NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Division of Quality Improvement

Spring Provider Training

Division of Quality Improvement (DQI) email:

quality@opwdd.ny.gov

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Welcome and Opening Remarks

Leslie Fuld

Deputy Commissioner

Division of Quality Improvement (DQI)

OPWDD System COVID-19 Update

- As of April 14, 2021, there have been 10,338 confirmed COVID-19 positive cases statewide.
- Of those that tested positive, 7,047 individuals resided in certified residential programs.
- A total of 649 individuals statewide who tested positive have passed.
- A total of 14,423 staff were reported as confirmed COVID-19 positive.

COVID-19 Vaccination Update

- As of April 12, 2021, vaccination data for the five distinct cohorts of individuals and staff for which OPWDD is collecting information, is as follows:
  - For individuals living in residential (with 98.9% programs reporting), 80.4% of the total individuals in certified residential have received at least one vaccine dose.
  - For staff working in residential (with 98.9% programs reporting), 27.9% of the total staff in certified residential have received at least one vaccine dose.

COVID-19 Vaccination Update (Con't)

- For staff associated with day and waiver services, excluding residential and family care (with 82.8% programs reporting),
  - 27.7% of the total staff have received at least one vaccine dose.
- For adults (18 and over) receiving day, waiver, and care management services, excluding residential and family care (100% programs reporting),
  - 26.2% of the total individuals have received at least one vaccine dose.
- For care managers, 21.3% have received at least one vaccine dose.

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Statewide Standardization of Levels of Supervision (LOS) for Individuals Receiving Services

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Division of Service Delivery - State Operations and Statewide Services

Course Objectives

To provide a comprehensive overview of the:

- Purpose for the development of standardized levels of supervision (LOS)
- LOS terminology and definitions
- Process for determining an individual's LOS, and
- Special considerations when implementing LOS

Purpose

- Prior to issuance of 20-ADM-07, LOS were often subjective, with varied definitions and interpretations statewide
- 20-ADM-07 establishes consistent terminology, definitions, and factors to consider when planning, documenting, and delivering the necessary LOS to individuals receiving services
- To provide guidelines for determining and establishing a minimum LOS using a Least Restrictive Environment Approach that is individualized and specific to activities and settings

Applicability

The requirement for use of standardized LOS terminology in care planning processes is applicable to all individuals receiving OPWDD authorized Care Coordination and/or receiving services in the following OPWDD certified settings:

- all residential facilities certified or operated by OPWDD, including family care homes;
- all facilities certified by OPWDD, except:
  - respite programs and services;
  - clinic treatment facilities; and
  - diagnostic and research clinics.
- day habilitation services (whether or not provided in a certified facility); and
- prevocational services (whether or not provided in a certified facility).

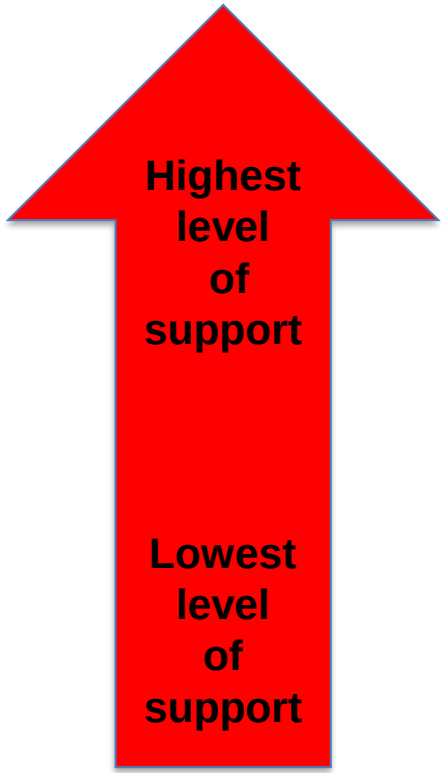
Please note that the applicability and requirements of a defined level of supervision may extend to locations and situations not specifically identified above, as determined by the individual's program planning team.

Levels of Supervision

Levels of Supervision (LOS)

- LOS are determined by the individual's care planning team and may vary across settings, circumstances and activities
- Overarching protections in Life Plans are expanded upon in Staff Action Plans and other plans created by the provider
- The Coordinated Assessment System (CAS) is a way that the individual's degree of independence and/or support needs may be assessed, as it relates to specific activities/tasks

Levels of Supervision



- one-to-one (total assistance)
- line-of-sight (maximal assistance)
- range of scan (extensive assistance)
- periodic checks (limited/cueing)
- independent w/ staff present (set-up help only)
- independent

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One-to-One Supervision

- One to one direct supervision; close proximity
- One or more staff assigned to one individual (e.g., 1:1, 2:1); staff cannot supervise more than 1 individual at a time with this level and cannot perform other work duties besides supervision of the individual
- Staff must maintain close proximity based on the needs of the individual and the circumstances surrounding the need for such supervision
- Specific proximity requirements must be specified in the service plans
- Must be able to respond **immediately**
- This is a form of supervision where total assistance is required to support the individual

Line-of-Sight Supervision

- Direct supervision; field of vision/visual path at all times; close proximity
- Staff may supervise more than one individual and must be in the same area as the individual(s) and requires that staff remain aware of the individual(s) and the environment
- Staff must be able to respond **efficiently** to prevent/minimize risks; “Efficiently” means that staff must continuously monitor the environment, evaluate risks, while providing support when needed
- Staff may not be assigned activities (other than supervision) that could delay their response or result in not seeing the individual at all times
- Specific proximity requirements, circumstances and response time must be specified in the individual(s’) service plans

Range of Scan Supervision

- Within range of scan of staff: staff can see the individual(s) when looking around; proximity determined by specific needs and circumstances described in their service plans
- Staff may supervise more than one individual and perform duties outside of supervision, if specified in the service plans
- Staff must be able to respond **efficiently** to prevent/minimize risks; Efficient response is similar to line-of-sight supervision
- This is a form of supervision where extensive assistance is required at times, but not continuously

Periodic Checks

- Limited level of support needed, checks can be visual, audio, or both
- Staff may supervise more than one individual and can perform duties other than supervision
- The frequency, type of supervision, proximity, and staff response time are specific to activity and are detailed in the individual(s') service plans

Independent with Staff Present

- Individual has a higher level of independence and requires a lower level of supervision within a particular environment
- Staff may supervise more than one individual and can perform duties other than supervision
- Staff remain aware of the individual(s') location and is within the vicinity to assist if needed; no specific schedule of checks
- If specific proximity is required, it will be specified in the service plans

Independent

- Individual does not require a specified level of supervision, and is considered independent
- Staff may be assigned to supervise other individuals, may have duties other than supervision, and do not need to be present at all times
- Staff may be available to the individual, as needed

	1:1 Supervision or Close Supervision	Line of Sight Supervision	Range of Scan Supervision	Periodic Checks	Independent with Staff Present	Independent
1. Staff Assigned to the Individual	One or more staff assigned to one individual (e.g., 1:1, 2:1).	The individual(s) must be within the visual field of staff.	Assigned staff can see the individual(s) when they look around.	Staff observe the individual(s) as specified in their plan (can be visual or audio). This includes the signs of life checks.	Staff member is aware of the location of the individual(s) and is within a planned vicinity to assist the individual(s); no schedule of checks.	Individual does not require a specified LOS.
2. Proximity of Staff to the Individual	Staff must maintain a proximity that allows them the greatest chance to prevent or minimize the impact of the issue for which 1:1 is assigned. Any specific proximity requirements must be specified in the individual plan	Staff must be in the same area (e.g., room, area of the vehicle) as the individual(s) or maintain a proximity that allows the staff to prevent or minimize the impact of the issue for which the line of sight is assigned. Details pertaining to proximity, etc., are specified in the individuals' plan	Assigned staff are generally in the same area as the individual(s) (e.g., room, area of the vehicle), depending on the reason for range of scan, and can see the individual(s)	On site. Staff must have the ability to visually see, audibly hear or otherwise have a clear awareness of (depending on the reason for the periodic checks) the individual(s) when required, as determined by the plan. Ex: Staff visually checks on/sees the individual(s) within a specific timeframe (15 minutes; 1 hour; 2 hours; 2x per night)	If specific proximity is required, this should be specified in the individuals' plan. Ex: Staff may be strategically located to hear the individual(s) at all times.	As needed
3. Response Time required for staff action	Immediately	Efficiently	Efficiently	As needed	As needed	As needed
4. Tasks & Assignments re: Supervision of more than one individual	No	Only if clearly defined in the plan specific to the environment or activity.	Yes, if in accordance with the plan	Yes	Yes	Yes
5. Tasks and Assignments - May perform duties other than supervision	No	May not be assigned activities that could delay staff response or result in staff not watching/seeing the individual(s) at all times	Yes, if in accordance with the plan	Yes	Yes	Yes
Details	See person-centered plans					

Supervision and Support

Level of Supervision	Level of Support Required
One to One	Total Assistance
Line of Sight	Maximal Assistance
Range of Scan	Extensive Assistance

Special Considerations:
Must determine the effect the level of supervision has on the ability of staff to properly supervise other individuals, as well as their ability to perform all functions associated with their employment.
For individuals who require one to one supervision or a similar level of supervision (e.g. 2:1), there must be daily documentation completed verifying that staff have provided the proper level of supervision. If this level of supervision is not provided as described in the individual's plan—it must be reported in accordance with 14 NYCRR Part 624.

Reporting in Accordance With 14 NYCRR Part 624

- OPWDD has received questions from providers related to Page 8 of the ADM for LOS. The language in the ADM is not intended to change the reporting of incidents related to supervision. Providers should continue to refer to the Part 624 Handbook, including 14 NYCRR Part 624, paragraph 624.3(b)(8) regulation and additional guidance.
- OPWDD will be updating the Part 624 Handbook with further clarification and guidance on supervision breaches and reporting neglect in the near future.

Implementation of Levels of Supervision

Levels of Supervision: The Assessment Process

- The CAS informs the care planning and treatment team of an individual's degree of independence and/or support needs as related to specific activities, settings and tasks
- Levels of Supervision are determined by the individual's care planning/treatment team and must be documented in the applicable service plans (i.e., Staff Action Plan, Behavior Support Plan, Site Specific Plan of Protective Oversight, etc.)
- *Guidelines for Developing and Implementing Levels of Supervision (LOS)* provides a framework for specifying an individual's minimum supervision needs in a service plan
- An individual's level of supervision may be contingent upon their environment, emotional state or other factors

Levels of Supervision Plans

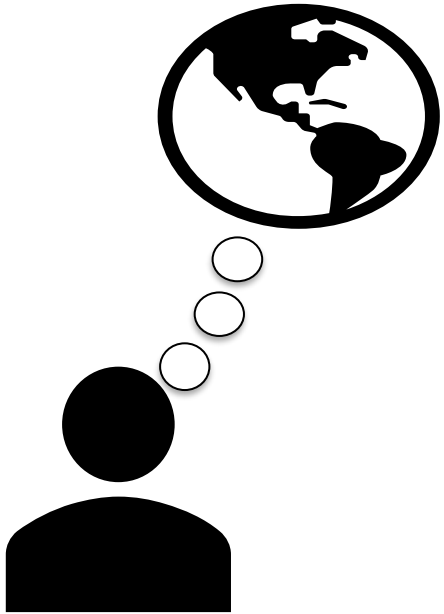
- Plans must:
  - Be specific
  - Be written in a manner that is easy for staff to understand and follow
  - Address variations of an individual's supervision levels and support needs across different settings/circumstances
  - Be kept current; as an individual's needs change, their supervision levels may change as well

What should plans include?

The number of staff assigned to the individual(s):

- How many staff must be assigned supervision responsibilities for the individual?
  - The number of staff assigned to the individual should be clearly documented and communicated.

What should plans include?



Environment and activity:

What are the circumstances or settings where the LOS must be provided?

Think about the individual's world:

- Where do they like to go to?
- Where do they dislike going?
- Who do they like?
- Who do they dislike?
- What activities do they enjoy?
- What activities do they dislike?

What should plans include?

Expectations of staff:

- How close does staff need to be with respect to the individual?
- How quickly are they required to respond if staff action is needed?
- How should they intervene if staff action is needed?

What should plans include?

Tasks and Assignments:

- Can staff supervise more than one individual?
- Can staff perform or be assigned other duties while providing the level of supervision?
  - Plans must state when the staff is exclusively designated to provide supervision only

What should plans include?

Transfer of supervision procedures:

- How does staff transfer supervision responsibilities from themselves to another staff?
  - Procedures must be established to ensure that supervision responsibilities are properly transferred when necessary, and staff must be trained on such procedures

What should plans include?

Location of LOS information:

- Where is the specific information regarding the levels of supervision? (i.e., Behavior Support Plan, Staff Action Plan, Safeguard Summary Plan, etc.)
- Staff must be trained on the plan that outlines the individual's supervision needs and know where to obtain a copy of the plan so that they can reference these documents efficiently
- Plans detailing levels of supervision must always be readily accessible to staff

Staff Training on Levels of Supervision

Prior to implementation, staff responsible for delivering services must be trained on the levels of supervision and on how to implement the supervision requirements for all individuals under their care.

Timeline for Implementation

Within twelve months of the issuance of 20-ADM-07, provider agencies must update service plans and documentation to incorporate the terminology established in 20-ADM-07.

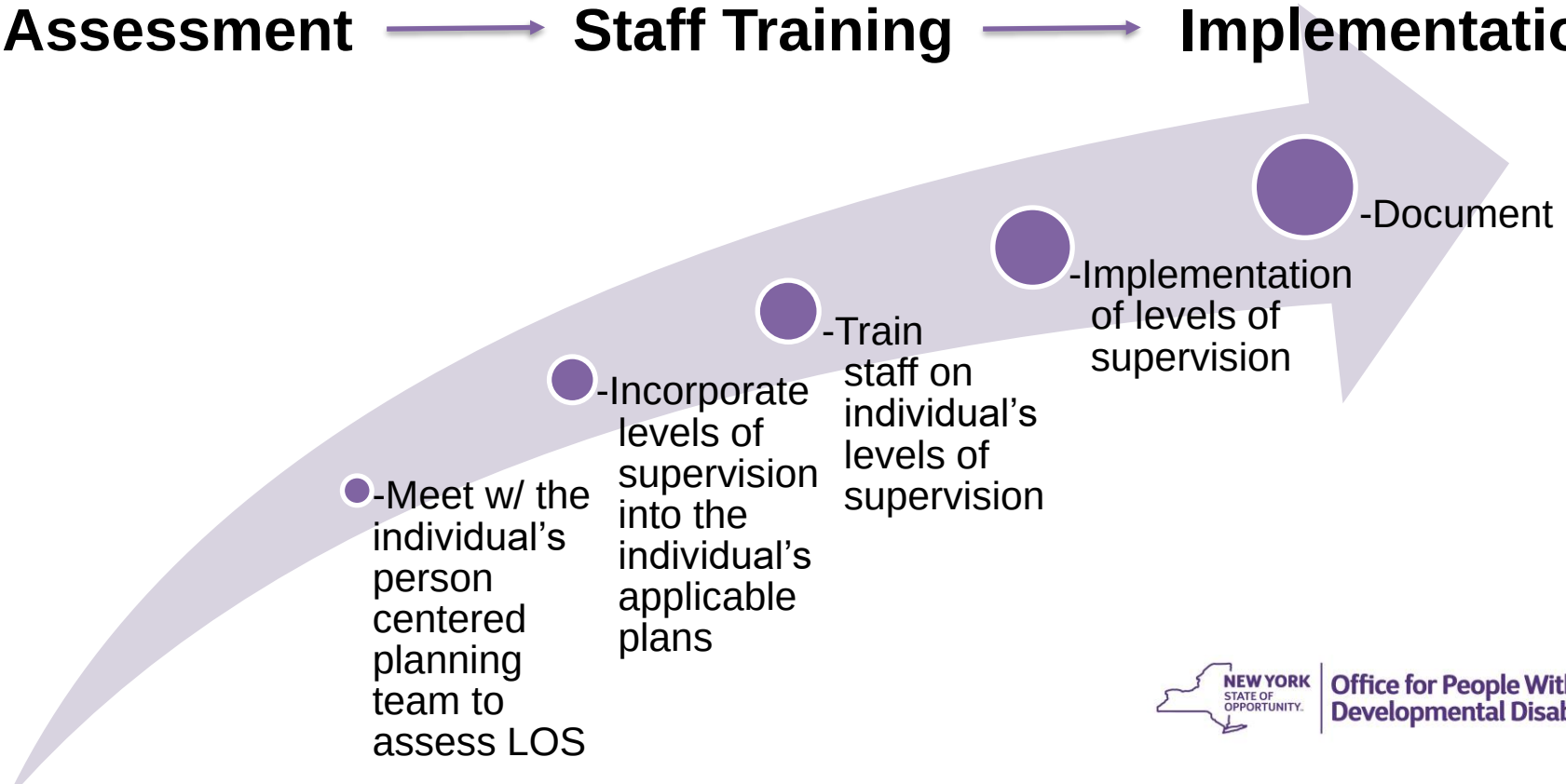
Care Coordination Organizations (CCOs) have an additional six months (eighteen months total) from the issuance of 20-ADM-07, to integrate into the Life Plan.

Documentation Requirements

Documentation pertaining to LOS, including plans, checklists, or daily notes providing evidence that the supports and supervision were delivered, shall be maintained in accordance with 14 NYCRR 633.10(a)(2) and applicable documentation and record retention requirements.

Levels of Supervision Process

Assessment → **Staff Training** → **Implementation**



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Recap

20-ADM-07 informs providers of the standardized terminology for levels of supervision, and provides the framework for specifying an individual's minimum supervision needs in a plan.

The needs of each individual must be considered when establishing levels of supervision. Treatment teams must strategize how a range of needs for several individuals would be met, across various settings and circumstances.

Service planning is fluid and will change as needs change. Knowing the individuals being served is a starting point for planning staff assignments, individuals' supervision levels, and procedures for managing competing needs while using the resources available.

Questions?

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Jonathan's Law: Notification, Record Access, and Documentation Requirements

Karisa Capone
Director
DQI – Incident Management Unit

Jonathan's Law Requirements

- Requirements pertaining to Jonathan's Law can be found in Mental Hygiene Law (MHL) Sections 33.23 and 33.25 and in OPWDD regulations in Sections 624.6 and 624.8.
- Jonathan's Law established procedures that agencies must follow to notify qualified parties of Reportable Incidents (Abuse and Neglect and Significant Incidents) and Notable Occurrences, and to provide investigative records to qualified parties for Reportable Incidents.
- Agencies must have policies and procedures concerning the process for Jonathan's Law notifications and the release of investigative records, including, but not limited to, identifying appropriate staff who are authorized to receive requests and those who are authorized to release records.

Qualified Persons

- A qualified person includes a person's legal guardian, parent, spouse, adult child and adult sibling. Adult sibling was added to Jonathan's Law on August 21, 2017.
- Adult siblings are entitled to access to past incidents that occurred prior to August 21, 2017, just as other qualified persons are, under Jonathan's Law.
- If the individual is a capable adult, the agency must provide the information required for notification to the individual if the individual does not have a guardian, parent, spouse, adult child, or adult sibling or if such parties are not reasonably available, or if there is written advice that such parties do not want to be notified. Under these same circumstances, if the individual is not a capable adult, the agency must provide notice to an advocate or correspondent, if one exists.

Jonathan's Law Notifications

- For all Reportable Incidents and Notable Occurrences, the agency must provide telephone notice to a qualified person.
- The telephone notice must be provided as soon as possible, but no later than 24 hours after entry of initial information into IRMA for a reportable incident or notable occurrence.
- The telephone notice may include more than one call. Follow up calls with additional required information must be made within a reasonable timeframe after the initial call. All phone call attempts should be documented.

Jonathan's Law Notifications

- Exceptions to this notification:
  - If the qualified person is the alleged abuser.
  - If there is a written statement from the qualified person that he or she objects to receiving such notification. The notice must be provided to another party who is a qualified party if one exists.
  - If the individual receiving services is a capable adult and objects to the notification being made to a qualified party. The capable adult must be provided the notice.

Jonathan's Law Notifications

- The telephone notice must include:
  - A description of the incident or occurrence and any actions taken to address the incident or occurrence.
  - An offer to meet with the agency's Chief Executive Office (or designee) to further discuss the incident.
  - For Abuse and Neglect incidents, an offer to provide information on the status and/or finding of the report, unless the individual is a capable adult who objects to the provision of this information.

Jonathan's Law Notifications

- Report on Actions Taken (OPWDD Form 148) must be provided to the qualified party within 10 business days for all Reportable Incidents and Notable Occurrences and must include:
  - Any immediate steps taken in response to the incident or occurrence to safeguard the health and safety of the individual.
  - A general description of any initial medical or dental treatment or counseling provided to the individual in response to address the incident or occurrence.

Jonathan's Law Notifications

- When a request is made, a copy of the incident/occurrence report must be provided to the qualified party within 10 business days for all Reportable Incidents and Notable Occurrences.
- The copy of the initial incident/occurrence report must be accompanied by a statement that all contents are preliminary and have not been substantiated.
- All reports and records provided must be redacted by the agency to protect the privacy rights of other parties.

Jonathan's Law Records Release

- Jonathan's Law also requires that investigations into Reportable Incidents (Abuse and Neglect and Significant Incidents) must be released to a qualified party upon a written request by the qualified party.
- Requests for investigative records must be made to the provider that was providing services to the individual at the time of the incident. Requests should be preserved as part of the agency's Jonathan's Law documentation.
- The agency is responsible for releasing the investigative report, regardless of the entity conducting the investigation.

Jonathan's Law Records Release

- Agencies are required to release investigative records to an eligible requestor (qualified party) no later than 21 days after the closure of an incident, or, if the incident is already closed, no later than 21 days after the date of the request.
- The records must be accompanied by a cover letter that includes specific language found in regulation. Sample cover letters can be found in the Part 624 Handbook.

Jonathan's Law Records Release

- Exceptions to the requirement for release:
  - If the eligible requestor is an alleged abuser, such requestor cannot receive any records pertaining to the investigation in which he or she was the targeted alleged abuser, regardless of the conclusion.
  - If the individual receiving services is a capable adult and objects to sharing the records with the eligible requestor.
  - If the request is made for records that are not covered under the records release provision.

Summary of Jonathan's Law Timeline

- Notifications
  - Phone notification within 24 hours of entry/completion of report
  - Report on Actions Taken within 10 business days of report
- Investigative Records Release
  - Within 21 days of request or closure, whichever comes first

Jonathan's Law Documentation

- OPWDD's expectation is that all information that documents compliance with Jonathan's Law be maintained by the agency and accessible by OPWDD.
- OPWDD's Agency Review Manual, utilized for surveys conducted by OPWDD's Bureau of Program Certification (BPC), outlines expectations for maintaining documentation of compliance with Jonathan's Law requirements.
  - https://opwdd.ny.gov/providers/prepare-your-survey
- BPC surveyors look for information in IRMA and within agency internal tracking mechanisms.
- Best practice is to utilize IRMA to maintain all documentation associated with the incident or occurrence. Certain documentation must be maintained in IRMA.

Jonathan's Law Documentation

- The agency must document Jonathan's Law notification(s) by completing the required fields under "Special Notifications" in IRMA. The link will appear in the light purple bar.
- If the response to any of the questions is "yes," additional fields will pop up requesting additional details.
- Printable 147 and 148 forms can be obtained by clicking on the links to the left of the individual's name. These forms can be redacted within the application prior to printing.
- While not required, OPWDD recommends that agencies utilize the "notifications" or "other" file folder in IRMA to upload any documentation maintained regarding Jonathan's Law requirements.
    - Agency policy/procedure should identify where to store documents so that they can be easily retrieved.

Special Notifications - Edit

Master Incident Number: [redacted] (1 individual) (0 documents)
Investigation delegated to:**Agency**
Investigation monitored by OPWDD? : **No**
Statewide Incident Number(s):
147 148 [redacted] [redacted] 1(RA - Physical Abuse)

Incident Details | Individual | Initial Findings | Physical Findings | Report of Death | Notifications | Investigation | Corrective Action Plan | IRC Minutes

Page 1 | Special Notifications | Notification History

+ **All fields are required to close the incident. For exceptions please refer to the Help.**

Incident Date January 03, 2018
Individual Name [redacted]

Was the eligible person contacted?

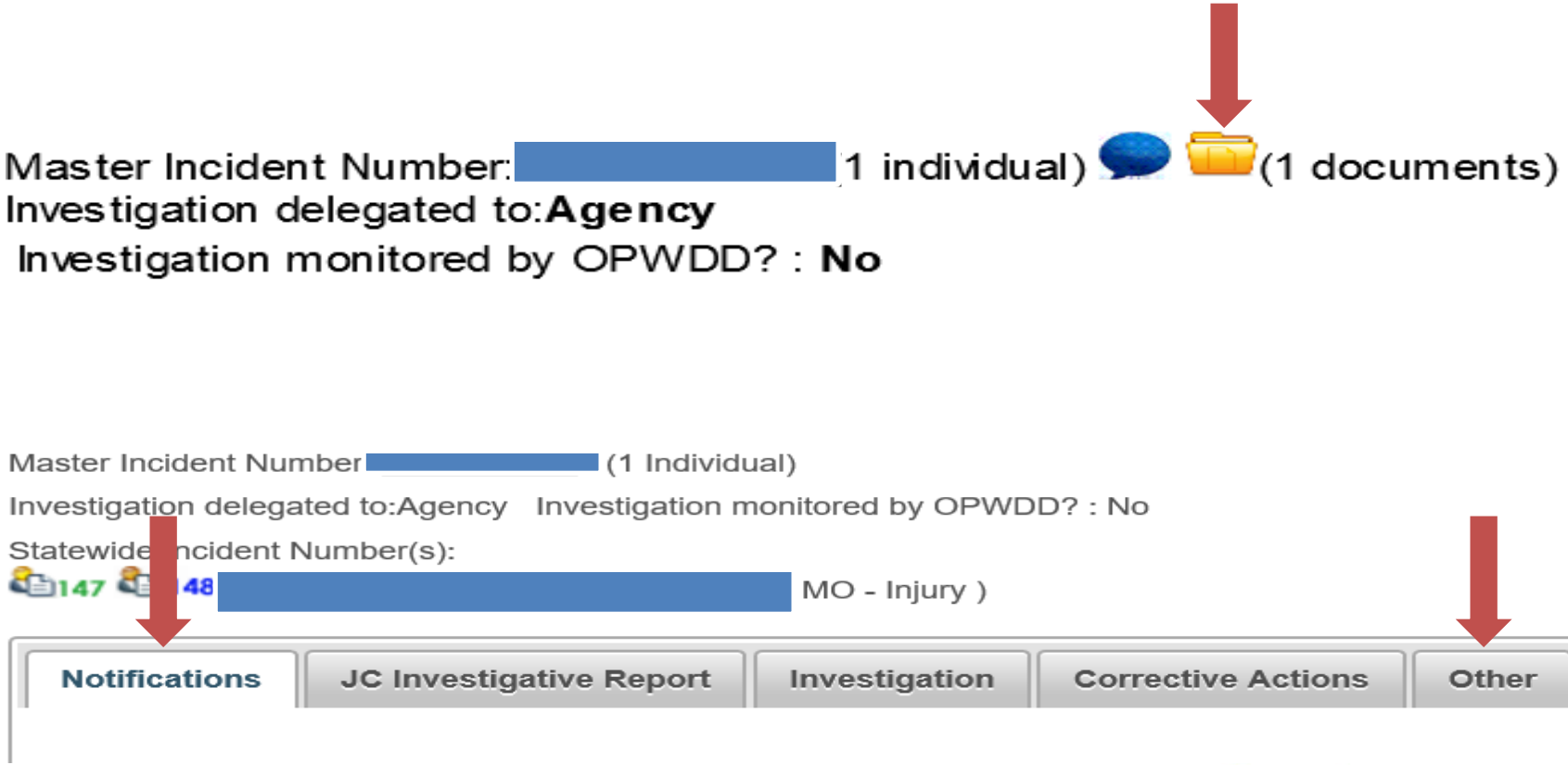
- ○ Yes
- ○ No

Date the OPWDD 147 was completed Month Day Year
Date the OPWDD 148 or equivalent was provided Month Day Year

Was a written request for the OPWDD 147 received?

○ Yes ○ No

Submit Reset


Master Incident Number: [redacted] 1 individual) (1 documents)
Investigation delegated to:Agency
Investigation monitored by OPWDD? : No
Master Incident Number [redacted] (1 Individual)
Investigation delegated to:Agency Investigation monitored by OPWDD? : No
Statewide ncident Number(s):
147 48 [redacted] MO - Injury)
Notifications
JC Investigative Report
Investigation
Corrective Actions
Other

Jonathan's Law Requirements

- Additional information on Jonathan's Law can be found on our website
  - https://opwdd.ny.gov/system/files?file=documents/2020/02/jonathans_law_requirements_08_27_2017.pdf
- Along with the Part 624 Handbook which also includes template letters
  - https://opwdd.ny.gov/system/files/documents/2020/01/final-part-624-hanbook-updated-9-2019.pdf

Questions?

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Meeting Incident Management Requirements

- Initial Reporting and Immediate Protections
- Timeframes for Investigation, IRC, and Other Agency Activities
- Other Important Reminders

Megan Adams
Statewide Compliance Officer
DQI – Incident Management Unit

Incident Management Unit

Today's training will cover the following topics:

- Initial Reporting and Immediate Protections
- Incident Report and Management Application (IRMA) Entry Timeframes
- Investigation Timeframes
- Incident Review Committee (IRC) Minutes
- Closing Incidents
- Other Important Reminders

Immediate Protections

- An individual's safety must always be the primary concern of the agency. The agency needs to ensure that an individual receiving services who has been harmed, receives any necessary treatment or care and that the individual is protected from any further harm and abuse.
- It is necessary to ensure all immediate protections are fully completed and implemented timely. This is an important part of incident management process to keep people safe.

Part 624 Incidents: Under Justice Center Authority

OPWDD's Incident Management Unit must be contacted by phone for a reportable incident or serious notable occurrence. The agency must also contact the NYS Justice Center for those reportable incidents that fall under the Justice Center's authority.

- IRMA entry does not replace the obligation of the agency to notify the NYS Justice Center or OPWDD.
- Initial information is automatically entered into the Incident Report and Management Application (IRMA) from the VPCR.
- Agencies need to review the information within 24 hours or by close of the next working day, whichever is later, and enter any missing information or address any discrepant information.

Part 624 Incidents: Initial IRMA Entry

When a report of a reportable incident or a serious notable occurrence is NOT under the NYS Justice Center's jurisdiction, the agency must enter initial information into IRMA within 24 hours or by close of the next working day, whichever is later.

- The agency must notify OPWDD of the incident by phone.
  - IRMA entry does not replace this obligation.
- Minor Notable Occurrences (MNOs)
  - State Operations is required to enter MNOs into IRMA. It is best practice for voluntary providers to enter this into IRMA. If a report is not made in IRMA a written initial incident/occurrence report must be completed. This must occur within 48 hours or by close of the next working day, whichever is later.

Part 625 Event/Situations: Initial IRMA Entry

- The agency is required to enter initial information about the event/situation into IRMA within 24 hours of, or by close of, the next working day, whichever is later. Actions taken to intervene and protect the individual must be also be entered.
- Agencies should notify OPWDD's IMU by phone of the event/situation.

Part 624 Incidents: Subsequent IRMA Entry

- Subsequent information must be entered by the close of the 5th working day.
  - If another provision of Part 624 regulations identifies a different timeframe, agencies must comply with that timeframe requirement instead (e.g., immediate protections)
  - Information about law enforcement notification must be entered into IRMA within 24 hours of the report being made (624.6(d)(ii))
- The Report of Death must be entered in IRMA within five working days of the discovery of the death.

Death Certificates

- Agencies are responsible for obtaining the Death Certificate. Death certificates can be obtained from the funeral home (if requested in a timely manner) or the county clerk's office in the county where the individual passed away.
- If an agency is having difficulty obtaining a death certificate, OPWDD can assist. Requests should be made by emailing cof.deathreview@opwdd.ny.gov with the following information:
  - Individual's name, address, date of birth, date of death, location of death, and address of the entity where the request will be directed.

Part 624 Incidents: IRMA Entry and Incident Review Committees

- Meet as determined by agency policy, but no less frequently than on a quarterly basis.
- Always meet within one month of the report of a reportable incident or serious notable occurrence, or sooner if warranted.
- Meet, as necessary, to comply with the timeframes for submission of a final report to the Justice Center for reportable incidents.
- IRC Minutes – for reportable incidents/serious notable occurrences, the portion of the minutes that discuss matters concerning the specific incident must be entered into IRMA within three weeks of the meeting.

Part 624 Incidents: Timelines for Investigations

- Initiate investigation immediately and within 24 hours of report
- Complete investigation within 30 days of the report
- Intermediate Care Facilities complete investigation within **five working days**

Part 624 Incidents: Timelines for Investigations

- The entirety of the investigative record must be submitted for Abuse/Neglect and Deaths under the auspices of an agency within 50 days of the report as follows:
  - For Abuse and Neglect under the Justice Center, submit to the Web Submission of Investigation Report Application (WSIR)
  - For Deaths, upload to IRMA
  - For Abuse and Neglect not under the jurisdiction of the Justice Center, upload to IRMA
- This includes testimony, the Form 149, all written statements, all documentary and demonstrative evidence.

Investigations and Law Enforcement Involvement

- When law enforcement tells an agency they are going to investigate, it is important for the agency to ask which tasks, if any, that the agency can work on if the agency is the investigative entity. Potential questions:
  - Can we proceed with interviewing anyone?
  - Can we proceed with collecting documents, securing the scene?
- In the event that an incident is open for a long duration and police are investigating exclusively, the agency is responsible to reach out to the police for updates so that monthly updates can be provided to the agency's IRC and OPWDD. The agency needs to inquire about when they can start the investigation.

Investigations and Law Enforcement Involvement

- If the agency is notified that the police will be investigating an incident, please make sure to contact the NYS Justice Center (for those incidents under their authority) with this update. The agency needs to update IRMA to indicate law enforcement is investigating as well.
- If the agency is made aware of an arrest made related to an incident, the agency is responsible to notify OPWDD's Incident Management Unit of the arrest.
- If the agency is made aware of an arrest, the agency is responsible to notify the Justice Center (if under the JC) and OPWDD.
- The agency will receive subsequent arrest notifications by the Justice Center's CBC Unit. The agency's authorized person (AP) will be notified.
    - The AP is typically staff from HR.

Part 624 Incidents and Part 625 Event/Situations: Reporting Updates

- **Monthly** updates need to be made for Incidents and Event/Situations as follows:
  - For reportable incidents and serious notable occurrences, updates into IRMA until closure of the incident or occurrence. This includes the status of the investigation and anything outside the agency's control that is preventing closure.
  - For event/situation, updates into IRMA until the event/situation is resolved. This includes information about subsequent interventions and include information about the resolution of the event/situation.

Part 624 Incidents: Corrective Action Plans

- For Abuse and Neglect under the jurisdiction of the NYS Justice Center, the Corrective Action Plan (CAP) is due 65 days from the Letter of Determination.
- The agency should have a mechanism in place to track these timeframes in order to meet the regulatory requirement of these Corrective Action Plans.
- The agency is also responsible to ensure CAPs for other incidents are done timely to prevent similar incidents from happening.

Part 624 Incidents: Closing Incidents

- Agencies are responsible to ensure timely completion of all required actions and entries for closure of an incident in IRMA.
- For Reportable Abuse and Neglect incidents under the jurisdiction of the Justice Center, the Letter of Determination (LOD) is required to close an incident.
- Additionally, in order to close an incident in IRMA, IRC minutes and the CAP Module entries must be completed.
- Agencies have the ability to run “open” incident reports in IRMA in order to follow up and bring incidents to closure.

General Incident Management Reminders

- Agencies should closely monitor the agency's dedicated mailbox on a regular basis as requests and guidance on incident management topics are sent to this email address.
  - There should be more than one person with access to this mailbox and it should not be a personal email address.
- Please be sure to log into IRMA on a regular basis to maintain access.
- It is the agency's responsibility to keep the Criminal Background Check roster up to date and that all Authorized Persons understand the different statuses in the Criminal Background Check system.

Incident Management Unit (IMU)

IMU has a number of trainings to support agencies on investigations, IRC/Corrective Action Plans, Entry of information into the Incident Report and Management Application (IRMA) and background check requirements. These trainings can be found on the NYS Statewide Learning and Management System (SLMS).

IMU Contact Numbers:

Main Number: 518-473-7032

Off Hours: 518-479-6763

Secure Application Reminder

- It is Provider Agency's responsibility when staff are on-boarded or off-boarded that their secure application access is processed appropriately.
- Some applications to keep in mind
  - Incident Reporting Management Application (IRMA) - OPWDD
  - CHOICES - OPWDD
  - Web Submission of Investigative Reports (WSIR) - Justice Center
  - Administrative Action Reporting Mechanism (AARM) - Justice Center
  - Criminal Background Check (CBC) - Justice Center
  - Mental Hygiene Law 16.34 (MHL 16.34) - OPWDD
  - Statewide Central Register Database Check (SCR) - Office of Children and Family Services (OCFS)
  - Staff Exclusion List (SEL) - Justice Center

Questions?

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COVID-19 Resources

- COVID-19 Wellness Resources Alert
- Facility Self-Assessment Tools

Barbara Van Vechten
Statewide Director
DQI – Incident Management Unit and
Continuous Quality Improvement

Health and Safety Alert:
COVID-19 Wellness Resources for Staff and Individuals

- Acknowledges impact of COVID-19 on the emotional, social, and psychological well-being on individuals and staff (i.e., everyone)
- Recognizes the need to address stress and anxiety
  - To ensure people function successfully at home and work, and
  - To prevent untoward events and interactions
- Provides a wide choice of practical and accessible resource links to help people cope with what they have been experiencing and feeling
  - Topics include: COVID-19 related stress, anxiety, fatigue and loss

Health and Safety Alert: COVID-19 Wellness Resources for Staff and Individuals

- Notification emailed to agencies: April 16, 2021
- Available on the OPWDD website at the following link:
  - https://opwdd.ny.gov/system/files/documents/2021/04/covid-19-wellness-health-and-safety-alert-03.31.2021_accessible.pdf
- Please share the alert with your employees
- Encourage and support their use of the resources
- Determine how to best support individuals in the use of the resources

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COVID-19 Self-Assessment Tools for Provider Use

- Tools to assist agencies to address COVID-19 responsibilities
- DQI emailed tools to agency mailboxes on April 13, 2021
- Two Routine Checklists:
  - Suggested implementation by direct support staff, site staff, and site supervisor
  - *COVID-19 Individual Monitoring Tool*
    - Focuses attention on individuals' status and changes in status, to identify illness promptly
  - *Infection Control Checklist*
    - Verifies implementation of high-level infection control practices and maintenance of PPE supply

COVID-19 Self-Assessment Tools for Provider Use

- Two Monitoring Checklists
  - Ensure and monitor that COVID-19 precautions and protections are readied and implemented in agency programs
  - Suggested implementation by supervisor, manager, nursing, and quality management staff
  - *Residence: COVID-19 Prevention and Control Review*
    - Verifies appropriate implementation of screening, cleaning, hygiene, PPE use and disposal, quarantine, and isolation
  - *Day Service: COVID-19 Prevention and Control Review*
    - Verifies implementation and adherence to safety plan guidelines and the program's safety plan

Questions?

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COVID-19 Guidance: Quarantine

Susan Prendergast
Director
Nursing and Health Services

NYS Department of Health Guidance

- The NYS Department of Health (NYSDOH) issued a document dated April 1, 2021 titled “Updated Health Advisory: Quarantine for Community Persons Exposed to COVID-19”.
- This guidance document includes quarantine requirements for those who are vaccinated and unvaccinated, as well as some travel guidance.
- It is important to note that this document is for those that live in the community.
- This does ***not*** apply to those living in a congregate setting / healthcare setting.

Center for Disease Control Recommendations

- The Center for Disease Control (CDC) continues to recommend that those persons in congregate settings/healthcare settings should continue to quarantine, stating:
  - “Fully vaccinated inpatients and residents in health care settings should continue to quarantine following prolonged close contact with someone with SARS-CoV-2 infection”.
  - “This is due to limited information about vaccine effectiveness in this population, the higher risk of severe disease and death, and challenges with physical distancing in healthcare settings.”

OPWDD Requirements

- Because the DOH document is related to those living in the community, and the CDC continues to recommend quarantine for those in healthcare settings, OPWDD has not made any changes to our quarantine guidelines.
- Currently, regardless of the vaccination status of any individuals or staff, any time there is a positive or presumed case in a residence, the house would be placed on quarantine, either mandatory if there is a confirmed positive case, or precautionary if there is a presumed case.
- All current guidance on this remains in place at this time.

Questions?

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Director of Nursing & Health Services

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Understanding Sepsis

Susan Prendergast
Director
Nursing and Health Services

Sepsis Facts

- Each year over 1.5 million people in the United States (U.S.) gets diagnosed with sepsis and about 270,000 die from it.
- 18 million people die of sepsis worldwide every year.
- Sepsis is the leading cause of childhood deaths.
- 1 in 3 patients who die in a hospital have sepsis.
- Sepsis is a leading cause of death and healthcare costs.
- Sepsis is the most expensive condition treated in the U.S.

What is Sepsis?

- Sepsis is caused when the body's immune system becomes overactive in response to an infection, causing inflammation which can affect how well other tissues and organs work.
- When sepsis is recognized early, people can be quickly given the right treatment.
- The signs and symptoms of sepsis vary and may be subtle, which can lead to it being missed if it is not considered early on.
- Infections that are often at the root of the cause are urinary tract infections (UTIs), pressure injuries, or respiratory infections such as pneumonia.

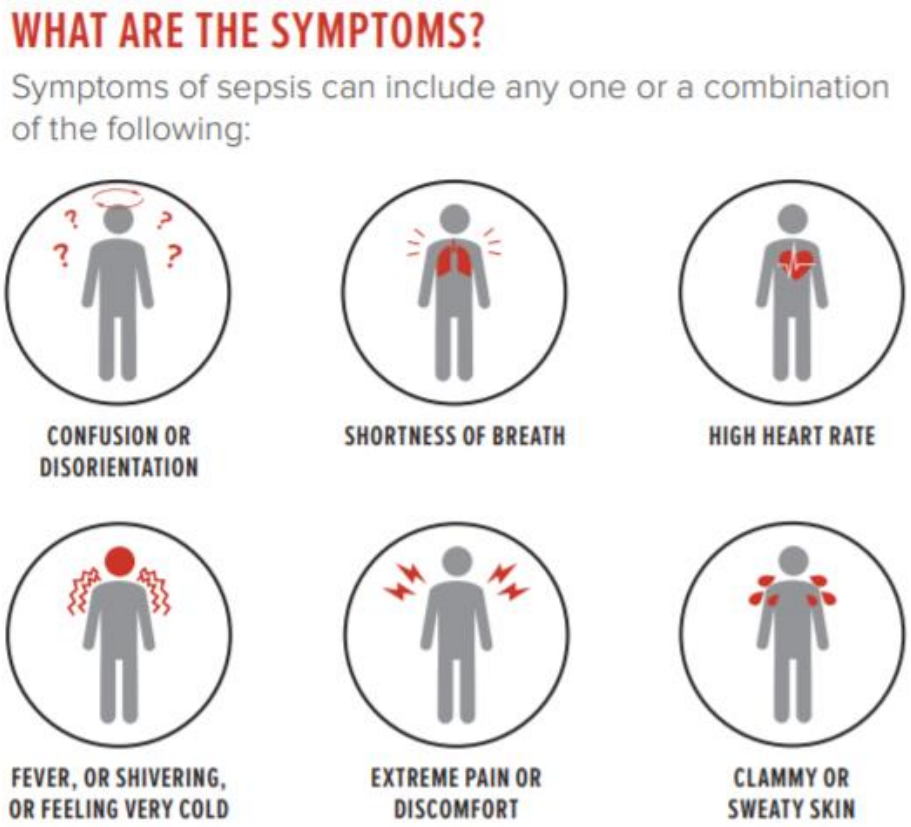
What is Sepsis?

- If not identified and treated promptly, Sepsis can result in:
  - Organ failure
  - Tissue damage
  - Death
- In severe cases, one or more organs fail.
- In the worst cases, blood pressure drops, the heart weakens and the individual may spiral towards septic shock.
- With septic shock, multiple organs – lungs, kidneys, liver – may quickly fail, leading to possible death.

Sepsis is a Medical Emergency!

Signs and Symptoms

- Confusion
- Short of breath
- Increased heart rate
- Blood Pressure
  Systolic less than 100mm Hg
- Fever
- Shivering
- Feeling cold
- Extreme pain
- Discomfort
- Clammy, sweaty skin
- Decreased urine output
- Skin rash



Helping to Watch for Signs of Sepsis

Signs of infection and sepsis at home

Common infections can sometimes lead to sepsis. Sepsis is a deadly response to an infection.

	Green Zone No signs of infection.	Yellow Zone Take action today. Call: _____	Red Zone Take action now! Call: _____
Are there changes in my heartbeat or breathing?	• My heartbeat is as usual. • Breathing is normal for me.	• Heartbeat is faster than usual. • Breathing is a bit more difficult and faster than usual.	• Heartbeat is very fast. • Breathing is very fast.
Do I have a fever?	I have not had a fever in the past 24 hours and I am not taking medicine for a fever.	Fever between 100°F to 101.4°F.	Fever is 101.5°F or greater.
Do I feel cold?	I do not feel cold.	• I feel cold and cannot get warm • I am shivering or my teeth are chattering.	• Temperature is below 96.8°F. • Skin or fingernails are pale or blue.
How is my energy?	My energy level is as usual.	I am too tired to do most of my usual activities.	• I am very tired. • I cannot do any of my usual activities.
How is my thinking?	Thinking is clear.	Thinking feels slow or not right.	My caregivers tell me I am not making sense.
Are there changes in how I feel after a hospitalization, procedure, infection or change in wound or IV site?	• I feel well. • I had pneumonia, a urinary tract infection (UTI) or another infection. • I had a wound or IV site. It is healing.	• I do not feel well. • I have a bad cough. • My wound or IV site looks different. • I have not urinated (peed) for 5 or more hours. When I do urinate (pee), it burns, is cloudy or smells bad.	• I feel sick. • My wound or IV site is painful, red, smells or has pus.

Who is at Risk for Sepsis?

- Those at *higher risk* include:
  - People 65 or older; infants less than one year old.
  - Chronic illnesses such as diabetes or cancer, kidney disease, lung disease or bacteremia.
  - Weakened immune systems.
  - Recently hospitalized or recovering from surgery.
  - Wounds, injuries, burns.
  - Invasive devices (catheters, breathing tubes, drains).
  - Organ transplants.
  - Has previously received antibiotics and/or corticosteroids.
  - People who have had sepsis in the past.

Sepsis Risk and Aging

- The elderly are more susceptible to infections due to:
  - Weakened immune systems
  - Fragile skin, bedsores, ulcerations
  - Multiple chronic conditions
  - Admissions to a hospital or other facility
- Some individuals may not be able to communicate symptoms of infection due to their intellectual/developmental disability (I/DD), dementia or having had stroke.

Sepsis May Present Differently in the Elderly

- Fever may be delayed, absent or low-grade, between 98.6°-100.4°F.
- Decline in functional status may be a symptom of infection, including:
  - Increasing confusion
  - Incontinence
  - Falling
  - Deteriorating mobility
  - Reduced food intake
  - Failure to cooperate with staff
- Signs of infection and organ dysfunction may be difficult to recognize with multiple comorbidities.

Diagnosing Sepsis

- Blood testing to look for:
  - Infection (high or low white blood cell count)
  - A blood culture that is positive for infection
  - Abnormal kidney or liver function
  - Clotting issues
  - Low blood oxygen levels
  - Electrolyte imbalances
- Imaging:
  - X-Ray to check lungs for pneumonia
  - CT Scan to check for infections in the pancreas or appendix
  - MRI will identify infections in the soft tissues

Diagnosing Sepsis

- Other ways to diagnose sepsis include:
  - Urinalysis – checks for bacteria in the urine
  - Wound drainage – a culture of drainage from open wounds to identify bacteria
  - Respiratory mucus – a culture of mucus that has been coughed up to that will be tested to identify bacteria

Treatment

- Antibiotics will be started quickly.
- Intravenous (IV) Fluids – increase blood volume and urine output, and keep fluids circulating to vital organs.
- Vasopressors – medication that constricts blood vessels and increases blood pressure.
- Corticosteroids – reduce inflammation and triggers tissue repair.
- Insulin – helps to control blood sugar levels.
- Pain relief – used for pain, discomfort and to help reduce fevers.
- Sedatives – used primarily if a ventilator is required for breathing.

Prevention

- Receiving vaccinations annually or as needed for flu, pneumonia and any other recommended vaccinations.
- Encourage good hygiene. Proper wound care, handwashing and bathing regularly.
- Sustain mobility to reduce weakness and prevent pressure injury.
- Maintaining sufficient nutritional status.
- Maintain good overall health and care for chronic conditions.
- Obtaining immediate care when signs of infection are recognized.
  - The sooner the treatment is received, the better the outcome.
- Prevent infections by keeping cuts clean and covered until healed and be watching for signs of infection.
- Take antibiotics as prescribed for any infection.

Importance of Reporting Change

- Sepsis is life threatening!
- The quicker symptoms are recognized the better.
- Individuals with I/DD are at a disadvantage due to limited communication skills and inability to report pain.
- Using behavior changes as an indicator for pain when individuals are unable to report is an acceptable approach.
- Respiratory infections and UTIs are common among individuals with intellectual and developmental disabilities.

Importance of Reporting Change

- Individuals with I/DD are at a higher risk for septicemia and would benefit from preventive measures and early recognition.
- Any changes or recognition that an individual has signs and symptoms of sepsis should be reported immediately to a Registered Nurse (RN) who will provide you with direction on what the next step is.
- Always document your findings in the individual's medical record. Include who you've made any reports to.

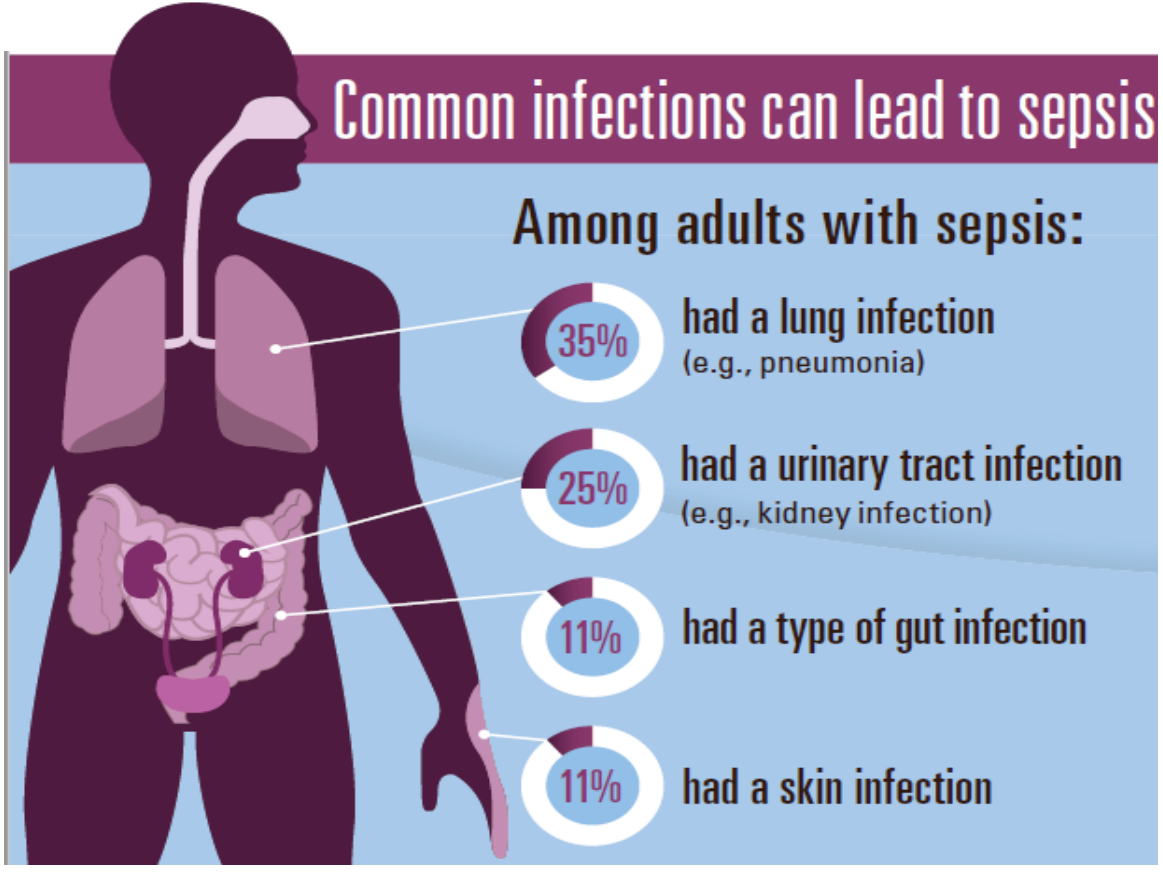
Sepsis as an Underlying Diagnoses

- We hear and see people that have died of:
  - Pneumonia
  - Abdominal infections
  - Kidney infections
  - Blood Poisoning
- Often, the cause of death may have been sepsis.

Sepsis and Infection

- You must have an infection to have sepsis.
- There are times when people do not know they have an infection.
- Sepsis can show up with different combinations of symptoms.
- Sepsis can develop after someone has been seen by a health professional.

Sepsis and Infection



Early Recognition is Important

- Every minute counts!
- For every hour that treatment is delayed, the risk of death increases by 8%.
- When sepsis is caught early, it:
  - Increases the chance for survival
  - Helps avoid long term health-related complications
  - Helps avoid sepsis related hospitalizations
  - Can be prevented from progressing to septic shock

Post Sepsis Syndrome

- A condition that affects up to 50% of sepsis survivors
- Physical and/or psychological long-term effects such as:
  - Impaired cognitive function – especially among older individuals
  - Mobility impairments (muscle weakness)
  - Disabling muscle and joint pain
  - Amputations
  - Loss of self-esteem
  - Extreme fatigue
  - Insomnia
  - Nightmares, hallucinations and panic attacks

Post Sepsis Syndrome

- There is a significant impact on family, friends and caregivers:
  - Increased dependency on caregivers
  - Inadequate hospital discharge education on what to expect during recovery
  - Difficulty accessing follow-up community treatment
  - Disruption to their lives
  - Cost

Sepsis Training

- OPWDD has training available on the Statewide Learning Management System titled “Recognizing Sepsis as a Medical Emergency”, which can be accessed at any time at the following link
  - https://nyslearn.ny.gov/index.html
- Also available on OPWDD’s website is a Health and Safety Alert, dated July 2018, titled “Preventing Sepsis”

For More Information on Sepsis, visit

www.sepsis.org

Questions?

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Lunch Time!

If you have any questions or suggestions, use the DQI email:

quality@opwdd.ny.gov

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Development and Implementation of an Effective Plan of Corrective Action (POCA)

Brian O'Donnell
Statewide Director
DQI – Bureau of Program Certification (BPC)

What is a Plan of Corrective Action (POCA)?

- A Plan of Corrective Action (POCA) is a plan developed by the agency to address an issue identified during a survey.
- A formal POCA response is required for any issue identified in a Statement of Deficiencies.
  - Although a formal POCA response is not needed for an Exit Conference Form issue, the agency should develop an internal POCA to address this issue systemically.
- A well written POCA can be a useful tool for an agency to correct issues on not just a programmatic level, but at an agency level.

POCA Development

1. How the corrective action will be accomplished for any resident or area affected by the deficiency:
   - The facility must correct the specific cited issue
   - When a deficiency involves multiple individuals, not all findings may be included in the statement of deficiencies.
   - The facility is still responsible for addressing corrective action for all individuals affected by the deficiency.

POCA Development

2. How the facility will identify other individuals or areas that could potentially be affected by the deficiency and what corrective action will be taken:
   - For any deficiency identified regarding the care plan of an individual, other individuals potentially impacted should be identified through review of assessments, plans, and data.
   - The POCA should include how you identified and will continue to identify the impacted individuals.
   - Avoid using “All residents have the potential to be affected by the deficiency.” Be specific! Some examples:
     - “All individuals identified at risk for falls…”
     - “All individuals who receive modified diets…”

POCA Development

3. The measures that will be put into place or systemic changes made to ensure that the deficiency will not recur:
   - Include, for example, in-service training, policy and procedure review/revision, assessment and care planning, and environmental changes that are necessary to prevent reoccurrence.
   - For Life Safety Code issues, consider monitoring outside contractors that may have had a role in the deficiency, and developing or revising systems for notifying the maintenance department.

POCA Development

4. How the Corrective Action will be monitored and title of the person responsible for monitoring compliance:
   - This is a crucial step in the implementation of an effective plan of corrective action.
   - The POCA must be developed and implemented, and the corrective action must be evaluated for effectiveness.
   - The POCA must be integrated into the Agency's Quality Management or Quality Assurance program.
   - Be specific about how you will monitor.
     - Include how you will evaluate the corrective action, how often, and who is responsible.
     - Your internal QA departments should review monitoring results/audits.
     - The facility should have evidence of monitoring its performance during the corrective action period.

POCA Development

5. The date when corrective action will be completed.
   - All deficiencies require a completion date for when the POCA will be fully implemented.
   - The completion dates should be realistic. A good practice is to have full POCA implementation 60 days after the completion of the survey unless it is a specific issue that may require a longer completion date.
     - An example would be a maintenance project.

Why is a POCA important?

- POCAs are vital for ensuring the health and safety of all individuals a provider serves.
- POCAs should be used as a learning tool and shared with all programs operated by a provider.
- A good POCA shared throughout an agency can prevent similar issues, reduce deficiencies agency wide, and better meet the needs of the individuals who receive services.

Additional POCA Considerations

- POCA development and implementation should occur immediately after notification of the deficiency.
  - An agency should not wait until they receive a formal statement of deficiencies report before developing a POCA.
- Immediate corrective action is crucial.
  - BPC can return to a site at any point to review implementation of corrective action if a serious issue had been identified during the course of the survey.
- BPC will also conduct visits to sites after becoming aware of significant incidents to ensure immediate protections are implemented.
  - Failure to implement corrective actions could result in significant survey findings.

Questions?

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Heightened Scrutiny and HCBS Settings Update

Alicia Matulewicz
Standards Compliance Analyst
DQI – Continuous Quality Improvement

Topics

- Review of HCBS settings requirements
- What is Heightened Scrutiny (HS)?
- Recap of HS requests and activities
- DQI's adjustment in HS process due to COVID-19
- Revisions to criteria for settings that trigger HS
- CMS revision to timeline for compliance and FAQs on 7-14-20
- Timeline and overview of upcoming HS activities
- Supporting documentation for HS sites requiring evidence packages
- Systemic recommendations for all providers to reach compliance with HCBS settings
- Examples of creative solutions to help combat social isolation during COVID-19
- Key Takeaways

Review of Key Components of HCBS Settings

- The setting is integrated in, and supports full access to, the greater community;
- Selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.
- Any modification of rights requires specific individualized assessed need, justified/documented in person-centered plan, data on effectiveness, ongoing review of continued need for modification.

Review of Key Components of HCBS Settings

- In provider-owned or controlled residential settings
  - Individual must have legally enforceable lease/agreement
  - Individual has privacy in their living unit including:
    - Lockable doors
    - Choice of roommates
    - Freedom to furnish/decorate
  - Individual controls own schedule
  - Individual has access to food at any time
  - Individual can have visitors at any time
  - Physical accessibility to the setting

What is Heightened Scrutiny?

- States are required to develop a Transition Plan demonstrating statewide compliance with HCBS settings
- The Transition Plan requires States to assess all HCBS settings and identify settings presumed to have a qualities of an institution
- Heightened Scrutiny (HS) is a process for submitting evidence to CMS for settings presumed to have the qualities of an institution but that are in reality compliant and NOT institutional
- DQI is responsible for assessing and determining whether the setting is subject to Heightened Scrutiny

Settings Presumed to be Institutional

Prong 1

Settings that are in a building that provides **inpatient institutional** treatment

Includes both public and private facilities

Prong 2

Settings that are adjacent or on the grounds of **public** institutions

Prong 3

Any other setting that has the effect of **isolating** individuals from the broader community

Institution definition includes nursing facilities, hospitals, ICF/IIDs, and inpatient rehab centers

CMS Criteria for Settings that Isolate (Prong 3)

- Due to design of how services are delivered in the setting, individuals have limited opportunities for interaction with the broader community, OR
- The setting restricts individual choice to receive services or to engage in activities outside the setting, OR
- The setting is physically located separate and apart from the broader community and does not facilitate opportunities to access the broader community and participate in community services, consistent with an individual's person-centered plan.
- Sites that fall into Prong 3 have a longer time to remediate and IF successful, may not have to put forward an evidence package to CMS *IF THEY SUCCESSFULLY REMEDIATE UNMET HCBS ISSUES BY JULY 1, 2021* (vs Prong 1 or Prong 2).

Recap of HS Requests and Activities

- DQI informed providers on the process for collection of evidence and supporting documents for providers with sites that triggered Heightened Scrutiny
- Providers with HS sites were asked to complete the following documentation and submit to DQI:
  - An agency worksheet with description of the site
  - Individual Experience Surveys
    - 2 for most sites; 4 for dayhabs over 30 people
  - HCBS Plan of Corrective Action

Recap of HS Requests and Activities

- Providers were given the option of submitting additional supporting documentation to heightened.scrutiny@opwdd.ny.gov mailbox or have available for BPC team to collect during on-site review
- For each site on the HS list, DQI surveyors were planning to complete:
  - A partial Person-Centered Review Protocol
  - An HCBS-focused site protocol
- However, on-site review activity by DQI ceased in March 2020 upon declaration of a Public Health Emergency due to COVID-19
- This means that DQI has had to develop new solutions to gather HS evidence and verify compliance with HCBS settings

Revised HS Process for DQI due to COVID-19

- A desk review was developed in Spring of 2020 in place of the on-site review documents that DQI surveyors were going to conduct
- Desk review was based on:
  - Previous review notes, observations and interviews conducted at the site
    - this cycle or previous cycles
  - Review of documentation provided by the agency, if any
  - A review of compliance history for the HCBS settings and rights protection standards in DQIA.
- Surveyors were asked whether the site has recently had:
  - Any current, unresolved, and/or repeat deficiencies that are HCBS or rights related
  - Whether the agency is currently on Early Alert or has had a 45-day letter recently (current, unresolved, and/or repeat adverse actions)

Desk Reviews Conducted by DQI-Spring 2020

Prong 3 Sites

1. This site has NO current or continuing isolating/institutional concerns, OR
2. This site needs some HCBS-related corrections, but full compliance with HCBS Settings requirements is expected to be reached 10-1-2021, OR
3. Due to ongoing and/or unresolved HCBS-related concerns and lack of plan and actions by agency to address, the site will have to assist OPWDD to prepare an evidence package for submission to CMS.

Prong 1 and 2 Sites

1. This site has NO current or continuing isolating/institutional concerns, OR
2. The site will likely not be able to overcome the presumption of heightened scrutiny and achieve compliance with HCBS settings by the compliance deadline of 10-1-2021, OR
3. There is not enough information available to make this determination:
   - No supporting or inadequate documentation was submitted by agency/site, and/or an on-site visit is needed first to make determination

Prong 1 and 2 Sites will have to go forward with an evidence package no matter what; desk review was designed to identify sites that may have greatest difficulty overcoming presumption of HS

Heightened Scrutiny-Final Disposition and Proof of Remediation Form: Spring 2021

- DQI surveyors were asked to provide a final attestation regarding status of each HS site
- Form was divided into two parts
  - PART 1: Summary of Unmet HCBS Standards
    - Based on past few years of on-site surveys, SODs, and ECFs
  - PART 2: Remediation
    - How the site has or has not corrected unmet HCBS areas over past few years, along with any relevant SOD, ECF, and POCA information related to HCBS
- Prong 3 sites with no unmet areas will not have to have evidence packages completed but site will still be listed on a separate tab of the HS list

Revisions to Criteria for Identification of HS Sites, Based on CMS Criteria

- As previously noted, *former ICFs* are no longer considered to trigger HS based on that status alone
- *Clustered or campus-based settings* no longer trigger HS based on that alone unless design results in isolation (prong 3)
- Upon clarification from CMS recently, *sites on or immediately adjacent to FORMER public institution property no longer trigger HS* based on that alone (prong 2 settings)
- This means that OPWDD has been re-evaluating sites on the HS list and fewer sites will have to go forward with HS and development of an evidence package
- Former Prong 2 sites with no unmet HCBS areas have been removed from HS list

Current Heightened Scrutiny Site Totals: With Reconciliation of Prong 3 Sites Still Currently in Progress

Prongs	Total	Comments
Prong 1 Sites (final)	5	3 sites are in a NH; 1 DH site is in an ICF; 1 DH site is in a NH
Prong 2 Sites (final)	0	38 sites taken off HS list due to no unmet issues; remainder were recategorized as a prong 3 site, due to characteristics needing remediation verified
Prong 3 Sites (in progress)	81	Currently in progress; includes sites formerly identified as prong 2 sites

CMS Implementation Timeline Extension and Revision to FAQs Issued 7-14-20

- CMS is extending the federal deadline for ensuring compliance with the HCBS Settings Regulation to 3/17/23, in response to the COVID-19 pandemic
- This gives states one additional year to complete activities required to demonstrate compliance with the settings criteria
- If a prong 3 setting has implemented remediation strategies that brings the setting into compliance with the settings criteria by **July 1, 2021**, then that setting will not need to be submitted to CMS for a heightened scrutiny evidence package review
- Prong 3 sites that have not completed necessary remediation will need an evidence package completed no later than October 31, 2021; these sites will have to reach compliance by 3/17/23
- HCBS Settings Regulation-Implementation Timeline Extension and Revised FAQs

Timeline of Upcoming Activities and Next Steps

Date	Action
March 2021	Draft list of OPWDD Prong 1 sites
7/1/21	• Prong 3 list becomes final • Any prong 3 sites with unmet issues will go forward with evidence package to CMS
10/1/21	OPWDD's HCBS Settings General Requirements 636-2 become effective
10/31/21	• List of HS sites submitted to CMS by DOH • Evidence packages with public comments completed by OPWDD
January 2023	DOH submits Statewide Transition Plan to CMS for final approval
3/17/23	Required CMS compliance with HCBS Settings regulation - ALL HCBS Providers

Supporting Documentation for Evidence Packages

- Upon finalizing the prong 3 list (due by 7/1/21), DQI may need to reach out to providers for additional supporting documents for those prong 3 sites with unmet issues
- DQI may need to schedule a telephone interview with site staff to obtain additional information about the site to be included in the evidence package
- Critical supporting documents include at minimum:
  - Agency Individual Rights documents and policies
  - Staff training roster/agenda and proof of staff training on key HCBS-related rights, PCP, etc.
  - Photos of the HS site

Examples of Documents that Support HCBS Compliance

- Examples of individualized and person-centered planning practices
- Physical maps or photos of the site
- Training curriculum and proof of training for DSPs on PCP and HCBS settings related areas
  - includes DSP competencies and code of ethics
- Policies on various PCP and HCBS-related areas such as: rights, choice, staff training on PCP and HCBS settings, rights restrictions, access to food, access to keys, lease agreement

Examples of Documents that Support HCBS Compliance

- Minutes from self-advocacy meetings
- Community activity calendars, logs and other examples of community and social involvement (can include zoom calls)
- Satisfaction surveys
- Letters from stakeholders, advocates, individuals, and staff supporting HCBS compliance and person-centeredness at the site
- Agency newsletters related to community involvement, DSP competencies, self-advocacy, and other content related to HCBS

Key Takeaways

- Providers will receive a follow-up notification after DQI finalizes the prong 3 list (after 7/1/21)
- This includes:
  - Providers with sites that no longer fall under one of the 3 prongs based on revised criteria
  - Providers with a prong 3 site that have successfully remediated (no evidence package will be required)
  - Providers of prong 3 sites with unmet issues remaining that will need to go forward with an evidence package
    - Prong 3 sites with unmet HCBS areas after 7/1/21
  - Providers with a site that falls under prong 1

Combatting Social Isolation and COVID-19

- Ensuring full access to technology and the internet for individuals is critical
- Look for online opportunities like a Zumba or yoga class, a chorus concert, a high school play, and other local activities that are now being streamed online
- Sign up for online classes on topics of interest to individuals
  - Such as local adult learning opportunities via library, high school, or local community college
- Think about partnering with a local nursing home and scheduling zoom calls with interested residents on various topics; create digital cards to share
- Go on a virtual museum tour; find a zoo that streams live videos

Examples of Creative Solutions for Social Isolation During COVID-19 from NYS and Other States

- Nevada's aging network developed a Social Support Action Team (SSAT)
- The SSAT offers one-to-one check-in calls and small-group peer support through teleconferencing and Zoom
- You can adapt this idea to have small peer support groups online within your agency and with other local agencies
- NYS Office for the Aging is using animatronic pets to reduce loneliness and isolation after studies proved their effectiveness
- For more info, go to
  - CHRT Health Policy Brief on Social Isolation and Loneliness

Examples of Creative Solutions for Social Isolation During COVID-19 from NYS and Other States

- Some states have regional and statewide landing pages where classes, volunteer opportunities, and online events are posted
- These landing pages are managed in conjunction with community partnerships
- Minnesota has a wiki-like page that is updated daily for seniors
- New York City has a webpage designed for people with disabilities that highlights local opportunities that can be streamed online
    - https://www1.nyc.gov/site/mopd/resources/mopd-virtual-activities-toolkit.page

Demonstrating HCBS Compliance: All HCBS Providers

Recap of Revised CMS Criteria to Support HCBS Compliance:

Operational policies, practices, and expectations of the site support meaningful opportunities are based on an individual's person-centered plan

The site has opportunities for interaction in broader community:

- Includes adequate staffing and transportation
- Role of natural supports

The design of the setting is NOT separate and apart from the broader community:

- Site characteristics support inclusion and integration
- The site is NOT institutional in appearance or practices

The site offers opportunities for individual choice:

- Independence
- Autonomy
- Rights

Recommendations for ALL HCBS Providers: RIGHTS

- Update your agency's 633.4 Individual Rights documents and policies with 636.1 PCP requirements and 636.2 general HCBS settings requirements
- This could be reviewed with individuals as their next planning meeting occurs; provide them with a copy
- Provide copies of these rights to family members, advocates and/or guardians
- Ensure all DSPs and other staff are thoroughly trained on and understand these enhanced rights for individuals
- Your agency's lease agreement can be included in this process

Recommendations for ALL HCBS Providers: RIGHTS

- Updating your Individual Rights documents and policies are significant **systemic** corrections
- It would provide evidence that **all staff** have been trained on HCBS settings and PCP rights
- It would also provide evidence that **individuals are fully informed of their rights** under HCBS and PCP
- Evidence supporting this should be retained, such as proof of staff training and review with individuals
- Use of PEC symbols or graphics and use of plain language is strongly encouraged

Recommendations for ALL HCBS Providers: RIGHTS

Existing 633.4 Rights

- Individuals have the right to have access to ***adequate*** and ***nutritious*** food
- Individuals have the right to receive visitors at ***reasonable*** times

Newer 636.2 HCBS Settings Rights

- Individuals should have access to food ***at any time***, including the ability to eat when and where they want to
- Individuals have the right to have visitors ***at any time***

Recommendations for ALL HCBS Providers: Keys and Lease Agreements

- All individuals in certified residential settings should have access to keys to both their home and bedroom
- This goes beyond simply having a “key assessment” form in their file
- If DQI asked the individual if they know they have the right to have their own key, what would the individual say?
- Each individual in certified residential settings should have a lease agreement by now; expect this to be reviewed by DQI during surveys

Key Takeaways

- **ALL HCBS providers** need to achieve compliance with HCBS settings and PCP requirements now, regardless of HS status of agency sites
  - HCBS settings requirements are here to stay!
- DQI will begin issuing formal Statements of Deficiencies (SODs) on unmet HCBS related areas
- **ALL HCBS providers** should look at systemic recommendations like updating policies and procedures, staff training, and rights documents

Questions?

Please e-mail
heightened.scrutiny@opwdd.ny.gov
with specific site questions

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Overview of Recent Regulations and Administrative Memorandums (ADMs) Issued Since October 2020

Janet Felker, Area Director
DQI – Continuous Quality Improvement

Regulations

Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)

- Adopted Regulations, effective January 6, 2021
- Add a new Subpart 635-16 to Title 14 of New York Codes, Rules, and Regulations (14 NYCRR)
- CSIDD services are Medicaid State Plan crisis services previously authorized by OPWDD as Systemic Therapeutic Assessment, Respite and Treatment (START) services
- Existing START services were certified by OPWDD as CSIDD services effective October 1, 2020

Regulations

CSIDD Program Requirements

- CSIDD is a short-term multidisciplinary rehabilitative service for individuals with intellectual and/or developmental disabilities who have significant behavioral or mental health needs
- Eligibility for CSIDD is determined by the Developmental Disabilities Regional Offices (DDROs)
- All services must be for the direct benefit of the individual and focused on assisting in the individual's stabilization
- Because it is a short-term service, discharge planning must begin at the time of intake and be reviewed with the treatment plan on a monthly basis

Regulations/ADM

ADM 2021-01(R2) Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD) Service Requirements and Billing Standards

- Includes program details and billing and service documentation requirements
- Link to CSIDD Regulations
  - https://opwdd.ny.gov/system/files/documents/2020/12/csidd-substantive-reg_final-draft-update-9.28.20-1.pdf
- Link to ADM 2021-01(R2)
  - https://opwdd.ny.gov/system/files/documents/2021/04/csidd-adm-final-revised-rerevised-3.31.212_.pdf

Regulations

Service Duration Regulations

- Adopted Regulations, effective March 24, 2021 (previously adopted as Emergency Regulations)
- Applicability: Group Day Habilitation, Supplemental Group Day Habilitation, and Site-Based Prevocational Services
- Amend 14 NYCRR 635-10.5 to provide for day service duration flexibility during the COVID-19 public health emergency
- Authorize payment for services in accordance with the HCBS Appendix K waiver and the commissioner's guidance for the period of 7/22/2020 through 10/14/2020

Regulations

Service Duration Regulations (continued)

- Allow delivery and payment for services delivered during mealtimes until the end of the COVID-19 public heath emergency
- Link to Service Duration Regulations
  - https://opwdd.ny.gov/system/files/documents/2021/03/service-duration-for-day-hab-adoption-text.pdf

Service Duration Regulations – Appendix K

- Emergency/Proposed Regulations, filed on February 10, 2021, with provisions retroactive to October 15, 2020
- Applicability: Group Day Habilitation, Supplemental Group Day Habilitation, and Site-Based Prevocational Services

Regulations

Service Duration Regulations - Appendix K (continued)

- Amend 14 NYCRR 635-10.5 to provide for continued day service duration flexibility, in accordance with guidance issued by the commissioner until the end of the COVID-19 public health emergency
- Identify conditions under which providers are authorized to bill for services using flexible definitions of the program day duration
- Link to Service Duration Regulations - Appendix K
  - https://opwdd.ny.gov/system/files/documents/2021/03/service-duration-regulations-appenidix-k.pdf

Regulations

Consent for Medical Treatment

- Emergency/Proposed Regulations, effective 12/20/2020
- Applicability: Consent for medical treatment for individuals who reside in OPWDD certified residential facilities
- Amend 14 NYCRR section 633.11 to provide additional means for obtaining informed consent for medical treatment, including administration of the COVID-19 vaccination
- Expand the authority of the Consumer Advisory Board (CAB) to provide informed consent for medical treatment to any Willowbrook Class member who lacks capacity to consent. That authority was previously limited to consent for class members with full CAB representation

Regulations

Consent for Medical Treatment (continued)

- Authorize use of an Informed Consent Committee, established in accordance with section 633.16, to provide informed consent for the limited purpose of administration of the COVID-19 vaccination to an individual who lacks capacity to consent and has no other surrogate designated to provide consent in accordance with section 633.11
- Link to Consent for Medical Treatment Regulations
  - https://opwdd.ny.gov/system/files/documents/2020/12/633.11-emergency-regulation_final-draft_12.29.20.pdf

Regulations

Medication Regimen Review

- Proposed Regulations (Previously filed as Consensus Regulations)
- Applicability: OPWDD certified residential programs
- Amend 14 NYCRR Part 633 section 633.17 subdivision (b) and section 633.16 consistent with a recently adopted amendment to 633.17(a). The amendments reduce the frequency of the semi-annual medication regimen review to annually and more frequently as needed
- Link to Medication Regimen Review Regulations
  - https://opwdd.ny.gov/system/files/documents/2021/01/633.16-and-633.17-medicine-regimen-review-proposed-text.pdf

Regulations

Annual Prevocational Assessment

- Proposed Regulation
- Applicability: Site Based and Community Based Prevocational Services
- Amends 14 NYCRR Subpart 635-4 to provide flexibility during the COVID-19 public health emergency*
- Amends a provision that specifies the Annual Prevocational Services Assessment must be conducted in the community at a non-certified site. The amendment would allow the assessment to be completed at “a location prescribed by OPWDD”

Regulations/ADM

Annual Prevocational Assessment (continued)

- Link to the Annual Prevocational Assessment Regulation
  - https://opwdd.ny.gov/system/files/documents/2021/01/annual-prevoc-assessment-reg-text_12.7.pdf
- ***ADM 2020-01R Prevocational Services was revised on December 31, 2020 to specify that assessments must be conducted in non-certified community-based settings “except during the New York State Disaster Emergency for COVID-19.”
- Link to ADM 2020-01R
  - https://opwdd.ny.gov/system/files/documents/2020/12/prevoc-adm_.2020-01r-final.pdf

Regulations

Reimbursement of Waiver Services

- Proposed regulations amend 14 NYCRR Subparts 641-1, 635-4, and 635-10
- Amendments to Subpart 641-1 are applicable to IRA/CR Residential Habilitation and Group Day Habilitation
- Amendment to Subpart 635-4 is applicable to financial reporting
- Amendments to 635-10 are applicable to Environmental Modifications and Adaptive Technologies
- Public comments were due by April 18, 2021
- Link to Reimbursement of Waiver Services Regulations
  - https://opwdd.ny.gov/system/files/documents/2021/02/waiver-amendment-text_1.26.21.pdf

Regulations

Repeal and Amendment to Outdated Rate Regulations

- Proposed regulations amend 14 NYCRR Subpart 641-2, and Parts 621, 676, 680, 681, and 690
- Amendments to Subpart 641-2 and Part 681 are applicable to the ICF rate setting methodology
- Amendments to Part 621 are applicable to financial assistance for capital construction and financing
- Amendments to Parts 676, 680, and 690 are applicable to Diagnostic and Research Clinics, Specialty Hospitals, and Day Treatment programs, respectively
- Public comments are due by May 23, 2021
- Link to Repeal and Amendment to Outdated Rate Regulations
  - https://opwdd.ny.gov/system/files/documents/2021/03/text-rate-repeal-reg.pdf

Administrative Directive Memorandums

ADM 2020-07 The Development or Modification Of Policies and Procedures Pertaining to Levels of Supervision (LOS) for Individuals Receiving Services

- Training was provided by the Division of Service Delivery earlier today.
- Link to ADM 2020-07
  - https://opwdd.ny.gov/adm-2020-07-levels-supervision-los-individuals-receiving-services

Administrative Directive Memorandums

ADM 2020-06 Forensic Notification

- The ADM addresses notification to the OPWDD Bureau of Intensive Treatment Services (BITS) when an individual receiving services is involved in certain criminal activity.
- Link to ADM 2020-06
  - https://opwdd.ny.gov/system/files/documents/2020/11/adm-forensic-notification-final.pdf

Administrative Directive Memorandums

ADM 2020-05 Statewide Forensic Advisory Committee (SFAC)

- The ADM describes the role of OPWDD's Statewide Forensic Advisory Committee. Attachments to the ADM include SFAC referral materials.
- Link to ADM 2020-05
  - https://opwdd.ny.gov/system/files/documents/2020/11/adm-sfac-final.pdf

Questions?

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

HCBS Waiver Oversight Activities: Preliminary Findings of the October 2018 – September 2019 Department of Health Life Plan Review

Don Moffitt & Lauren Porter
Division of Policy and Program Development

Background of DOH Review

- Annually the Department of Health (DOH) in collaboration with OPWDD Division of Quality Improvement (DQI) and Division of Policy and Program Development (DPPD) reviews agency documentation and Medicaid billing as part of oversight functions of the 1915(c) Comprehensive Home and Community-Based Services (HCBS) Waiver.
- Review entails comparison of Medicaid paid claims with HCBS Waiver Services that were outlined in an individual's Individualized Service Plan (ISP)/Life Plan (LP) and Habilitation Plan/Staff Action Plan.

Background of DOH Review

- Focus for today will be preliminary findings from a sample of individuals authorized to receive HCBS Waiver Services between October 2018 – September 2019.

DOH 2018-2019 Preliminary Findings

- Clear documentation of face-to-face contacts needed.
- Page 78 Care Coordination Organization (CCO) Policy Manual
  - Tiers 1-3: Quarterly
  - Tier 4: Monthly

DOH 2018-2019 Preliminary Findings

- Consistent documentation of Life Plan effective date throughout all sections.
- Page 28 Care Coordination Organization (CCO) Policy Manual
  - Twice annual review date range.
  - Existing services: Life Plan twice annual review date range.
  - New services: Review date on which new service was added.
    - Life Plan annual review date is 2/1/19-1/31/20.
    - New Respite service was added at 5/15/19 review.
    - Respite service effective date is 5/15/19-1/31/20.

DOH 2018-2019 Preliminary Findings

- Accurate listing of HCBS Waiver services in Life Plan.
- Page 26-28 Care Coordination Organization (CCO) Policy Manual
  - Section II or III: Must have at least one valued outcome related to service.
  - Section III: Must include applicable safeguards for service. Important for non-habilitative services (e.g., Respite) that do not require a Staff Action Plan.
  - Section IV: Required for billing per HCBS Waiver service specific ADM. Must include service, service provider, frequency, duration and effective date.

DOH 2018-2019 Preliminary Findings

- Complete listing of non-HCBS Waiver services in Life Plan.
- Page 28-29 Care Coordination Organization (CCO) Policy Manual
  - Section IV: Include State Plan services including CCO Care Management service (i.e., Health Home Care Management or Basic HCBS Plan Support).
  - Section V: Include non-State Plan/HCBS Waiver providers such as primary care physician.

DOH 2018-2019 Preliminary Findings

- Lack of HCBS Waiver safeguards in Section III of Life Plan.
- Page 27-28 Care Coordination Organization (CCO) Policy Manual
  - Section III should include all applicable safeguards for an HCBS Waiver service.
  - Crucial for HCBS Waiver services that do not require a Staff Action Plan (e.g., Respite).

DOH 2018-2019 Preliminary Findings

- Inconsistent safeguards between Staff Action Plans and Section III of Life Plans. Staff Action Plans included more safeguards than Life Plans.
- Page 27-28 Care Coordination Organization (CCO) Policy Manual
  - More details should be included in Staff Action Plans.
  - Life Plan should not exclude a safeguard (e.g., evacuation) because it is detailed in Staff Action Plan.

DOH 2018-2019 Preliminary Findings

- Missing signatures from the individual (or advocate) and Care Manager.
- Administrative Directive Memorandum (ADM) #2018-06R
  - Failure to finalize or review a Life Plan within the required timeframes may result in billing disallowances.

DOH 2018-2019 Preliminary Findings

- Staff Action Plans not reviewed twice annually.
- Administrative Directive Memorandum (ADM) #2018-09R
  - The Staff Action Plan must be reviewed at least twice annually and revised as frequently as necessary based upon the individual's needs.

Recommendations

- Review of Life Plans for consistency across all sections before finalization.
- Collaboration between HCBS Waiver providers and Care Managers to:
  - Accurately list services in Life Plans.
  - Address all safeguards in Life Plans.
  - Review Life Plans and Staff Action Plans twice annually.

Questions?

NEW YORK STATE | Department of Health

COVID-19 Information and Resources for Intermediate Care Facilities

Joanne M. Weldon, Acting Director
Bureau of ICF/IID Quality and Surveillance

Current Intermediate Care Facility (ICF) Demographics in NYS

Currently there are 351 Intermediate Care Facilities providing services to Individuals with Intellectual Disabilities in New York State.

- **12 are State/Owned Operated facilities.**
- **339 are owned and operated by Voluntary Service Provider Agencies.**

COVID-19 Response Policies and Procedures

Facilities must implement policies and procedures for response to the COVID-19 pandemic using regulatory guidance and resources found at:

1. **42 CFR Part 483.440-Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.**
2. **42 CFR Part 483.73- Appendix Z – Conditions of participation-Emergency Preparedness.**

Resources for Providers in Response to COVID-19

The following DOH and OPWDD links/resources are available to providers to provide guidance in the creation of policies and procedures in response to the COVID-19 pandemic:

1. https://opwdd.ny.gov/coronavirus-guidance/covid-19-guidance-documents

2. https://coronavirus.health.ny.gov/home

Regulatory Compliance with 42 CFR Part 483.440 - Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities during the COVID-19 pandemic.

Waivers of Certain Regulations by CMS

- **In response to the COVID-19 pandemic certain regulatory requirements found at 42 CFR- part 483.440 have been waived. These waivers can be found at the following link:**
- **https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf**
- **These waivers of regulations are only specific to the tags noted in this memorandum (Page 28); all other regulatory requirements continue.**

Infection Control Regulatory Requirements

Infection Control Policies Must Be In Compliance with the Following Regulations

483.470 (l) – Standard: Infection Control

- **Refer to W-tags W454-W458 for specific regulatory guidance when creating/implementing an Infection Control Policy/or plan.**
- **Ensure all staff working in the facility are trained in accordance with infection control policies and procedures. See further guidance at W 192. Training must focus on skills and competencies directed toward client health care needs.**

Infection Control Clarification for ICF/IID

- **W192- The facility must provide training related to the health and safety needs including infection control. Deficient practices related to this tag have been cited by DQI and DOH 23 times during infection control and recertification surveys conducted from 6/20-3/321**

- **W454 - The facility must provide a sanitary environment to avoid sources and transmissions of infections. Deficient practices related to this tag have been cited by DQI and DOH 53 times during infection control and recertification surveys conducted from 6/20-3/21**

- **W455 - There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Deficient practices related to this tag have been cited by DQI and DOH 25 times during infection control and recertification surveys conducted from 6/20-3/21**

Infection Control Clarification for ICF/IID W455 Guidance

Programs should include Procedures for:

- **Identification of the extent of infestation or infection.**
- **Protection and treatment of clients.**
- **Notification of family and legal guardian.**
- **Reporting to State and Local Health Departments as indicated.**
- **Continued follow-up to resolution.**

NEW YORK STATE | Department of Health

Infection Control Clarification for ICF/IID

W456 - The facility must implement successful corrective action in affected problem areas. Deficient practices related to this tag have been cited by DQI and DOH 23 times during infection control and recertification surveys conducted from 6/20-3/21

W457 - The facility must maintain a record of incidents and corrective actions related to infections.

W458 - The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients or their food.

NEW YORK STATE | Department of Health

Emergency Preparedness and Pandemics: Regulatory Requirements

Emergency Preparedness Plans Must Include a Pandemic Response

The Emergency Preparedness Plan must be updated to include the Policies and Procedures developed to address the facility's response to the Coronavirus Pandemic COVID-19 and be available for review by State Survey Agencies upon request.

Risk Assessment Applicable to Pandemics

Based on and include facility and community-based Risk Assessment:

- **High probability and impact events.**
- **Address facility population at risk because of their resident/clients unique needs.**
- **Identification of services that must be provided in an emergency**
- **Continuity of Operations/Delegation of Authority.**
- **Process for cooperation with community response.**
- **All Hazards Approach.**
- **Reviewed and updated every two years or with significant change.**

Training

- ✓ **Initial training in emergency preparedness to all new and existing staff, on hire.**
- ✓ **Individuals providing services under arrangement, and volunteers consistent with their role.**
- ✓ **Maintain documentation.**
- ✓ **Ensure that staff can demonstrate knowledge.**

Oversight: Infection Control Surveys

Infection Control Surveys and CMS

- Targeted Infection Control Surveys:
- Federal CMS and State surveyors will conduct targeted Infection Control surveys of providers identified through collaboration with the Centers for Disease Control and Prevention (CDC) and the HHS Assistant Secretary for Preparedness and Response (ASPR). They will use a streamlined review checklist to minimize the impact on provider activities, while ensuring providers are implementing actions to protect the health and safety of individuals to respond to the COVID-19 pandemic.

Source CMS QSO 20-20- dated 3-23-2020

Infection Control Survey Stats

- OPWDD and DOH have completed a total of 276 recertification/Infection Control Surveys during the COVID-19 pandemic.

- CMS has ruled prioritization of Infection Control Surveys during the pandemic is paramount to continue to ensure client safety and continuity of care.

Questions?

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NEW YORK STATE | Department of Health

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Thank you for attending DQI's Spring Provider Training

Enjoy the rest of your day!

If you have any questions or suggestions, use the DQI email:

quality@opwdd.ny.gov