care
- Be authorized to receive Medicaid Community Based Long Term Care
- Be at least 18 years of age or older
- Be considered part of an aggregate group that can be cared for at less cost in the community than a similar group in a nursing home
- Choose to live in the community as a participant in this waiver rather than in a nursing home
- Not participate in another HCBS waiver

Traumatic Brain Injury

(TBI)



Traumatic Brain Injury (TBI)

- The Traumatic Brain Injury (TBI) Waiver Program is another option available to New Yorkers with severe brain injuries, so they may receive services in the community rather than in a Nursing Home.
  - A Brain Injury is any injury that results in brain cell death and loss of function.
  - Traumatic Brain Injury (TBI) is caused by an external trauma to the head or violent movement of the head, such as from a fall, car crash or being shaken. TBI may or may not be combined with loss of consciousness, an open wound or skull fracture.

TBI Service Philosophy

- Individual is the primary decision maker
- Dignity of risk and the right to fail
- Support of the person's right to choose where to live, who to live with and socialize with and what goals and activities to pursue

Brain Injury Severity

- Mild – Mild brain injury is also known as a concussion. Many people do not seek medical assistance because, at the time, they do not believe the injury is severe. Symptoms may not appear until later. "Post Concussive Syndrome" can include temporary headaches, dizziness, mild mental slowing and fatigue. Symptoms of mild brain injury usually improve over 1-3 months.

Brain Injury Severity

- Moderate – A moderate brain injury is a loss of consciousness that can last for minutes or a few hours and is followed by a few days or weeks of confusion. Persons with moderate TBI may have a longer period of impaired consciousness, more impaired verbal memory shortly after the injury.

Brain Injury Severity

- Severe – Severe brain injury is a loss of consciousness, or coma, for 6 hours or longer, either immediately after the injury or after an intervening period of clarity. Individuals who suffer a severe TBI are at risk for long-term disability.

General Patterns of Dysfunction by Location of Injury

Left Side of Brain

- Difficulties in understanding
- Difficulties in speaking or verbal output
- Depression, anxiety
- Verbal memory deficits
- Decreased control over right-sided movements
- Impaired logic
- Sequencing difficulties

Right Side of Brain

- Impairment in visual-spatial perception
- Decreased awareness of deficits
- Left-neglect or inattention to the left side of space or body
- Altered creativity and music perception
- Visual memory deficits
- Decreased control over left-sided movements

General Patterns of Dysfunction by Location of Injury

(continued)…

- Diffuse Injury
  - Reduced thinking speed
  - Increased confusion
  - Reduced attention and concentration
  - Increased fatigue
  - Impaired cognitive functions across all areas

Cognitive Consequences

- Many families find that the cognitive deficits and personality changes that occur are the most difficult to accept. When we can see a disability, it is easier for us to understand the limitations of the individual and what we can expect of him. Cognitive and personality changes cannot be easily "seen" therefore, they are often more difficult to explain, understand, and accept.

Cognitive Consequences

(continued)…

- When providing cognitive support to individuals with brain injury, remember, their cognitive functions worked adequately to support them prior to the injuries. They also probably remember how they used to function, and the present challenges may frustrate them. They should be approached as you would any other person their same age. Do not speak down to a person or "baby" them. Treat people with dignity and respect, as you would want to be treated if you had the same injury.

Behavioral/Emotional Consequences

- Individuals with brain injury may show a lack of interest in the world around them and a decrease in motivation. They may exhibit extreme and rapid changes in emotion, irritability, depression and a lack of initiative. Difficulty controlling impulses and emotions, resulting in temper flare-ups, aggression, cursing, and generally lowered frustration tolerance may be exhibited. This may cause some to act upon sexual impulses inappropriately. Such persons may also exhibit social immaturity by making "overly friendly" or "silly" comments.

Tips for Working with Individuals with Brain Injury

- Consistency is important
- Treat the individual as an adult
- Be patient
- Model calm and controlled behavior yourself
- Expect the unexpected
- Always remember, people with brain injuries are more sensitive to stress

SERVICE SPECIFIC TRAINING

SERVICE COORDINATION (SC)

Service Coordination

- The Service Coordinator supports and encourages the individual to increase his/her ability to problem solve, be in control of life situations, and be as independent as possible. The Service Coordinator works closely with the participants to ensure their needs are met. This is balanced by the need to assure the Waiver participant's health, safety, well being, and inclusion in the community. The Service Coordinator develops, with the participant, the Initial Service Plan, outlining all needed services, and addendums. There is a required six month review for TBI participants and yearly for NHTD participants.

Service Coordinator

- Assists individual to access and maintain services and housing, if necessary
- Coordinates and monitors provision of services in Service Plan
- Promotes individual's integration into the community
- Promotes activities, services, supports to maintain health and welfare
- Ensure all other supports and services have been accessed prior to waiver services
- Have working knowledge of all other funded services

Service Coordinator Responsibilities

- Must complete a monthly face-to-face meeting with individual
- Must meet with individual in their home at least every 6 months
- Develop and complete Application Packet and Service Plans
- Assure accuracy of information
- Assure implementation of services and supports

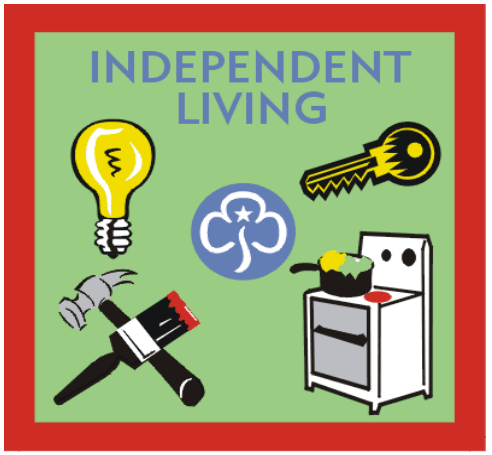
Service Coordinator Responsibilities

(continued)

- Support participant to become effective self-advocate and problem-solver
- Assure participant engages in making informed choices
- Initiate and oversee participant's level of care
- Ensure participant's goals and outcomes are reflected in Service Plan
- Assure coordination, communication, and cooperation between all sources of support and services
- Assist with locating housing as needed

Independent Living Skills Training Services

(ILST)



Role & Responsibilities

- Independent Living Skills Training Services (ILST) are individually designed to improve or maintain the ability of the waiver participant to live as independently as possible in the community.

- ILST assists in recovering skills that have decreased as a result of onset of disability. Also, ILST will primarily be targeted to those individuals with progressive illnesses to maintain essential skills. ILST may be provided in the waiver participant's home and in the community. This service will primarily be provided on an individual basis; only in the unique situation where the waiver participant will receive greater benefit from other than a 1:1 situation, will a group method of providing service be approved.

- ILST services may include assessment, training, and supervision of an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

- It is the responsibility of the ILST provider to conduct a comprehensive functional assessment of the waiver participant, identifying the participant's strengths and weaknesses in performing ADL and IADL related to his/her established goals. The Provider will use the results of the assessment to develop an ILST Detailed Plan. The Detailed Plan will identify milestones to be met during the six (6) month period. The assessment must also include a determination of the participant's best manner of learning new skills and responses to various interventions. This comprehensive and functional assessment must be conducted at least annually from the date of the last assessment.

WHAT ARE…

Activities of Daily Living?

Instrumental Activities of Daily Living?

(ADL'S) (IADL'S)

Activities of Daily Living (ADLs)

- These are the basic self-care tasks that we initially learn as very young children. They are sometimes referred to as "Basic Activities of Daily Living" (BADLs).

- They include:
  - Walking, or otherwise getting around the home or outside. The technical term for this is "ambulating."
  - Feeding, as in being able to get food from a plate into one's mouth.
  - Dressing and grooming, as in selecting clothes, putting them on, and adequately managing one's personal appearance.
  - Toileting, which means getting to and from the toilet, using it appropriately, and cleaning oneself.
  - Bathing, which means washing one's face and body in the bath or shower.

- Transferring, which means being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

Instrumental Activities of Daily Living (IADLs)

- These are the self-care tasks we usually learn as teenagers. They require more complex thinking skills, including organizational skills.

- They include:
  - Managing finances, such as paying bills and managing financial assets.
  - Managing transportation, either via driving or by organizing other means of transport.
  - Shopping and meal preparation. This covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
  - Housecleaning and home maintenance. This means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
  - Managing communication, such as the telephone and mail.
  - Managing medications, which covers obtaining medications and taking them as directed.

HOME AND COMMUNITY SUPPORT SERVICES (HCSS)

What is an HCSS Medicaid Waiver?

- A Waiver:
  - Is an opportunity for comprehensive services to be available in the community rather than in an institution
  - Allows states to assemble a package of carefully tailored services to meet the needs of a targeted group in a community-based setting
  - Maintains the waiver participant's health and welfare through an individualized service plan
  - Assures the overall cost of serving waiver participants in the community is less than the cost of serving a similar group in an institution

Home and Community Support Services (HCSS)

- Home and Community Support Services (HCSS) are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the participant living in the community. Oversight and/or supervision may be needed for safety monitoring to prevent an individual from harmful activities (for example wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. If the applicant/participant does not require oversight and/or supervision, HCSS would not be appropriate.

HCSS Worker
Primary Role & Responsibilities

- Oversight & Supervision
- Environmental Support
- Nutritional Support
- Personal Care Functions

Environmental Adaptations

- Assistive Technology
  - This service allows the purchase and maintenance of technology that can help the individual to stay in the community.

- Environmental Modifications Services (E-mods)
  - This service is intended to pay for modifications to the individual's home or vehicle to allow them barrier-free access to their environment.

COMMUNITY INTEGRATION COUNSELING

(CIC)

The Purpose of Community Integration Counseling

- Community Integration Counseling (CIC) is an individually designed service intended to assist waiver participants who are experiencing significant problems managing the emotional responses inherent in adjusting to a significant physical or cognitive disability while living in the community.
- It is a counseling service provided to the waiver participant who is coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others.
- This service is primarily provided in the provider's office or the waiver participant's home. It is available to waiver participants and/or anyone involved in an ongoing significant relationship with the waiver participant when the issues to be discussed relates directly to the waiver participant. It is expected that CIC will be conducted on a short-term basis.
- The need for CIC could occur at the time of transition from a nursing home or at various times during the participant's involvement in the NHTD waiver.

Community Integration Counseling
Continued…

- While CIC Services are primarily provided in a one-to-one session to either the waiver participant or a person involved in an ongoing relationship with the participant, there are times when it is appropriate to provide this service to the waiver participant or other in a family counseling or group counseling setting.

- Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with federal standards and accepted professional standards regarding client confidentiality.

- CIC must not be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as SCs, ILST and Home and Community Support Services (HCSS).

POSITIVE BEHAVIORAL INTERVENTION SERVICE

(PBIS)

Positive Behavioral Interventions and Support Services (PBIS)

Positive Behavioral Interventions and Supports (PBIS) NHTD

- Services intended to decrease the frequency or intensity of the waiver participant's significant behavioral difficulties that may jeopardize his/her ability to remain in the community of choice due to inappropriate responses to events in his/her environment. PBIS should be provided in the situation where the significant maladaptive behavior occurs.

Positive Behavioral Interventions and Support Services (PBIS) TBI

- Services are provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The primary goal of PBIS services is to decrease the intensity or frequency of targeted behaviors, and to teach more socially appropriate behaviors.

PBIS services include but are not limited to:

- A comprehensive assessment of the individual's behavior in the context of his/her medical diagnosis, abilities/disabilities and the environment which precipitates the behaviors.
- A detailed holistic behavioral treatment plan including a clear description of successive levels of intervention starting with the simplest and least intrusive.
- Arrangements for training informal supports and waiver and non–waiver service providers to effectively use the basic principles of the behavioral plan.
- Regular reassessments of the effectiveness of the plan and modifying the plan as needed.
- An emergency intervention plan when there is the possibility of the participant becoming a threat to himself, herself or others.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Waiver Housing Programs

Introduction

- The Nursing Home Transition and Diversion (NHTD) and Traumatic Brain injury (TBI) Housing Program are rental subsidy programs of last resort for Medicaid recipients participating in the TBI or NHTD 1915(c) Home and Community-Based Services waiver programs, respectively.

- Each TBI and NHTD waiver participant has unique housing needs

- The goal of the TBI/NHTD Housing Program is to address housing-related barriers to community-based long-term care until alternative funding sources become available, such as through Housing and Urban Development (HUD) Housing Choice Vouchers, other housing finance programs, or the Participant's personal resources.

Principles Of The TBI/NHTD Housing Program

- TBI/NHTD waiver participants should be afforded the opportunity to live in appropriate, community-integrated, safe and accessible housing.

- The TBI/NHTD Housing Program is a program of last resort and offered only after all other personal, federal, State and local resources are exhausted.

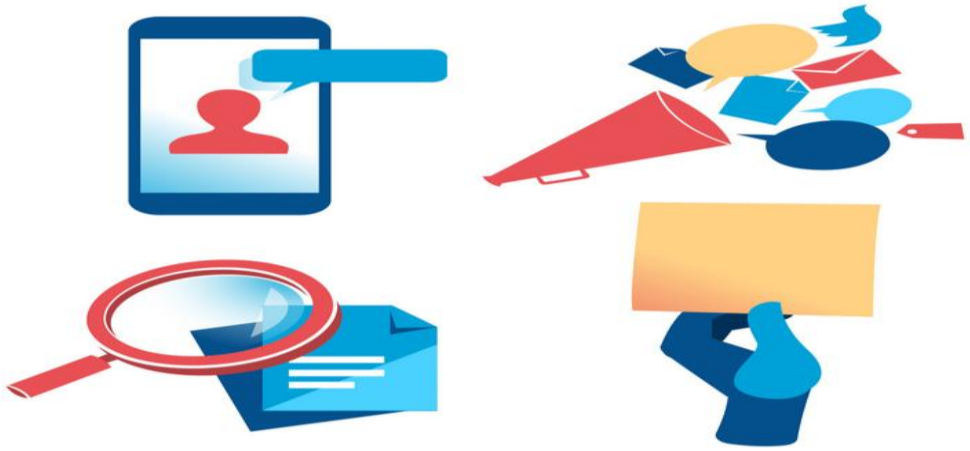
- Not all TBI/NHTD waiver participants require or are qualified to receive a housing subsidy or housing support assistance through the program.

Funding For The NHTD/TBI Housing Program

- The NHTD/TBI Housing Program is a limited funding resource. Availability of initial and continued funding of housing supports is contingent upon annual appropriations provided through the New York State Legislature. As such, all subsidies will be reviewed/re-submitted and approved on an annual basis, consistent with the State budget cycle.

Participation For The NHTD/TBI Housing Program

- To qualify individuals must:
  - Be Medicaid eligible
    - Individuals with excess income must arrange to meet their obligation on a monthly basis through a spend-down in order to maintain full Medicaid eligibility
  - NHTD/TBI Medicaid Waiver
    - Have an approved service plan and be actively receiving waiver services
  - Not reside in settings of four or more unrelated individuals
  - Not reside in a congregate care or assisted living setting
  - Not have current or future ownership or investment rights in the residence.



COMMUNICATION!

Communication Do's and Don'ts

DO's

- DO be accepting
- DO take every issue seriously
- DO address people age appropriately
- DO convey respect
- DO assist them in problem solving
- DO state relevant facts to those that needs to know
- DO remember that you don't know how they feel
- DO be their equal
- DO be sincere

DONT's

- DON'T be blame/fault finding
- DON'T ignore an issue
- DON'T talk down to anyone
- DON'T patronize
- DON'T take responsibility for their situations
- DON'T gossip
- AVOID saying things like "I know," & "I know how you feel."
- DON'T make promises you can't keep
- AVOID domination

Key Components To Building A Successful Relationship

- The way in which we interact is primarily influenced by how we view each person whom we serve. If we believe that someone who experienced an injury is helpless, we may approach him as helpless. If we view someone as defiant or non-compliant, rather than someone who may be confused, overwhelmed and in need of assistance, we may treat that person in ways that may be undignified. All people have the right to be treated with respect and dignity.

Team Meetings

What is a "Team Meeting"?...

- Regularly scheduled meetings to review, update and modify participant services.
- Addresses barriers to achieving participant's goals and any issues affecting the participant.
- An essential part of assuring the participant's health and well-being.

Team Meetings

- Occur every 6 months to develop RSP
- Held at least 6 weeks prior to expiration of current NOD
- All waiver service providers must attend, including HCSS & Structured Day Program representatives, if participant receives these services

Team Meeting Best Practices

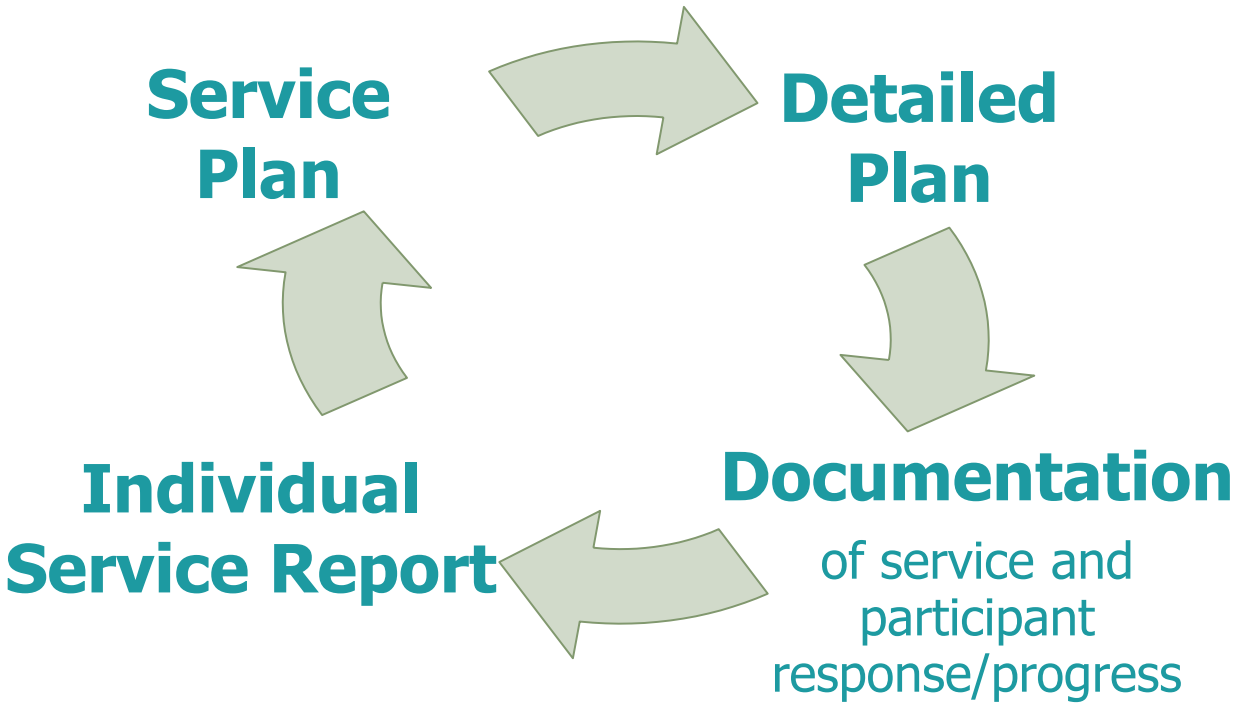
- The participant is the "core" of the team and is encouraged to invite informal supports and advocates.

- Everyone's participation in team meetings assures effective communication between the participant and all team members.

Participant Records

- Application Packet includes:
  - Vital information about the participant
  - Information needed for billing
- Individual Service Reports
- Service Plan Packet and Notice of Decisions
- Service specific assessments
- Contacts with family, informal supports, providers, RRDC and DOH
- Service Notes

The Paperwork Cycle



Service Plans (SP)

- Service Coordinator assists the participant to develop the Service Plan.

- All Service Plans contain:
  - Participant's goals, strengths, challenges
  - Provider activities that support the goals of the waiver participant

Service Plans

(continued)

- Initial Service Plan (ISP)
- Revised Service Plan (RSP)

- **Service Plans:**
  - Show you what other providers are doing
  - Make sure services are consistent

Service Plans

(continued)

- You need to read the Service Plan to understand:
  - Participant's wishes and personal goals
  - What other providers are doing
  - Progress and setbacks the participant is experiencing

*****Ask your supervisor any questions you have about medical or technical terms*****

Detailed Plan - Goals

- Goals are long term objectives that are meaningful to the participant and encompass the individual's unique needs.

- They might be things like being able to:
  - Live on his/her own
  - Manage his/her own finances

Detailed Plan - Goals

(continued)

- Meaningful goals are developed by interviewing:
  - The Participant
  - Anyone selected by the participant

NOTE:
If goals and objectives
are not personally meaningful
to the participant, all best efforts
will fail!

Detailed Plan – Goals

(continued)

- For each goal, a detailed plan must include:

  - **Milestones** — Steps to get there
  - **Interventions** — What you do
  - **Timeframes** — How long it will take

Detailed Plan - Milestones

- Skills or individual steps for participant
- Connected to the goal
- Completed in the short term
- Measurable and observable

Detailed Plan - Planned Interventions

- Tell you…
  - Exactly what to do and how to do it.
  - How to provide for the health, welfare and supervision of the individual during home and community activities.

Detailed Plan - Timeframes

- Frequency and length of interventions
- How long the participant and provider expect it will take for the participant to reach the selected goal
- Realistic time frames (6 months)

Service Notes

- Providers must document each encounter with the participant including:
  - Participant's Name
  - Date (month/day/year)
  - Time (start – end of encounter)
  - Location of service provided

Service Notes

(continued)

- Service provided
- Participant response to the service
- Description of activities
- Progress made
- Signature of staff providing service

- Documentation of encounters:
  - Tell if intervention is effective
  - Clear description of staff action
  - Participant response to that action
  - Must be related to goals/milestones

Service Notes

(continued)

- Track other important information about participant:
- Health and welfare
- All provider's contact with family, friends, and other providers
- Issues, complaints or concerns
- Actions taken to resolve any problems

Observe, Record and Report

- Any significant changes in the individual:
  - Must be reported immediately to your supervisor and/or Service Coordinator
  - Must be documented in service notes
- Significant changes in:
  - Eating/drinking
  - Weight
  - Ability (cognitive, physical)
  - Alertness
  - Energy level
  - Behavior

Individual Service Report (ISR)

- The Individual Service Report (ISR) is a summary including:
  - Detailed Plan review for the prior 6 months
  - Success of plan for the individual
  - Goals that are in the new Detailed Plan for the next six months
  - Suggestions for changes in service

Individual Service Report (ISR)

(continued)

- The ISR is:
  - Required DOH document
  - Filled out by providers
    - (*except AT, Congregate & Home Delivered Meals, CTS, e-Mods, Moving)
  - Submitted to the Service Coordinator prior to or at the team meeting (6 weeks prior to the end of the current service plan)

What is a Crisis Situation?

- Natural Disasters
- Severe Weather
- Medical Emergency
- Fire
- Behavioural Crisis
- Mental Health Crisis
- Power Blackouts

What To Do In a Crisis?

- Define the crisis situation
- Contact your supervisor – do not do it alone – know your agency's policies
- Dial 911 - if warranted
- Take steps to ensure the immediate safety of the participant, others in the area and yourself

What To Do In a Crisis?

(continued)

- Be familiar, in advance, with the individual's:
  - Plan of Protective Oversight (PPO)
    - PPO is reviewed and updated by Service Coordinator and participant at least every 6 months
    - PPO outlines basic information for the participant's overall health and welfare
  - Individual's plan for medication administration and monitoring
  - Any other necessary medical needs, devices and/or life sustaining treatments
  - Individual's ability to get out of home in an emergency

Incident Reporting

- Function of Quality Assurance/Quality Management
- Identify, investigate and remedy potentially harmful situations
- Prevent or minimize incidents from recurring
- Lead to program consistency and improvement
- Allow the provider agency to identify trends and address needed policy changes

Types of Incidents

- Serious Reportable (SRI)
- Recordable incidents

Serious Reportable Incidents (SRI's)

- A Serious Reportable Incident (SRI) is:
  - Any situation when someone has knowledge that a Participant's safety and well being is compromised
  - A significant event or situation endangering a your well being

- Because of the severity or sensitivity of the situation, an SRI must be reported

Serious Reportable Incidents (SRI's)

(continued)

- Witnessing vs. discovering an incident
- Recent vs. past occurrence
- Assigning incident number and verifying classification/category
- Assigning provider agency to investigate
- Reporting forms and Timelines

Investigation of SRIs

(continued)

- Assigned Investigator - Qualified individual
- Clear objective description of incident
- Unique or repeat occurrence
- Details of interviews conducted
- Conclusions
- Recommendations for further action
- Reviewed by provider agency's Serious Incident Review Committee

SRI Classifications of Abuse

- Physical abuse
- Sexual abuse
- Psychological abuse
- Seclusion
- Use of adverse conditioning

- Mistreatment
- Neglect
- Restraint
- Exploitation (NHTD only)

Other SRI Classifications

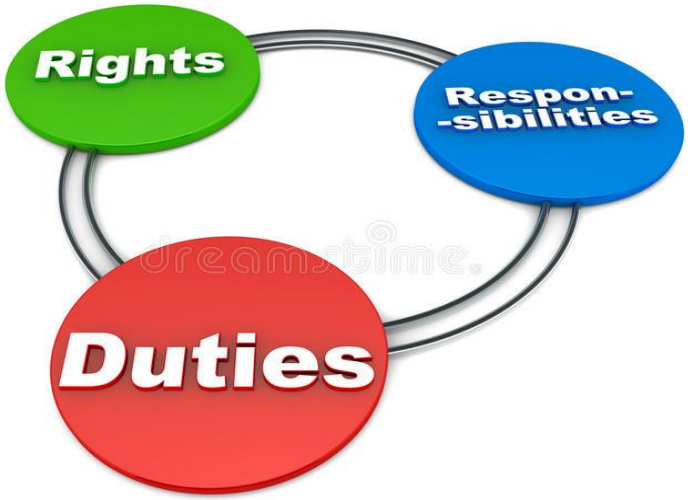
- Violation of a person's Civil Rights
- Missing person
- Death of a waiver Participant due to circumstances that were not of a natural cause.
- Unplanned Hospitalization which results in admission/ observation for greater than 24 hours
- Possible criminal action
- Medication error or refusal
- Medical Treatment
- Sensitive Situation

Recordable Incidents

- Recordable incidents include:
  - Injury accidental in nature
  - Death due to natural causes when in a treatment facility or hospice environment: must be reported to the RRDC within 24 hours and the RRDC will determine if it will be categorized as an SRI
  - Sensitive situation
- Recordable incidents are maintained by the waiver provider and are reported annually to the RRDC

Participants
Rights And Responsibilities

- Waiver participants are assured certain rights, and must agree to certain responsibilities related to participation in the waiver program.



Participant's Rights And Responsibilities

Continued…

- The Service Coordinator is responsible for explaining to the waiver applicant/participant, the rights and responsibilities of being a waiver participant. These rights and responsibilities should be reviewed with the participant at least annually, and any time the Service Coordinator is aware that the participant does not understand his/her rights or responsibilities.

Internal Complaint Procedure

- Agency must have a complaint policy for receiving, investigating and responding to participant complaints

Conflict Of Interest

- A conflict of interest is any interest (business, financial or personal) held directly by a member of the governing body, management or staff which would or might affect his/her decision or action with respect to business transactions and other affairs of the Agency, or would in any way be adverse to, or in competition with the interests of the Agency.

- A conflict of interest also occurs when a member of the governing body or management is an owner, partner, shareholder, member, officer, director or employee of any organization in which the actions of that organization with respect to business transactions and other affairs would in any way be adverse to or in competition with the interest of the Agency.

Conflict Of Interest

Continued…

- **Examples of conflict of interest situations:**
  - An employee has interest which materially affects the amount of time or attention that is to be devoted to implementing job functions.
  - An employee has a business interest in an organization or has a relationship with an individual that is known to be unethical.
  - An employee has a relationship that permits him/her to personally benefit through influencing dealings with the Agency.
  - An employee is involved in a situation that can influence his/her impartiality in making decisions which impact upon the best interests of the agency.
  - The employee takes personal advantage of an opportunity that properly belongs to the Agency.
  - An employee discloses confidential or proprietary information about the Agency to unauthorized persons.
  - An employee accepts financial or other gifts intended to influence purchasing decisions.

When a conflict, potential conflict or a situation which gives the appearance of a conflict is reported or becomes known, management will determine whether a conflict exists and decide on the appropriate course of action to be taken.

DOH NHTD/TBI Waiver Program Manual Website

Long Term Care directory at:

http://www.nyhealth.gov/facilities/long_term_care/index.htm

or directly at:

http://www.nyhealth.gov/facilities/long_term_care/waiver/nhtd_manual/index.htm

THANK YOU!!!

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