2019-2020 Provider Orientation

South Carolina Department of Disabilities and Special Needs

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Contract Compliance Review Process

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Why Do We Review Providers?

The South Carolina Department of Disabilities & Special Needs employs a Quality Management system that includes the cycle of design, discovery, remediation and improvement.

SC DDSN contracts with Alliant ASO, a federally recognized Quality Improvement Organization, to conduct assessments of providers of Case Management, Early Intervention, and DDSN Operated/Contracted Waiver service providers by conducting a review of key components of the provider contracts and service standards as a part of its quality assurance process. During these reviews, records are evaluated for compliance, consumers and staff are interviewed, and observations are completed to ensure that services are being implemented as planned and based on the consumer's need, that the consumer/family still wants and needs them, and that they comply with contract and/or funding requirements and best practices.

This process is required for the State of South Carolina's participation and receipt of funding through Medicaid Home and Community-Based Waiver. SCDDSN uses the data gathered during the Alliant reviews to provide evidence of the State's compliance with Waiver requirements to CMS.

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Review Notification

- A formal notification will be coordinated prior to the Administrative Record Review (via onsite meeting, Skype, or conference call) with a designated staff from the provider agency. Providers will receive a telephone call and email regarding any upcoming review.

- The provider may choose to include additional staff.
- Points of Contact will be established for both the provider and Alliant.

Review Procedures

Individual Record Reviews are unannounced and will begin without prior notice to the Provider Agency for Case Management, Residential and Day Services. The QIO will begin the record review utilizing information available through the electronic record, including Therap and CDSS. Alliant will schedule a time to go on-site to review any information that is not required in an electronic format, or the provider may choose to upload the documentation required for review.

**Early Intervention services will have a one week prior notice for review.*

The Provider will receive a 48 hour notice for their Administrative Indicator review. This can be an on-site review or a desk review with the provider uploading required information.

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Review Procedures

Providers with sample sizes of 15 or less will automatically receive a desk review, unless there are extenuating circumstances.

Providers with sample sizes of 16 or more will have the choice of a desk review or onsite review. Providers should consider this choice carefully. Keep in mind that due to the sample notification process, once the review type has been selected, the provider will not be able to change the desk or on-site review format.

Please note that any records that are available electronically may be reviewed off-site.

Review Procedures

To prepare for the Administrative Review, the Provider will assemble the following information prior to the entrance conference:

- ❑ Human Rights Committee Minutes and Membership information
- ❑ Risk Management Committee Review Documentation
- ❑ Outlier documentation to validate services
- ❑ Verification of Review/Analysis for Critical Incident, Abuse and Death Reporting and Therap documentation
- ❑ Quarterly Unannounced Management Reviews in all residential settings
- ❑ HASCI Rehabilitation Supports documentation (if applicable)
- ❑ Residential Admissions, Transfers and Discharges documentation
- ❑ Swallowing Disordes Checklists and Follow-up Documentation
- ❑ **New for FY20**: List of Individuals receiving Behavior Support Services

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Review Procedures

- Documentation for the Administrative Records Review (included on prior slide) MUST be available at the time of Alliant's arrival on-site or uploaded by the designated time. It is important for the provider to communicate with their Review Team Lead regarding any questions about deadlines and/or any technology/upload concerns.
- Individual Record Review and Administrative Indicator Review may occur simultaneously, or they may take place on different dates. The QIO will coordinate the review process to ensure both reviews are completed within 7 business days.

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Review Procedures

The provider will be required to submit a full listing of all employees *and contractors* that work directly with people receiving services to Alliant within 24 hours of the Administrative Review Notice. Alliant will select the personnel files to be reviewed for pre-employment and training requirements and provide a sample prior to their arrival on-site. It is expected that most provider files will be available within 2 hours of the notice provided. If additional time is needed, providers will work directly with the Review Lead to determine additional time needed.

Since providers have prior knowledge of the information to be reviewed (via Key Indicators), files should be ready when selected for the review.

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Administrative Review Requirements

The following items are needed to conduct the Administrative Review:

- Documentation verifying compliance with standards, manuals and policies for each of the Administrative Review sections.
  This may include, but not be limited to the following:
  - ❑ Identification of Human Rights Committee members with their start dates, as well as identification of member composition
  - ❑ Verification of HRC initial training (for new members during review period) and tabbed ongoing training for all corrective actions
  - ❑ HRC Minutes

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Review Procedures

- Risk Management/Safety Committee Meeting Minutes
- Verification of analysis of ANE, CI, & Death Reporting Data and actions taken to prevent future recurrence of any concerns, as applicable. This will include a review of the provider's data available in R2D2 on the DDSN Applications Portal.
- Database of recorded/tracked, analyzed, trended medication errors including corrective actions
- Database of recorded/tracked, analyzed, trended use of restraints
- Documentation of follow-up for consumers referred for GERD/ Dysphagia Consultation.

Review Procedures

- Verification of quarterly visits to all homes by upper-level management (tabbed by home)
- A list of homes/service locations with names of their designated coordinators (staff responsible for the development and monitoring of residential plans)
- Statements of Financial Rights for all residential admissions during the period in review
- Verification that employees are made aware of False Claims Recovery Act & Whistleblower Laws annually (The verification will be reviewed for the personnel files selected for review.)

Review Procedures

- Community Residential Admissions/Discharge/ Transfer Reports with:
  - Verification the residential location has been changed in Therap
  - A copy of the license for each applicable home, current for the date of the ADT.
  - The monthly census reports for the months of the admissions & transfers (Screenshot will be acceptable, showing consumer name and dates)

Review Procedures

- Outlier contracts including:
  - Approved staffing grids
  - Master schedule and corresponding verification/confirmation of staff coverage
  - Logs, etc.
- System for 24/7 access to assistance (Service Coordination providers only)

**Additional documentation may be required during the Administrative Review in order to provide evidence of the provider's compliance with DDSN and Medicaid Requirements.*

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Exit Summary

- A written exit summary will be provided at the end of the review. The Provider will receive a brief, written summary of findings provided by the next business day. The provider will also have the option of an exit conference via WebEx or Skype to discuss the findings.
- The provider may upload additional information to be considered for the review within 48 hours of receipt of the review summary. If documentation is accepted for reconsideration, the citation will be removed. The review is closed after documentation is received and processed. The provider will also have the option of an exit conference via WebEx or Skype to discuss the findings that will remain after the reconsideration period.

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Report of Findings and Plan of Correction

- The Report of Findings (ROF) will be posted to the Alliant portal within 30 days from the final exit conference.
- The Report will be made available on the Alliant portal to designated provider staff.
- The Provider must submit completed Plan of Correction in its entirety via the portal within 30 days of report release date, unless items are formally appealed.
- If appealing a citation, the Provider must check the appeal box within the Plan of Correction electronic format to initiate further review. Please be sure to “submit.”
- Plans of Correction will be reviewed within 30 days of receipt.
- If specific lines on the Plan of Correction are not approved, provider must resubmit the line within 5 days of notification.

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Appeals

- The Provider may appeal citations received during the Contract Compliance Review (CCR) within 30 days of receipt of the ROF.
- The Provider may submit only one appeal request per cited indicator during the review cycle (i.e. an appeal can not be re-considered for appeal once a decision has been made by DDSN).
- Provider must complete the DDSN Appeal Request Form that is located on the Alliant provider portal.
    - *Provider must attach supporting documentation with the Appeal Request Form to be considered.*
    - *Both the Appeal Request Form and supporting documentation must be uploaded into the provider portal.*
    - *The Appeal box must be checked on the Plan of Correction template and the form must be "submitted."*

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Appeals (Cont'd)

- DDSN will provide a final ruling on the request for Appeal after a review by the appropriate program staff.
- The Alliant management team will initially review the request and documentation and submit a recommendation to DDSN program staff for final review within 30 days.
- DDSN program staff will also review the appeal request and the supporting documentation to make a determination to uphold or remove the citation and notify the provider of the outcome. The QIO will be advised of the outcome of the appeal so that future reviews will be conducted in accord with DDSN's decision.

Appeals (Cont'd)

- Based on the results of the appeal, if needed, a revised Report of Findings will be issued within 72 hours.

- A Plan of Correction for all citations must be submitted to the QIO within the timeframe identified by DDSN, but no later than 30 days after the appeal decision. Corrections are required to be completed no later than 90 days after receiving the QIO report unless otherwise specified and subsequently approved by DDSN.

Follow Up Reviews

The CMS requires a Follow-up Reviews for all HCB Waiver related citations in a provider's Contract Compliance Reviews. The purpose of the Follow-up is to ensure successful remediation of the citation and implementation of the Plan of Correction.

- The Follow-up Review will be conducted approximately 180 days after the exit conference and it will focus only on those indicators that were found noncompliant during the regular review.
- The follow-up sample will consist of a minimum of the records cited during the Contract Compliance Review along with an equal number of new files.
- In the event the indicators reviewed remain non-compliant, an additional Plan of Correction will be required and subsequent follow-up reviews will be scheduled.

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New/ Revised Indicators Changes

A1-05:– Revision to Guidance: (underlined information added)
developing contingency plan/<u>disaster plan</u> to continue services in the event of an emergency or the inability of a service

A1-06: **- Revision to Guidance:** (strikethrough information deleted and underlined information added)
Provider must utilize data available within the DDSN Incident Management System ~~and Therap GER provider reports~~ for the prior 12 month period.
<u>Residential and Day service providers must also document review of data entered in the Therap GER module.</u>

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New/ Revised Indicators

A3-28 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-29 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-30 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019

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New/ Revised Indicators

A3-31 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-32 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-34 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-35 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

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New/ Revised Indicators

A3- 36 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

A3-37 Revision to Guidance: (underlined information added)
Includes a review of Provider Contractors/Sub Contractors beginning 10/1/2019.

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Deleted Administrative Review Indicators

A3-58 Key Indicator Deleted
A3-59 Key Indicator Deleted
A3-60 Key Indicator Deleted
A3- 61 Key Indicator Deleted
A3-62 Key Indicator Deleted
A3-63 Key Indicator Deleted

Where there is an alternative valid, reliable data source to provide evidence of compliance with a performance measure, DDSN has removed the Key Indicators.

New/ Revised Indicators

CM-01 Revision to Key Indicator: (strikethrough information deleted and underlined information added)
The person's file contains ~~either an Authorization Letter from SCDHHS for MTCM or approval from DDSN for State Funded Case Management dated on or prior to the first reported case management activity~~ approval for Case Management.
Revision to Guidance: (strikethrough information deleted and underlined information added)

~~This indicator is applicable for services starting on or after May 1, 2014. For services starting prior to May 1, 2014 – Form 259 (transition form) must be present in the person's file.~~

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New/ Revised Indicators

A valid precertification date range ~~on CDSS~~ is acceptable documentation for approval of ~~SFCM~~ Case Management.
Source: SCDDSN Waiver Case Management Standards, SCDDSN Non-Waiver Case Management Standards

CM-03 Key Indicator Deleted

CM-04 Key Indicator Deleted
CM-14 Revision to Key Indicator: (strikethrough information deleted and underlined information added) ~~Service~~ Case notes are appropriately documented and include ~~must document~~ all Case Management activity on behalf of the person and justify the need for Case Management

CM-15 Key Indicator Deleted

New/ Revised Indicators

Waiver Case Management indicators are provided for information only. These indicators are not applicable for the FY20 Review Period, but will become effective on July 1, 2020.

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New/ Revised Indicators

RS1-01 NEW Key Indicator:
Key Indicator: For new residential admissions, prior to providing residential habilitation, a preliminary plan must be developed to ensure health, safety, supervision and rights protection while the person is undergoing functional assessment for goal planning. At the time of admission, the preliminary plan for the person must be implemented.

Guidance: Prior to providing residential habilitation, a preliminary plan must be developed to ensure health, safety, supervision and rights protection while the person is undergoing functional assessment for goal planning. At the time of admission, the preliminary plan for the person must be implemented. When assessments are completed and training needs/priorities have been identified with the participation and input of the person, the residential support plan will be completed and will replace the preliminary plan.

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New/ Revised Indicators

RS1-02 Revision to Key Indicator: (underlined information added)
The Residential Support Plan must include the person's goals/objectives related to Residential Habilitation including

RS1-05 Key Indicator Deleted and information added to RS1-01

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New/ Revised Indicators

RS1-05 Revision to Key Indicator: (strikethrough information deleted and underlined information added) The effectiveness of the residential plan is monitored and the plan is amended when:
*No progress is noted on ~~an intervention~~ a goal
*A new ~~intervention,~~ strategy, training, or support is identified; or
*The person is not satisfied with the ~~intervention~~ support.

Revision to Guidance: (strikethrough information deleted)
As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the ~~strategy~~ plan must be amended. ~~and if necessary, the Plan as well.~~

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New/ Revised Indicators

RS1-07 Revision to Guidance: (strikethrough information deleted)
All people residing in CTH I, CTH II, CRCF, CIRS, SLP I and SLP II must be informed of their rights and supported to learn about and exercise their rights, ~~unless there is documentation in the file that the person is fully capable of understanding their rights and there is an assessment that confirms this.~~

RS1-10 Revision to Guidance: (strikethrough information deleted)
All people who reside in CTH I, CTH II, CRCF, CIRS, SLP II and SLP I require training in what constitutes abuse and how and whom to report it, ~~unless there is documentation in the file that they are capable of reporting and there is an assessment to confirm this.~~

New/ Revised Indicators

RS1-12 Revision to Guidance: (underlined information added)
The health care received is comparable to any person of the same age, group and sex. (i.e. mammogram for females 40 and above, annual or as prescribed by a physician pap smears, prostate checks for males over 50, etc.)

RS1-14 New Key Indicator :
Each resident must be provided with a key to his/her bedroom.
Guidance: Source: Residential Habilitation Standard

RS1-15 New Key Indicator:
Key Indicator:
Each resident must be provided with a key to his/her home.
Guidance: Source: Residential Habilitation Standard

New/ Revised Indicators

For the RS2 Section of the Key Indicators, the person's behavior support services will be reviewed. Not all indicators are related to the work of the Behavior Supports Provider.

For FY20, several of the indicators that included multiple components from FY19 were broken out into several indicators to capture specific requirements.

New/ Revised Indicators

RS2-02 Revision to Key Indicator: (strikethrough information deleted and underlined information added) Prior to the development of a behavior support plan, indirect assessment ~~including the following~~ must be conducted, <u>including a review of the</u> ~~Record review of~~ DDSN Support Plan and, if they exist, existing behavior support plan and supervision plan.

~~*Interview using the Functional Assessment Interview Form (O'Neill, et al., 2014)~~ <u>or</u> ~~another empirically validated functional assessment instrument - such as the QABF (Questions About Behavioral Function, Matson & Vollmer, 1995) - with two or more people who spend the most time with the person (can include the person) must include (or be supplemented by additional assessment documentation which includes) the following: *Description of problem behavior *Listing of ecological and setting events that predict the occurrence and/or non-occurrence of the behavior *Listing of possible antecedents that predict the occurrence and/or non-occurrence of the behavior *Listing of possible consequences (access, escape/avoid, automatic) that maintain the problem behavior *Record of information on the efficiency of the problem behavior *List of functional alternatives the person currently demonstrates *Description of the person's communication skills *Description of what to do and what to avoid in teaching *Listing of what the person likes (potential reinforcers) (Listing of the history of the problem behavior(s), previous interventions, and effectiveness of those efforts *Development of summary statements based on the *Functional Assessment Interview* (contains information on setting events, antecedents, problem behavior, and consequences)~~

Revision to Guidance: (strikethrough information deleted) Written information in the BSP and/or assessment file indicates that each component of the assessment was conducted. *Does the Support Plan reflect the need for behavior support services?

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New/ Revised Indicators

RS2-03 New Key Indicator

Prior to the development of a behavior support plan, indirect assessment must be conducted, including an interview using the Functional Assessment Interview Form (O'Neill, et al., 2014) or another empirically validated functional assessment instrument - such as the QABF (Questions About Behavioral Function, Matson & Vollmer, 1995) - with two or more people who spend the most time with the person (can include the person) must include (or be supplemented by additional assessment documentation which includes) the following: 1. Description of problem behavior, 2. Listing of ecological and setting events that predict the occurrence and/or non- occurrence of the behavior, 3. Listing of possible antecedents that predict the occurrence and/or non-occurrence of the behavior, 4. Listing of possible consequences (access, escape/avoid, automatic) that maintain the problem behavior, 5. Record of information on the efficiency of the problem behavior, 6. List of functional alternatives the person currently demonstrates, 7. Description of the person's communication skills, 8. Description of what to do and what to avoid in teaching, 9. Listing of what the person likes (potential reinforcers), and 10. Listing of the history of the problem behavior(s), previous interventions, and effectiveness of those efforts.

New/ Revised Indicators

RS2-04 New Key Indicator
Prior to the development of a behavior support plan, indirect assessment must be conducted, including the development of summary statements based on the Functional Assessment Interview (contains information on setting events, antecedents, problem behavior, and consequences)

Guidance: Setting events, antecedents, problem behavior, and consequences must be specified in the functional assessment document.

Source: Residential Habilitation Standards 5.1

New/ Revised Indicators

RS2 – 06 Revision to Key Indicator: (strikethrough information deleted and underlined information added)
Behavior Support Plans must contain a description of the person and his/her background: ~~Description of the person:~~
*Name, age, gender, residential setting, ~~*Diagnoses (medical and psychiatric),~~
*Intellectual and adaptive functioning, ~~*Medications (medical and psychiatric),~~
*Health concerns, *Mobility status, *Communication skills, ~~*Daily living skills,~~
*Typical activities and environments, *Supervision levels, *Preferred activities, items, and people, and *Non-preferred activities, items, and people, ~~**Locations where BSP will be implemented and identification of program implementers. Problem Behaviors and Replacement Behaviors in terms that are observable, measurable, and on which two independent observers can agree. Summary of direct assessment results. Objectives for each problem behavior, including:** *Person's name, *Operational, measurable and observable way to describe behavior, *Conditions under which the behavior occurs or should occur, and *Criteria for completion (performance and time). **Competing Behavior Model for each class of problem behavior that includes function of problem behavior and replacement behavior based on direct assessment. Objectives for each replacement behavior, including:** *Person's name, *Measurable and observable way to describe behavior, *Conditions under which the behavior occurs or should occur, and *Criteria for completion (performance and time). *Support Procedures, *Setting Event/Antecedent Strategies *Teaching Strategies, *Consequence Strategies, *Crisis Management Strategies, *Data Collection Forms~~

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New/ Revised Indicators

RS2-07 New Key Indicator:
Behavior Support Plans must contain details of locations where BSP will be implemented and identification of program implementers.

RS2-08 New Key Indicator: Behavior Support Plans must contain Problem Behaviors and Replacement Behaviors in terms that are observable, measurable, and on which two independent observers can agree.
Guidance: 1) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.
2) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing.

Note: If N/A, then explanation is needed
Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-09 New Key Indicator:
Behavior Support Plans must contain a summary of direct assessment results.

Guidance:
a) Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.
b) If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing.

Note: If N/A, then explanation is needed

Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-10 New Key Indicator:
Behavior Support Plans must contain objectives for each problem behavior, including:

1) Person's name,
2) Operational, measurable and observable way to describe behavior,
3) Conditions under which the behavior occurs or should occur, and
4) Criteria for completion (performance and time).

Guidance:
Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.

Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-11 New Key Indicator:
Behavior Support Plans must contain Competing Behavior Model for each class of problem behavior that includes function of problem behavior and replacement behavior based on direct assessment.

Guidance: Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.

Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-12 New Key Indicator:
Behavior Support Plans must contain objectives for each replacement behavior, including:

1) Person's name,
2) Measurable and observable way to describe behavior,
3) Conditions under which the behavior occurs or should occur, and
4) Criteria for completion (performance and time).

Guidance: Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.

Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-13 New Key Indicator:
Behavior Support Plans must contain Support Procedures that include each of the following:

1) Setting Event/Antecedent Strategies
2) Teaching Strategies
3) Consequence Strategies
4) Crisis Management Strategies
5) Data Recording Method
6) Data Collection Forms

Guidance: Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.
Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-14 Revision to Key Indicator: (strikethrough information deleted) ~~Behavior Support Plan Implementation –~~ DSP(s) responsible for implementing a BSP must be fully trained to: *collect behavioral data, and *implement the BSP procedures

~~**Procedures for training DSP(s) on implementation must include:** *written and verbal instruction, *modeling, *rehearsal, and *trainer feedback.~~ ~~**Documentation of DSP(s) training must accompany the plan and must include:** *person's name, *date of initial training, *date of additional DSP(s) training, *names and signatures of DSP(s) trained, and *name of trainer and/or authorized secondary trainer.~~
~~**Fidelity procedures must occur quarterly and must document direct observation of DSP(s) implementing procedures according to the plan. Documentation must include:** *person's name, *name(s) of DSP(s) being observed, *date, location and time (including duration) of observation, *description of procedures observed, *directions and/or description for scoring DSP performance, *signature of observed DSP, and signature of the observer.~~

Revision to Guidance: (strikethrough information deleted) **Collect behavioral data in accordance with the Residential Habilitation Standards 6.0 – 6.5.** ~~**Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation. Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of anyaddendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on #1 if needed.**~~
~~***Note: N/A with explanation may be acceptable***~~

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New/ Revised Indicators

RS2-15 New Key Indicator:
Procedures for training DSP(s) on implementation must include:

*written and verbal instruction,
*modeling,
*rehearsal, and
*trainer feedback.

Guidance: Procedures for training DSP(s) must be documented in either the BSP, training materials, or training documentation.

Source: Residential Habilitation Standards

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New/ Revised Indicators

RS2-16 New Key Indicator:
Documentation of DSP(s) training must accompany the plan and must include:

*person's name,
*date of initial training,
*date of additional DSP(s) training,
*names and signatures of DSP(s) trained, and
*name of trainer and/or authorized secondary trainer.

Guidance: Documentation of DSP training must be present to indicate training prior to the effective date / implementation date of any addendum/amendment to the BSP. Documentation must specify: 1) training on observation and behavioral data collection system and on treatment procedures, and 2) retraining on #1 if needed.

Source: Residential Habilitation Standards

New/ Revised Indicators

RS2-17 New Key Indicator:
Fidelity procedures must occur quarterly and must document direct observation of DSP(s) implementing procedures according to the plan. Documentation must include:

*person's name,
*name(s) of DSP(s) being observed,
*date, location and time (including duration) of observation,
*description of procedures observed,
*directions and/or description for scoring DSP performance,
*signature of observed DSP, and signature of the observer.

Guidance: Note: N/A with explanation may be acceptable. If opportunities to observe (a) antecedent, teaching, or consequence strategies for acceptable behavior, (b) response strategies to problem behavior, or (c) both are infrequent or not observed during a fidelity check, it would be sufficient to observe the DSP(s) practicing the BSP procedures by role-playing. If the BSP addresses more than one setting (e.g., Day Program, Home, etc.), then the fidelity check should, on a rotating basis, be conducted in each setting addressed by the plan.

Source: Residential Habilitation Standards

New/ Revised Indicators

Revision to Key Indicator: (strikethrough information deleted)
Progress monitoring must occur at least monthly and rely on progress summary notes that include:
Graphs that are legible and contain:

*Title related to behavior measured,
*X- and Y-axis that are scaled and labeled
*Labeled gridlines
*Consecutive and connected data points,
*Legend for data points (when more than one type is used), and
*Phase lines and labels for changes (i.e., programmatic, environmental, medical, and/or medication changes)

~~**Visual analysis that includes description of the level, trend, and variability of each behavior along with discussion related to programmatic, environmental, medical, and/or medication changes. Future (planned) implementation must be described and include any barriers that need to be addressed (e.g., inaccurate implementation, incomplete data collection, etc.), and any changes that need to be made to the procedures based on lack of progress or deteriorating performance.**~~

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New/ Revised Indicators

RS2-19 New Key Indicator:
Progress monitoring must occur at least monthly and rely on progress summary notes that include a visual analysis that includes description of the level, trend, and variability of each behavior along with discussion related to programmatic, environmental, medical, and/or medication changes.

RS2-20 New Key Indicator:
Progress monitoring must occur at least monthly and rely on progress summary notes. Details of future (planned) implementation must be described and include any barriers that need to be addressed (e.g., inaccurate implementation, incomplete data collection, etc.), and any changes that need to be made to the procedures based on lack of progress or deteriorating performance.

New/ Revised Indicators

RS2-21 New Key Indicator:
If fidelity procedures reveal that the BSP is being properly implemented and data properly collected, yet no progress is observed for the problem behavior, replacement behavior, or desired behavior for 3 consecutive months, then the Functional Assessment and its summary must be revisited with input from program implementers to determine the benefits modifying or augmenting BSP procedures or enhancing DSP training.

Guidance: Note: If the fidelity procedures reveal that the BSP is not being properly implemented or data are not being properly collected, then re-training of the DSP(s) is sufficient, and no team meetings or plan modifications are required.

New/ Revised Indicators

RS2-28 Revision to Key Indicator: (underlined information added)
Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible and a GER is entered in Therap by the end of the shift.

Revision to Guidance: (underlined information added)
Source: Directives 567-04-DD and 600-05-DD, GER Requirements for DDSN providers

New/ Revised Indicators

DS1-14 Revision to Key Indicator: (underlined information added)
Restraints are employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible and a GER is entered in Therap by the end of the shift.

Revision to Guidance: (underlined information added)
Source: Directive 567-04-DD and 600-05-DD, GER Requirements for DDSN providers

DS2-03 Revision to Key Indicator: (underlined information added)
The record will contain notations that show evidence of monitoring and evaluation of progress towards achieving and maintaining work.

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New/ Revised Indicators

DS2- 04 New Key Indicator:
An individual plan of employment is developed by the Program Director or his/her designee with participation from the individual and/or his/her legal guardian based on the results of the assessment.

DS2-05 Key Indicator Deleted

DS2-05 New Key Indicator:
Employment activities are specific to obtaining the individual's employment goal.

DS2-06 Key Indicator Deleted

New/ Revised Indicators

EI -06 Revision to Key Indicator: (strikethrough information deleted)
Documentation exists that the Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary (COS) ~~screen in BRIDGES~~ at entry.

EI-08 Revision to Key Indicator: (strikethrough information deleted)
Documentation exists that the Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary (COS), ~~screen in BRIDGES~~, if applicable, at exit

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FY 20 Recoupable Indicators

- During a provider's Contract Compliance Review, all of the applicable Key Indicators are reviewed, including Administrative and Service-Specific indicators. Indicators that are marked with a bold "R" are "recoupable" indicators. When citations are identified for any indicator marked as recoupable indicator, there is a possibility that paid claims will be reversed for any services delivered during the time the indicator was out of compliance.
- The provider has the option to appeal any citation noted in the Report of Findings, including Recoupable Indicators. If a provider does not appeal the citation, or if the citation is upheld during the appeal determination, then services related to the indicator will be subject to the claims reversal process.

FY 20 Recoupable Indicators

- Before the provider is charged back for any paid claims, DDSN Waiver Coordinators and Finance staff review the citation to ensure the claims reversal is warranted. There may be citations that do not result in recoupment.
- DDSN Finance staff also verify the services billed through Medicaid fall within the dates the noted indicator is cited for non-compliance.
- Upon completion of a secondary review, the provider is notified of any reversal of claims for delivered services. DHHS will recoup the amount of the services billed by DDSN. DDSN will then seek payment from the provider of services billed while the indicator was out of compliance.

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Licensing Reviews

- Reviews will be conducted annually for SLP II, CTH I, CTH II, CIRS, and Respite homes as well as Day Service programs.
- Providers will receive same day notification via phone of their upcoming review. Providers are expected to have a staff available at the home on that day. The staff person available does not have to be a management or supervisory staff. The notice for CTH I licensing inspections may vary according to individual need.
- Reviews will be based upon DDSN Residential, Day Service, and Respite Standards.
- Some documentation may be uploaded for review.

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Residential Required Items

- Most recent State Fire Marshal Inspection
- Water Analysis – If home is on well water
- Health and Sanitation Inspection – If licensing for Children
- Policy for disposition of medication
- Key assessments if any form of lockable storage is not available
- Current MARs and past MARs (90 days)
- Medication Error Reports (current and past 90 days)
- Medication Error Rate (current and past 90 days)

Residential Required Items (Cont'd)

- Self Administration Assessments (if any individuals Self Administer their own medications)
- SLP – Medication storage assessments if medications are not in the apartments.
- Pet Vaccinations – If pets are in the home
- Approved Exceptions, if any, as granted by DDSN

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Day Service Required Items

- Fire and disaster drills for the last year
- Policy addressing alternate coverage for staff members who are ill
- Most recent fire marshal, electrical systems, HVAC, and sprinkler system inspections
- Monthly vehicle maintenance records (past year)
- Daily vehicle checklists (past 90 days)

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Day Service Required Items (Cont'd)

- Written authorization for consumers to be administered medication (all individuals who receive medications)
- Complete Staff list of staff that work in the Day Program
- Staff defensive driver training and fire safety training
- Current and past MAR's (past 90 days)

Day Service Required Items (Cont'd)

- Medication Error Reports (current and past 90 days)
- Medication Error Rate (current and past 90 days)
- Policy for disposition of medication
- Any approved Exceptions granted by DDSN

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Licensing Review Process

- The Provider must make arrangements for a staff person to open the location and be present during the review. This does not have to be a program or supervisory staff and the staff assigned may vary by location.
- Applicable records for each of the licensing indicators must be on site or uploaded to the Alliant Portal within 24 hours.
- An Observation of the Day or Residential Services provided may occur at the same time.

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Review Findings

- The Provider will receive a brief, written summary of findings no later than noon of the next business day. The provider may request a Webex/Skype meeting, if needed, to review the findings.
- The Provider may upload additional information for consideration within 24 hours.
- Report of Findings will be posted to the Alliant portal within 30 days from the exit summary.
- Report will be made available on the Alliant portal to designated provider staff.

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Plan of Correction

- The Provider must submit completed Plan of Correction in its entirety via the portal within 15 days of report release date, unless individual findings are appealed.
- If appealing a citation, the Provider must check the appeal box within the Plan of Correction electronic format to initiate further review. The POC/Appeal must be “submitted” to be processed.
- The Plans of Correction will be reviewed within 30 days of receipt.
- If specific lines on the Plan of Correction are not approved, provider must resubmit the line within 5 days of notification.

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Appeals

- The Provider may appeal any citation received during the Licensing Review within 15 days of the ROF.
- The Provider must complete the DDSN Appeal Request Form which is located on the Alliant provider portal.
- The Provider must attach supporting documentation to be reviewed with the Appeal Request Form.
- **Both the Appeal Request Form and supporting documentation must be uploaded into the Alliant provider portal.**

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Appeals (Con't)

- The Alliant management team will initially review the appeal request and documentation.
- The Alliant management team will submit a recommendation to DDSN program staff for final review.
- DDSN program staff will provide a final ruling on the request within 30 days.
- Provider will be notified once an appeals decision has been reached and the outcome has been posted to the portal for their review.

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Follow-up Reviews
Licensing

- A follow-up review will be conducted approximately 180 days after the exit conference to ensure remediation.
- The follow-up review will consist of citations noted during the Licensing Review to ensure the successful implementation of the Plan of Correction. Most follow-up reviews are completed via desk review. For desk reviews, providers will be requested to submit supporting documentation within 24 hours.

Follow-up Reviews
Licensing (Con't)

- For multiple citations for the same indicator, there may be a combination of a desk and onsite review.
- In the event the indicators reviewed remain non-compliant, an additional Plan of Correction will be required and subsequent follow-up reviews will be scheduled.

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Residential and Day Observation

- Approximately 25% of a Provider's Residential Locations and 100% of Day Service locations will have an Observation completed by the Alliant review team.
- The Observation will be a separate review component. It is not a part of the Contract Compliance Review. The Observation may take place at the same time of the Contract Compliance Review or a Licensing Review, or they may take place intermittently throughout the year.
- Observation visits will occur without prior notice.
  If community activities are planned, the observation will not interrupt those plans.
- The Tools to be used for the Observation are available on the DDSN Web-site and on the Alliant Portal.

Data collected through the Residential and Day Observation Process will be used as evidence of DDSN's compliance with the HCBS Settings Regualtion.

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