Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

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

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints may only be applied in emergency situations where there is imminent risk of serious harm to the individual or others. The restraint may only be applied for as long as the threat remains critical and only when there are no less restrictive alternative methods of mitigating risk available.

In all settings when the need for a restraint in an emergency is anticipated (based on past events, condition, and nature and intensity of risks), then the individual is afforded the opportunity to engage in the Individually-Based Limitations (IBL) process and provide consent for the protective measures to be included in the person-centered service plan. The IBL process is part of the person-centered service planning which address proposed modifications to HCBS protections, including the freedom from restraint.

Restraints (referred to as Safeguarding Interventions), when indicated, must be part of a positive behavior support plan and included in the person-centered service plan, and must be directed by a medical professional or qualified Behavior Professional. The maneuver must be compliant with ODDS approved curriculum.
OAR 411-415-0070(3)(d)(A)(B) Service Planning:
(3) INDIVIDUALLY-BASED LIMITATIONS.
(d) An individually-based limitation must only include a safeguarding intervention that --
(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150, OAR 411-304-0160, and applicable program rules.
(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional qualified to author the safeguarding intervention according to ODDS-approved behavior intervention curriculum and certification as described in OAR 411-304-0150.

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=237519

Paid care providers applying the maneuver must be trained in fundamentals of behavior support intervention and be specifically trained to apply the maneuvers *prescribed by the individual's Professional Behavior Support Plan*. Data collection, reporting and monitoring are identified as a component of the IBL.

When restraints are applied in an emergency and are not included in an IBL, the paid provider applying the restraint must report the event to the case management entity. If there are more than three emergency applications of a physical intervention not addressed in a person-centered service plan, the planning team must meet to determine if formal behaviors support services are necessary.

*In Children's Developmental Disability Foster Care, Host Homes and Group Care Homes, a child may only be placed in a restraint if the child has an individually-based limitation and specific safeguarding interventions included in their Positive Behavior Support Plan. There is no exception to this requirement for unexpected/unforeseen emergencies. In Children's Developmental Disability Foster Care, Host Homes and Group Care Homes, a child may only be placed in a restraint if the child's behavior poses a reasonable risk of imminent serious bodily injury to the child or others and less restrictive interventions would not effectively reduce the risk. The restraint may only be used as long as the child's behavior poses a reasonable risk of imminent serious bodily injury, and the restraint must use the least amount of physical force and physical contact possible. During the restraint, the child must be continuously monitored.

In Children's Host Homes and Group Care Homes, all restraints applied to children must be reported quarterly to ODDS by each program.*

Restraints are never permitted based on provider convenience or as a punitive measure.
Restraints may not include any of the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, prone restraints, punishment, and supine restraints.

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

ODDS is responsible for quality assurance monitoring of plans that include the use of restraints.

ODHS quality assurance staff compile, review and analyze performance data through CDDP reviews, electronic file reviews and data reports for reviews that occur every two years. *ODHS* quality assurance staff's analysis of the performance data asks three questions: 1) Did the CME meet the required compliance rate for each question related to the areas of Health and Welfare, to include IBLs (Modifications to Conditions), and Monitoring; 2) What case specific and/or systemic corrective action is required to bring the CME into compliance; and 3) Are there immediate health and safety risks/concerns that need to be addressed. Corrective action/remediation plans are submitted to CDDPs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CDDPs to ensure appropriate action is taken.

The ODDS Licensing Unit conducts licensing visits and respond to reports or complaints of when unauthorized restraints are used or when restraints are inappropriately applied. During licensing renewals and compliance reviews, plans are reviewed to ensure that the IBL process is in place for individuals requiring restraints.

In order for a restraint to be authorized, the use of the restraint must be directed by a medical practitioner in a medical order or by a behavior professional in a Positive Behavior Support Plan (PBSP). Restraints identified in an individual's plan may only be applied by a caregiver who has been properly trained specific to the individual and in accordance with ODDS-approved curriculum on the application of the technique or equipment.

Each use of restraint applied in an emergency and not included in an IBL must be documented and reported to the case management entity. The case manager must then review the incident report and take appropriate follow up action.

*In Children's Developmental Disability Foster Care, Host Homes and Group Care Homes, a child may only be placed in a restraint if the child has an individually-based limitation and specific safeguarding interventions included in their Positive Behavior Support Plan. There is no exception to this requirement for unexpected/unforeseen emergencies. In Children's Developmental Disability Foster Care, Host Homes and Group Care Homes, a child may only be placed in a restraint if the child's behavior poses a reasonable risk of imminent serious bodily injury to the child or others and less restrictive interventions would not effectively reduce the risk. The restraint may only be used as long as the child's behavior poses a reasonable risk of imminent serious bodily injury, and the restraint must use the least amount of physical force and physical contact possible. During the restraint, the child must be continuously monitored.

In Children's Host Homes and Group Care Homes, all restraints applied to children must be reported to ODDS quarterly by each program.*

Anyone can make reports of complaints regarding unauthorized use of restraints. Restraints that are unauthorized may be considered abuse. All providers of ODDS HCBS services are considered mandatory reporters and must make report of any suspected abuse, including the use of unauthorized restraints.

ODDS has also adopted a formal complaints process which allows for the receipt of complaints from individuals or on behalf of individuals. The complaints may be received locally by CDDPs or Brokerages and must be logged and reported to ODDS. Individuals may file a complaint directly with ODDS. Individuals must be notified of their right to make complaints on at least an annual basis. Individuals are entitled to assistance as needed and desired to support their ability to make reports.

Additionally, Oregon has documentation requirements which also help to identify if there are issues with the application of interventions. Whenever a restraint is applied, the event must be documented by the service provider and submitted to the case management entity. If the emergency use of a restraint is applied more than three times in a six-month period, the case manager must evaluate and address if there is a need for professional behavior services and/or an Individually-Based Limitation (Modifications to Condition).

ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint *ODHS*/OHA oversight committees. The *ODHS*/OHA oversight committee meets at least twice a year to review quality assurance overview reports. *ODHS* staff also address individual problems with designated OHA staff on an ongoing basis. OHA exercises oversight of Medicaid/CHIP programs by *ODHS* in related committees and reviewing and approving *ODHS* reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to *ODHS* quality control processes for Medicaid/CHIP programs managed by the *ODHS* to assure proper oversight of central office and field operations. This includes ongoing review and approval of *ODHS* operational oversight and quality assurance activities. As designated OHA staff and the *ODHS*/OHA oversight committee receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid Operations Coordination Steering Committee thus informing executive management of OHA and *ODHS*.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

Restrictive interventions may only be used when based on an individual-specific need to address critical health and safety risks. Restrictive interventions must be person-centered and may only be used when there is no less restrictive alternative to address a current significant health and safety risk specific to the individual and their situation and may only be used as long as the significant risk is imminent. Restrictive interventions may be employed to support individuals to comply with legal mandates, conditional releases, and to maintain safety.

The specific types of restrictive interventions that are permitted are individual-specific dependent upon nature and severity of risk. The use of restraint interventions are primarily reactive strategies and must be directed by a medical or behavior professional, dependent on the nature of the risk or condition presented.

Although the restrictive interventions are individualized, there are specific restrictions on interventions. Interventions used must not be abusive, aversive, coercive, for convenience, disciplinary, demeaning, prone or supine restraints, pain compliance, punishment, or retaliatory. Interventions cannot be provider or setting driven. Restrictive interventions may only be applied if they are the least restrictive method for addressing the identified risk and consent to by the individual. Practices that result in involuntary seclusion or isolation of an individual are not permitted.

Restrictive interventions that result in limitations to the HCBS protections for individuals residing in provider owned, controlled, or operated residential settings will be addressed through the Individually-Based Limitations process. These protections include freedom to furnish and decorate, lockable bedroom or unit door, freedom and support to control personal schedule, access to food, visitors at any time, and choice in roommate.

Restrictive interventions which include the use of restraints by a paid caregiver apply in any setting. See "The use of restraints is permitted during the course of the delivery of waiver services under items G-2-a-i and G-2-a-ii".

All restrictive interventions will be included in the person-centered service plan.

Restrictive intervention are never permitted based on paid provider convenience or as a punitive measure. Restrictive interventions must not have the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, punishment, or seclusionary.

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

ODDS is responsible for quality assurance monitoring of plans that include the use of restrictive intervention.

ODHS quality assurance staff compile, review and analyze performance data through CDDP reviews, electronic file reviews and data reports. *ODHS* quality assurance staff's analysis of the performance data asks three questions: 1) Did the CME meet the required compliance rate for each question related to the areas of Health and Welfare, to include IBLs (Modifications to Conditions), and Monitoring; 2) What case specific and/or systemic corrective action is required to bring the CME into compliance; and 3) Are there immediate health and safety risks/concerns that need to be addressed. Corrective action/remediation plans are submitted to CDDPs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CDDPs and Brokerages to ensure appropriate action is taken.

The ODDS Licensing Unit conducts licensing visits and respond to reports or complaints of when unauthorized restrictive interventions are used or when restrictive interventions are inappropriately applied, for individuals living in a licensed setting or receiving services from a certified provider to ensure that the interventions are documented in the ISP and implemented in accordance with administrative rule and as described in the individual's plan.

ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint *ODHS*/OHA oversight committees. The ODDS QA reviews occur every two years. The *ODHS*/OHA oversight committee meets at least twice a year to review quality assurance overview reports. *ODHS* staff also address individual problems with designated OHA staff on an ongoing basis. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving *ODHS* reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to *ODHS* quality control processes for Medicaid/CHIP programs managed by the *ODHS* to assure proper oversight of central office and field operations. This includes ongoing review and approval of *ODHS* operational oversight and quality assurance activities. As designated OHA staff and the *ODHS*/OHA oversight committee receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid Operations Coordination Steering Committee thus informing executive management of OHA and *ODHS*.

Case managers authorize the use of restrictive interventions with qualifications as indicated in Appendix C of the waiver which include:
Each case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services related experience.

Agency, licensed, certified, endorsed, and independent providers must all have the ability to provide services adequate meet the health and safety needs of the individual. This ability includes knowledge and understanding of behavior support strategies specific to the individual. Providers must implement support strategies in accordance with the authorized Individually-Based Limitation which identifies the restrictive interventions appropriate to the individual. If restraints are an identified support strategy, then the providers must have training in ODDS-approved curriculum and have training specific to the individual in the appropriate application of intervention techniques.

Each use of restraint, unusual events, and incidents of significant injury to the individual must be documented and reported to the case management entity. The case manager must then review the incident report and take appropriate follow up action.

Anyone may make reports of complaints regarding unauthorized restrictive interventions. Restrictive interventions that are unauthorized may be considered abuse. All providers of ODDS HCBS are considered mandatory reporters and must make report of any suspected abuse, including the use of unauthorized restrictive interventions.

ODDS has also adopted a formal complaints process which allows for the receipt of complaints from individuals or on behalf of individuals. The complaints may be received locally by the case management entity (CME) and must be logged and reported to ODDS. Individuals may file a complaint directly with ODDS. The source of complaints can be from anywhere and, in most cases, will be responded to by the CME. ODDS and its designees may also partner with other community resources or groups, including protective services and the Oregon Residential Facilities Ombudsman to identify and resolve issues.

Individuals must be notified of their right to make complaints on at least an annual basis. Individuals are entitled to assistance as needed and desired to support their ability to make reports.

Additionally, Oregon has documentation requirements which also help to identify if there are issues with the application of interventions. Whenever a restraint is applied, the event must be documented by the service provider and submitted to the case management entity. If the emergency use of a restraint is applied more than three times in a six month period, the case manager must evaluate and address if there is a need for professional behavior services and/or an Individually-Based Limitation. These documentation requirements allow for tracking and reporting should there be a need to address situations where unauthorized or inappropriate restrictive interventions have been utilized.

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In Children's Host Homes and Group Care Homes, all restraints applied to children must be reported to ODDS quarterly by each program.*

The use of restrictive interventions is authorized by the individual's case manager. The intervention may only be authorized once the Individually-Based Limitations (IBL) (Modifications to Conditions) process has been applied. The IBL process is a part of the person-centered planning process which engages the individual in identifying safety risks and strategies to address the risk specific to the individual.

The IBL process results in the completion of the CMS documentation requirements for a Modification to the Condition of HCBS freedoms. The process includes identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered, a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is included in the Individual Support Plan (ISP).

Some individuals may have treatment plans developed by other professional providers who support the individual in services outside of ODDS HCBS services. The individual's HCBS provider may help the individual follow recommended treatment plans, but interventions must be consented to by the individual and represent the most appropriate, least restrictive measures for addressing risk.

The use of restrictive interventions is monitored by the case manager in accordance with the individualized plan included in the ISP specific to the limitation. Some interventions will have frequent monitoring while others may be evaluated and authorized every 12 months at a minimum.

Additionally, ODDS licensing monitors plans that include IBLs for individuals living in a licensed setting or

receiving services from a certified provider to ensure that the interventions are documented in the ISP and implemented in accordance with administrative rule and as described in the individual's plan. ODDS Quality Assurance also conducts a sample review of ISPs which includes identifying if IBLs are in place and implemented in accordance with administrative rule and as described in ISPs.

ODDS requires that the CMS documentation requirements for Modification to the Conditions (IBLs in Oregon) be included in the ISP. Currently, ODDS utilizes a specific form which walks the case management entity through all of the CMS documentation requirements including: identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered, a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is then attached to and included in the ISP.

As part of the documentation process, the person-centered planning team must identify a plan for measuring the effectiveness of the intervention. This includes a plan for data collection, documentation, and tracking when interventions are implemented. The data tracking is highly customizable to be individual specific, dependent on the nature of the intervention, and to promote efficiency in the delivery of support to individuals.

ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint *ODHS*/OHA oversight committees.