Oklahoma Long-Term Living Choice Project
Operational Protocol

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Version 1.9

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EXECUTIVE SUMMARY

The Oklahoma Long Term Living Choice Project is created to promote community living for persons 19 years of age or older with disabilities or long-term illnesses and to implement systems changes to rebalance the long-term care system. With grant funding from the Centers for Medicare and Medicaid Services (CMS) under the Money Follows the Person Rebalancing Demonstration, the Oklahoma Health Care Authority (OHCA) will facilitate the transition of individuals 19 years or older with disabilities or long-term illnesses from institutional settings to their own homes in the community. Staff from the OHCA have partnered with staff from each of the following organizations to facilitate these transitions and to rebalance Oklahoma's long-term care system:

Oklahoma Human Services – Community, Aging and Protective Services (CAP)
Oklahoma Human Services – Developmental Disabilities Services (DDS)

Additionally, these partners are currently facilitating transitions:

Ability Resources
CompleteCare Private Services, LLC
Complete Home Services
Country Style Healthcare
Elara Caring
ETL Plus
Magna Health Care
Oxford Healthcare
University of Oklahoma College of Nursing
Venerate

As the lead agency in the Living Choice project, the OHCA will be responsible for the following:

- Supervision and monitoring of the Living Choice Project
- Procedures for resolving complaints
- Financial management
- Contracting and arranging service delivery
- Quality improvement

Each of the agency partners will be responsible for coordinating activities related to each of the target populations in the Living Choice project.

Older persons with disabilities or long-term illnesses and persons with physical disabilities are eligible for transition if they have resided in an institution for at least sixty days prior to their proposed transition date. Persons targeted for transition must also be approved for Medicaid

services at least one day prior to transition. Once an individual who wishes to transition from an institution is identified as a result of targeted outreach efforts to primary and secondary referral sources, the Living Choice nursing staff will begin a pre-assessment process to screen and identify program appropriate members for the Living Choice Project. If OHCA determines that a member is eligible for participation in the Living Choice Project, one of the partner agencies will begin the transition planning process. Grant funds of the Living Choice project may be used for home establishment services such as housing deposits, furniture, utility deposits, and other services deemed appropriate and approved by OHCA staff.
Each individual transitioning from an institution to a home in the community will receive a range of necessary medical and home and community-based services for one year after moving from the institution. Once this year-long transition period is complete, transitioned individuals will have the opportunity to continue to receive needed medical and other services through one of the Medicaid home and community-based waivers, Program of All-Inclusive Care for the Elderly (PACE) or state plan options.

This protocol and all of its attachments will provide a framework for the establishment of the Living Choice Project, a statewide long-term care rebalancing and institutional transition program. This protocol was written according to procedures outlined by the CMS. The Oklahoma Long-Term Living Choice Project will comply with P.L.109-171, the Deficit Reduction Act of 2005.

PROJECT INTRODUCTION

Mission Statement

The mission of the Living Choice Project is to make community living a reality for Oklahomans 19 years or older with disabilities or long-term illnesses.

Vision Statement

The Living Choice Project will empower individuals to have choice and control of the services and supports necessary to live in and be part of the community.

Guiding Principles

When the lives of persons 19 years or older with disabilities or long-term illnesses are enhanced, the community at large will be enriched. The commitment of resources to community-based services will result in substantial, long-term savings to families, citizens, long-term care systems, and the State of Oklahoma.

Evidence Based Practices

Supports and services are based on the best research evidence integrated with clinical expertise and an individual’s preferences.

Person-Centered Philosophy

All persons are capable of growth and development.

All persons have value.

All persons must be involved in and carry the primary responsibility for the decisions which affect their lives.

All persons should live and work in the most natural and integrated settings.
All persons should live in and be part of the community.

All citizens have the right to fully exercise their rights as guaranteed by the Constitution of the United States.

People First language will pervade all communications and interactions. People are considered people first and are not identified by their disability, race, background, culture and socioeconomic status.

The Living Choice Project approach to transition planning promotes a holistic view of the person during the transition planning process and enhances coordination of supports and services.

The Living Choice Project facilitates individual and professional collaboration at both the state and local level including program development, implementation, evaluation, and policy formation.

PROJECT OVERVIEW

The mission of the Oklahoma's Living Choice Project is to make community living a reality for persons 19 years or older with disabilities or long-term illnesses by expanding and enhancing community-based long-term care. The Living Choice Project will give persons 19 years or older with disabilities or long-term illnesses the opportunity to control their own lives through the effective use of community-based supports and services. Individuals participating in the Living Choice Project will be able to live in their own homes with the necessary supports and services to ensure their presence in the community.

In order to transform the current long-term care system, staff from the Living Choice Project and partner agencies must increase the capacity of the current home and community-based services system to support additional individuals who choose to live in the community. Under the current long-term care system in Oklahoma, persons 19 years or older with disabilities or long-term illnesses are able to transition from institutions to the community as Medicaid funding for community services is available. Persons 19 years or older with disabilities or long-term illnesses who wish to transition from a nursing facility, or a public institution often face significant barriers to community living such as finding accessible housing and having dependable direct care staff.

A common barrier for all populations targeted for transition is accessing appropriate health care in the community. Results from the Prognostic Belief Scale developed by Siperstein and Wolraich (1994) indicate that a physician's attitude, expectation and prognosis for individuals with intellectual disabilities is influenced by his or her past experiences rather than from supervised, clinical experience. This prognosis is more pessimistic than all other professional groups who provide care to persons with intellectual disabilities.

This pessimistic prognosis of adults with intellectual disabilities affects a physician's ability to provide health care to persons with intellectual disabilities. With a negative view of an

individual's capabilities and capacity to live successfully in the community, many individuals remain in institutional settings because health care is more accessible than in the community.

Compounding this problem is Oklahoma's poor health status. Data from the United Health Foundation, 2012 Rankings, ranks Oklahoma 43rd in the nation in overall health status. Oklahoma's strengths include a low prevalence of binge drinking, a high per capita public health funding, and a moderate incidence of infectious diseases while its challenges include a high prevalence of smoking and obesity, limited availability of primary care physicians, and a low use of prenatal care.

Older Person with a Disability or Long-term Illness

An older person with a disability or long-term illness who wishes to move from a nursing facility to his or her own home must first complete a screening process to determine his or her eligibility for one of the home and community-based waiver programs or PACE. The waiver program that currently serves older persons with disabilities or long-term illnesses is the AD*vantage* waiver. The waiver program that currently serves individuals who are 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disabilities is the Community waiver. PACE is a Medicaid and Medicare program designed to help adults with long-term care needs live as freely as possible. This means helping participants to live outside of a nursing home or other care facility. PACE allows them to receive low-cost but quality health care services in the community. You must be 55 years of older, live in a PACE service area and meet nursing home level of care.

Person with a Physical Disability

An individual with a physical disability, perhaps acquired because of a motor vehicle accident, may live in a nursing facility because he or she is not eligible for any of the existing waiver programs. These individuals often "fall through the cracks" and have few options for community living because they must remain in a nursing home to receive any direct care services. Unlike older persons with long-term illnesses, persons with physical disabilities do not easily fit into existing disability service categories. Consequently, their services are limited only to services that can be provided in a nursing facility.

Person with Intellectual Disabilities

A person with intellectual disabilities who is identified through the PASSR process as requiring community placement; on the waiting list for waiver services and resides in a those private intermediate care facility for persons with intellectual disabilities (ICF/IID); not on the waiting list for waiver services, resides in a private ICF/IID but whose needs exceed the capacity of that or a similar facility; or resides in the Robert M. Greer Center public ICF/IID, and who wishes to move to the community must meet with his or her person-centered planning team to develop a goal for transition to the community. If the individual's person-centered planning team believes that community living is possible, the team will develop a goal for the individual to transition to

the community. The person-centered planning team must consider the needs of the individual and the community resources and supports that may be available. Many individuals with intellectual disabilities often have no family involvement which makes transition to the community a challenge. Once an individual moves to the community, he or she is also responsible for paying household expenses.

Innovative Approaches to Rebalancing

Older person with a Disability or Long-term Illness

Staff and partner agencies of the Living Choice Project have targeted persons 19 years or older with disabilities or long-term illnesses who face significant challenges when transitioning to the community. The older persons targeted represent persons with disabilities or long-term illnesses who often do not have natural supports available to assist them with living in the community. With the Living Choice project, older persons with disabilities or long-term illnesses will be able to access Living Choice Project demonstration services to pay for household start-up expenses such as rental deposits, home furnishings, utility deposits, and other services deemed appropriate and approved by OHCA staff.

Data from the 2010 Nursing Home Data Compendium published by the CMS indicate that over 42 percent of older persons currently living in nursing facilities in Oklahoma do not require significant assistance with activities of daily living, as of 2009. Targeting these individuals will have a notable impact on the current long-term care system in Oklahoma because these persons should be able to live in the community. These older persons will be able to access supports and services through community-based provider agencies that have not been available through previous Medicaid home and community-based waivers. The Living Choice Project was developed to serve these individuals after their transition into the community. This demonstration project includes community transition services that will provide funds for household establishment expenses.

Person with a Physical Disability

Providing community-based services to persons with physical disabilities who are currently unserved represents the most significant change and innovation resulting from the Living Choice Project. In Oklahoma, people with physical disabilities such as spinal cord injuries and traumatic brain injuries often move to nursing facilities because they do not qualify for existing home and community-based waivers, or their needs far exceed individual cost caps within existing waivers.

In Oklahoma, staff from Centers for Independent Living (CIL) assists persons with physical disabilities in transitioning from nursing facilities to their own homes in the community by advocating on behalf of the individual, assisting with transition expenses, and educating the public about independent living for persons with disabilities. CIL's provide transition assistance as federal funding and private donations permit.

Person with Intellectual Disabilities

Providing community-based services to persons with physical disabilities who are currently unserved represents the most significant change and innovation resulting from the Living

Choice Project. In Oklahoma, people with physical disabilities such as spinal cord injuries and traumatic brain injuries often move to nursing facilities because they do not qualify for existing home and community-based waivers, or their needs far exceed individual cost caps within existing waivers.

PROJECT GOALS AND OBJECTIVES

Oklahoma's Living Choice Project is designed to transform the current long-term care system by promoting home and community-based services instead of institutional services. Following the Olmstead decision from the United States Supreme Court, members of the Oklahoma Legislature created the Olmstead Strategic Planning Committee to ensure that state agencies in Oklahoma used an "even-hand" to provide services to persons who choose to live in the community. The recommendations of Oklahoma's Olmstead Strategic Planning Committee influence the Oklahoma Living Choice Project by providing the opportunity for statewide collaboration on long-term community-based care issues.

To fulfill the mission of the Living Choice Project, staff from the OHCA along with the Oklahoma's key stakeholders plus case management agencies, home health agencies, durable medical equipment providers, assisted living centers, and other service agencies will accomplish the following goals as outlined in the Deficit Reduction Act of 2005 (P.L. 109-171).

Goal 1: Increase the use of home and community-based rather than institutional services.

Objective 1.1: Working with partner organizations, staff from the OHCA will facilitate the transition of people with disabilities from nursing facilities or public ICFs/ID.

Strategy 1: Market the Living Choice Project to nursing facilities, aging and disability advocacy organizations statewide.

Strategy 2: Educate individuals with disabilities or long-term illnesses on the benefits and services of the Living Choice Project.

Strategy 3: Identify, refer, and screen persons 19 years or older with disabilities or long-term illnesses for participation in the Living Choice Project.

Strategy 4: Develop a training program for transition coordinators that emphasizes best practices in nursing facility transition.

Strategy 5: Modify existing case management training to include training in nursing facility transition.

Strategy 6: Develop an individualized transition plan for each individual participating in the Living Choice Project.

Objective 1.2: Develop new home and community-based waivers for persons transitioning through the Living Choice project and ineligible for the existing home and community-based waivers including services specific to the needs of persons with disabilities transitioning from an institution to the community. [This objective has been accomplished. The My Life; My Choice

(2010) and Sooner Seniors (2011) waivers are operational. Effective 10.1.2015 the My Life; My Choice and Sooner Seniors waivers were terminated. Older persons and persons with physical disabilities completing 365 days in the Living Choice project will transition into the AD*vantage* 1915 (c) waiver or the Program for All Inclusive Care for the Elderly (PACE) or state plan personal care (SPPC) depending on the continuity of need and input from the member.

Strategy 1: Include transition coordination and community transition expenses as services within the new waivers.

Strategy 2: Convene stakeholders to research relevant approaches to serving persons with physical disabilities.

Strategy 3: Implement OHCA policies and procedures to provide continuing support for the new waiver programs for older persons with disabilities or long-term illnesses and persons with physical disabilities.

Objective 1.3: Expand the use of the Medical Home approach for persons 19 years or older with disabilities and long-term illnesses transitioning to the community.

Strategy 1: Identify core Medical Home components (active care plan, continuity of care with one primary care physician, collaboration with other community-based providers) for participants.

Strategy 2: Train transition coordinators and provider agencies on the Medical Home approach and health care coordination.

Strategy 3: Identify and recruit primary care practices who will accept individuals with disabilities or long-term illnesses transitioning to the community and provide Medical Homes.

Strategy 4: Provide technical assistance to primary care practices regarding best practice for specific conditions of individuals in the Living Choice Project.

Strategy 5: Provide technical assistance to primary care practices regarding community resources available to individuals in the Living Choice Project.

Strategy 6: Provide technical assistance to primary care practices regarding implementation of core Medical Home components.

Objective 1.4: Provide a system of care for individuals with behavioral health needs who are transitioning to the community.

Strategy 1: Transition coordinators will identify individuals with behavioral health needs and connect them with local community behavioral health providers.

Objective 1.5: Ensure that individuals who have transitioned to the community have appropriate medications and are free from adverse drug reactions.

Strategy 1: Provide pharmacological evaluations to persons at risk for adverse drug reactions.

Goal 2: Eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable

Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

Objective 1.6: Strengthen housing efforts by collaborating and partnering with various housing entities throughout the State of Oklahoma to identify and locate affordable and accessible housing options.

Strategy 1: Increase the affordability and availability of community housing options for persons with disabilities or long-term illnesses

Strategy 2: Develop an online housing resource database to include affordable and accessible community housing options for persons with disabilities or long-term illnesses.

Strategy 3: Conduct home visits prior to the member's transition to ensure that the home is safe and accessible.

Strategy 4: Add the necessary supports to promote the best opportunity to a quality transition

Objective 2.1: Fund demonstration services to ensure that individuals with disabilities or long-term illnesses have the necessary services to remain in the community.

Strategy 1: Design a specific demonstration benefit package for each targeted population of individuals participating in the Living Choice program.
Strategy 2: Blend available funding resources to develop individualized budgets for individuals who wish to self-direct their services. [This strategy has been accomplished. Self-direction services are operational as of November 15, 2012.]
Strategy 3: Expand options for self-direction in the existing home and community-based waivers or state plan options. [This strategy has been accomplished. Self-direction services are operational as of November 15, 2012. They will be fully established in the agency's rules for Living Choice by July 2013.]

Objective 2.2: Fund community based long term care services to individuals with disabilities or long-term illnesses consistently across residential placements.

Strategy 1: Amend existing home and community-based waivers and state plan options to provide equivalent health care services to individuals living in the community that they would receive when living in an institution.

Goal 3: Increase the ability of the SoonerCare program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting.

Objective 3.1: Request additional state funds to support the expansion of services within current waivers or state plan options.

Strategy 1: In its annual budget request, OHCA shall request funds for developing new waivers or amending existing waivers or state plan options to serve persons with physical disabilities currently unserved by home and community- based waiver programs.

Objective 3.2: Develop ongoing political support for new waivers or state plan expansion by

educating members of the Oklahoma Legislature and the public about community based long term care.

Strategy 1: Develop a “Fast Facts” one-page summary on home and community-based waivers in Oklahoma.

Strategy 2: Conduct an annual training and technical assistance symposium for the Living Choice Project and home and community-based waivers.

Strategy 3: Develop a website that contains up to date information on best practices in institutional transition and the current status of the Living Choice Project in Oklahoma. [Living Choice has a website that is updated on a regular basis to show new services, policy, and other information to our providers, participants, and other interested parties.]

Objective 3.3: Expand the existing community based residential services workforce.

Strategy 1: Fund training for transition coordinators and case managers that will enable them to meet the specific needs of persons transitioning from institutions to the community.

Strategy 2: Collaborate with partner agencies to ensure that existing training programs include training on the needs of persons transitioning from institutions to the community.

Objective 3.4: Collaborate with agency partners to identify persons at risk for institutionalization and educate them about home and community based long term care options.

Strategy 1: Collaborate with staff from partner agencies to develop mechanisms to identify individuals at risk of institutionalization to receive information about home and community based long term care options.

Strategy 2: Collaborate with hospital administrators, social services staff, and discharge planners to identify individuals admitted to their facilities who may be discharged to long term care nursing facilities for continuing recovery or who may already be a Living Choice or waiver participant and in need of medical care.

Goal 4: Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

Objective 4.1: Expand existing quality assurance efforts by educating persons 19 years or older with disabilities or long-term illnesses and their caregivers on all aspects of self-determination.

Strategy 1: As the lead agency, the OHCA will develop a well-defined process that conforms to the level of quality management in the existing home and community-based waivers and the additional Money Follows the Person grant quality assurances.

Strategy 2: Provide peer mentoring to individuals with disabilities transitioning from the institution to the community.

Strategy 3: Ensure that each individual’s transition plan includes information on his or her rights to be free from abuse, neglect and exploitation.

Strategy 4: Representatives from all stakeholder groups, including persons transitioned, personnel from the OHCA and partner agencies will participate in the continuous quality improvement process.

Strategy 5: The OHCA will provide clear, accurate and timely information regarding all aspects of its continuous quality improvement strategy to individuals transitioned, agency personnel, policymaking bodies and other stakeholders.

Goal 5: Ensure that all Living Choice participants have their safety guaranteed to the best of the project's ability regardless of whether they live in an urban or rural environment in the state.

Objective 5.1: Build upon existing risk assessment and risk mitigation policies for participants by entering discussions with the State of Oklahoma Department of Emergency Management.

Strategy 1: Meet with a representative from the Oklahoma Developmental Disabilities Council to learn the "who" and "how" of their beginning discussions for the persons with disabilities they represent to be found and assisted during state, county, and city level emergencies.

Strategy 2: Contact the Director of the Oklahoma Department of Emergency Management to request a meeting to initiate discussions.

Strategy 3: Educate the personnel of the Oklahoma Department of Emergency Management about Living Choice and the waivers borne from the project.

Strategy 4: Work with the Oklahoma Department of Emergency Management to develop effective emergency plans for Living Choice participants that can be implemented by the participant, his/her transition coordinator, his/her informal support, and others involved in the participant's case.

Strategy 5: Work with personnel from the Oklahoma Department of Emergency Management to gain attendance at regularly held agency meetings where there is discussion of emergency planning.

Strategy 6: Extend an invitation to the Oklahoma Department of Emergency Management for an agency representative to join the Living Choice Advisory Committee.

Strategy 7: Seek guidance and assistance from the Oklahoma Department of Emergency Management to extend the state-level plan(s) developed for Living Choice participants to the county and city levels.

Goal 6: Educate transition coordinators on employment pathways for those transitioning from nursing facilities into the community.

Objective 6.1: Provide participants in the Living Choice program the option of going to work for the first time, returning to work, or volunteering in their communities to improve their quality of life and have improved opportunities for socialization.

Strategy 1: Establish a dialogue with the Oklahoma Department of Rehabilitation

Services to educate them about the Living Choice project and those who will transition to community living who may apply for their services.

Strategy 2: Establish a dialogue with the Oklahoma Employment Securities division to obtain information about their services that would be available to Living Choice participants transitioning to the community who may be seeking employment.

Strategy 3: Work with the Social Security Administration to help Living Choice staff, the transition coordinators, and the participants understand substantial gainful employment and other methodologies for returning to work and not having a major impact on the participants' current income.

Strategy 4: Work with transition coordinators to help them develop sources for volunteering for participants who do not want to earn an income but who still want to become active in the communities to which they transition.

BENCHMARKS

Benchmark 1: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration. The OHCA Medicaid Management Information System (MMIS) has been able to track Living Choice participants since January 1, 2009. Persons with intellectual disabilities and persons with physical disabilities are the only category of persons that transitioned in calendar year 2009. Case managers at the OHS-DDS include institutional transition services as a part of the targeted case management services provided by OHS-DDS staff. Older persons with disabilities or long-term illnesses and persons with physical disabilities began transitioning in January 2010.

Grant year	Older persons	Persons with Physical disabilities	Persons with ID	PRTF	TOTAL
2018	12*	15*	0	35*	62*
2019	6*	8*	0	0	14*
2020	12*	18*	0	0	30*
2021	10*	15*	0	0	25*
Projected Totals	40*	56*	0	35*	131*

*Note: All figures for Grant Years 2018- 2021 are projected transitions
Note: Persons in the ID population stopped transitioning in 2016, however, under the new MFP funding announcement, DDS will resume transitioning persons in the ID population effective October 1, 2021. Persons in the PRTF population are no longer transitioning as of December 2018.

Benchmark 2: This benchmark shows the total amount of qualified expenditures for the HCBS during each year of the demonstration program. These data represent home and community-based services (HCBS) expenditures for all waiver programs. Calendar year (CY) 2007 represents the base year and each subsequent year was trended forward based on the number of transitions each year of the project. Demonstration services are those services that individuals receive during the first year of transition. Supplemental services are one-time

expenses associated with each transition. These services are placed in a separate line and are based on actual supplemental services provided during each year of the project. These figures are based on the projected cost increases for the home and community-based waivers for each year of the project. The totals were calculated by adding the costs of the demonstration services to the projected costs of the home and community-based services expenses.

Grant Year	HCBS	Demonstration	Supplemental	Totals
2007	448,192,874	0	0	448,192,874
2008	499,850,955	0	0	499,850,955
2009	499,269,785	930,147	0	500,199,933
2010	479,849,624	4,092,307	0	483,938,776
2011	485,134,890	3,929,873	0	489,064,763
2012	457,829,646	3,843,687	0	461,673,332
2013	466,731,679	5,861,892	0	472,593,570
2014	495,319,352	15,038,163	0	511,250,334
2015	501,260,312	8,474,516	0	513,037,277
2016	516,688,509	1,108,083	0	528,516,850
2017	522,533,546	347,681	0	503,798,591
2018	480,719,110	457,046	0	482,123,779
2019	489,852,773*	226,935	0	490,942,551*
2020	499,159,976*	230,342	0	500,254,625*

Note: All figures for Grant Years 2007-2018 are actual numbers.
*Note: All figures for Grant Years 2019-2020 are estimated numbers.

Benchmark 3: Increases in an available and trained community workforce.

	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Number of trained transition coordinators	25	30	0	0	0	0	0	0

Indicator 1: Transition coordinators at community provider agencies will be trained on best practices in nursing facility transition during the length of the project.

All training is developed by the OHCA. Mentorship to all trained transition coordinators will be ongoing throughout the project.

Benchmark 4: Increases in the availability of self-directed services for Living Choice participants. Self-direction services will be optional in the Living Choice Project and the new waivers that serve participants who complete 365 days in the demonstration project.

	CY 2018	CY 2019	CY 2020	CY 2021
Number of persons self-directing a portion of their services each year	0	0 (Older) 0 (PD)	0 (Older) 0 (PD)	0 (Older) 0 (PD)

Indicator 1: An estimated 25 percent of older persons with disabilities will self-direct a portion of their services each year of the project.

Indicator 2: An estimated 25 percent of persons with physical disabilities will self-direct a portion of their services each year of the project.

Benchmark 5: During CY2013, Dynamic Independence and Sandra Beasley Independent Living Center, which are providing outreach and information services for Living Choice through funding from the ADRC project in the OHS-CAP, will be trained to become Living Choice project transition coordination agencies. Through this methodology they can begin actively working with consumers in their service areas in nursing facilities to transition to community living through the Living Choice project. This benchmark will be achieved by these providers showing as active providers on the OHCA's MMIS in the Provider subsystem having been assigned provider identification/location numbers.

DEMONSTRATION POLICIES AND PROCEDURES

Participant Recruitment and Enrollment

A comprehensive, early identification system is used to recruit, identify, screen and assess individuals with disabilities or long-term illnesses for participation in the Living Choice Project. This system includes significant outreach to individuals and their family members who are considered primary referral sources. Nursing facility administrators, hospital discharge planners, consumers, board members, and staff from Oklahoma's Centers for Independent Living and OHS ombudsman are considered secondary referral sources. The public relations strategy of the Living Choice Project is to educate and inform targeted groups, e.g., individuals, family members, Ombudsmen, and others about the Living Choice project. Nursing home administrators are asked to identify residents who wish to receive their services in the community. Discharge planners are asked to identify residents who may benefit from community based long-term care services. MDS Coordinators at nursing homes have been asked to send referral information on all residents who state they want to receive services in the community when asked the questions found in Section Q of the MDS 3.0 Resident Assessment Instrument.

The Living Choice project will also educate and inform family members of persons in institutions about the Living Choice project. The individuals interested in community living and the family members of persons who live in institutions are some of the main referral sources to the Living Choice project. Family members are also able to refer individuals directly to the OHCA through

the Living Choice project website. This website contains the Living Choice brochure and all the forms of the Living Choice project. Family outreach consists of a statewide media campaign targeted at family members of persons residing in institutions. The Living Choice Advisory Committee has also been asked to assist with statewide recruitment efforts.

Local Ombudsman at OHS offices currently assists with identification of persons who wish to receive community based long-term care services. All persons 19 years or older with disabilities or long-term illnesses in Oklahoma who wish to live in the community who are eligible for the Living Choice project and whose health and safety needs can be met through the Living Choice project are identified and screened. The OHCA will develop a comprehensive intake, assessment, and service planning system for the Living Choice Project. This comprehensive system includes procedures for identifying individuals from nursing facilities or public ICFs/ID who have met the institutional placement requirement of sixty consecutive days prior to transition in the Living Choice Project. These facilities comprise the primary referral sources for the Living Choice Project.

Recruitment Strategies for Older Persons with a Disability or Long-term Illness

Oklahoma has one of the highest rates of nursing home placement in the United States. The Living Choice Project and partner agencies targets members from long term care institutions who can live safely in the community. Identification of older persons with disabilities or long-term illnesses is being done through extensive community outreach among nursing facility residents, family members, Areawide Aging Agencies (AAAs), advocacy networks and community social service organizations and Ombudsmen at county OHS offices. The OHCA has a data use agreement with CMS to extract information from the Medicaid Minimum Data Set that can be used to identify individuals who wish to live in the community.
Building upon a successful recruitment effort, the Living Choice Project continues to recruit and identify older persons with disabilities or long-term illnesses statewide. Specific community outreach methods for older persons with disabilities or long-term illnesses statewide include:

- Outreach to the target cities through AAA's
- Outreach to family advocacy networks such as Oklahoma Family Network and the Family Supportive Health Care Network
- Notification to nursing facility administrators through continuing education and training
- Information dissemination to local Ombudsmen through OHS
- Marketing and education through each CIL and the Statewide Independent Living Council

Staff from the Living Choice Project electronically sends project information packets to each nursing facility administrator statewide. The information packet contains the following information:

- a brochure about the project including contact information of project staff
- eligibility information
- copy of the Living Choice Common Intake Form www.okhca.org/Livingchoice

Living Choice team members are available by phone or in person to answer specific questions that nursing facility staff may have about the project. Recruitment efforts are conducted statewide.

Recruitment Strategies for persons with intellectual disabilities

Staff at Greer will inform parents and guardians about the Living Choice Project. In addition, staff from Greer will give Living Choice project information to Greer residents who have indicated transition to the community as a goal on their Individual Plan. The Greer case manager will disseminate information about the Living Choice project to all team members of individuals whom wish to transition to the community.

The DDS marketer/recruiter will inform persons living in ICF/IIDs, their parents or guardians about the Living Choice Project. In addition, the DDS marketer/recruiter will give Living Choice project information to private ICF/IID residents who have indicated transition to the community as a goal on their Individual Plan. The DDS marketer/recruiter will disseminate information about the Living Choice project to all team members of individuals who wish to transition to the community.

Staff at OHS-DDS will also include information about the Living Choice project in their division newsletter which is mailed to all OHS-DDS staff, families, provider agencies. Living Choice project staff also participates in OHS-DDS conferences.

Screening and Intake

The Living Choice Common Intake form is readily available to complete online. If a member or family has questions regarding the information required on the Living Choice Common Intake form, they can reach the Living Choice toll-free number at 888-287-2446. Our Living Choice coordinator will assist the member or a representative in completing the online form.

Staff at the OHS-CAP and the Living Choice project will ensure that transition coordinators at provider agencies for the AD*vantage* program have been trained in the proper use of the Living Choice common intake form as a method of determining whether an individual is eligible for transition through the Living Choice project. This form is included in the Appendix of this operational protocol. The Living Choice Project Director and LC staff members have trained representatives from each agency on the appropriate use of the form. Once trained, staff will screen all individuals referred to the Living Choice Project. An individual's screening will occur within five business days of the referral to the agency. Screening may take place in person or by telephone.

Each agency partner involved in the Living Choice Project, except the OHS-DDS, shall utilize common identification and screening processes. The OHS-DDS is exempt from these processes because all of the individuals targeted for transition reside in the OHS-DDS operated Greer public ICF/IID, in a private ICF/IID or are identified via the PASRR process. Moreover, the services provided to individuals with intellectual disabilities through the Living Choice Project are identical to existing services provided to individuals with intellectual disabilities in the home and community-based waiver.

Individuals with disabilities, their family members or other representatives may contact the Living Choice staff directly by telephone, through the OHCA website or through a central directory such as 211 Oklahoma, Oklahoma Areawide Services Information System (OASIS) or the Joint Oklahoma Information Network (JOIN). The referral source must provide the Living Choice Project with sufficient information to determine whether an individual is eligible to participate in the Living Choice project.

Program Eligibility Determination

Staff from the Living Choice partner agencies and transition coordinators at provider agencies is responsible for submitting the Living Choice common intake form to the OHCA for review. Upon receipt of a completed Living Choice Project Common Intake form, staff from the OHCA, determine eligibility for the Living Choice project. To be eligible for transition through the Living Choice project, an individual must meet all the following requirements:

- the individual must be at least 19 years of age
- the individual must be determined eligible for SoonerCare, Oklahoma's Medicaid program for at least one day prior to transition
- the individual must have lived in the institutional setting for sixty consecutive days prior to transition
- skilled nursing services or skilled rehabilitative services days are counted towards the length-of-stay requirements.

If an individual is determined to be eligible for services, the staff from the OHCA, will complete an assessment to determine the level of supports and services necessary to live in the community. If an individual referred is not eligible for the Living Choice Project, then the individual will be notified in writing. If an individual does not agree with the decision, staff from the Living Choice Project will explain the individual's rights for an appeal. With approval from the individual, Living Choice Project staff may refer the individual to other services. Staff from the Living Choice Project, its partner agencies or transition coordinators from provider agencies will also notify individuals with disabilities or long-term illnesses if another service or organization can best meet the needs of the individual who wishes to transition.

It is the responsibility of Living Choice Project staff to be aware of other community resources for persons 19 years or older with disabilities or long-term illnesses who does not meet the criteria for the Living Choice Project. If an individual is eligible for home and community-based services outside of the Living Choice project, staff from the OHCA will refer individuals to the programs for which they are eligible. The Living Choice Project Director has developed procedures to ensure that staff from the Living Choice partner agencies and residential provider agencies has the necessary information to ensure efficient referrals to other community-based programs.

Pre-Transition Cycle

Members interested in returning to community living will be referred to their respective case management agency of choice. An established set of pre-transition criteria is developed and coordinated into a Transition Cycle of payment deliverables. Transition coordinators must achieve the identified pre-transition criteria before they can be authorized to continue the pre-transition process. Please see Figure 1.

To implement this:

- Living Choice staff will require transition coordinators to submit case notes for review in order to monitor progress of the member on a 30-day basis.
- Living Choice will actively communicate with transition coordinators to inquire about, assist with, and resolve any outstanding issues that could keep the member from transitioning.
- Living Choice staff will track and authorize the number of units the case manager uses to assist the member in transitioning during the pre-transition period, rather than after it.

When no progress is made or it becomes clear that a member cannot safely transition back into the community, Living Choice staff may make recommendations to suspend the member from Living Choice enrollment, and they will provide notice to the member and case management agency if the member's case is suspended.

Figure 1: Pre-Transition Cycle

	Pre-Assessment	Phase 1: Orientation and Housing	Phase 2: Service Plan Development	Phase 3: Transition into Community
Performed by	MFP Nursing Staff	Case Management Agency	Case Management Agency	Case Management Agency
Goal	Screen and evaluate members	Locate and secure safe housing	Develop service plan and locate service providers	Transition member into the community
List of Activities	1. Perform UCAT Assessment	1. Agency Orientation	1. Develop service plan with member and other stakeholders the member selects	1. Purchase items for member to transition
	2. Get requisite forms filled out	2. Find and Secure Housing	2. Write and submit Service Plan to Living Choice staff	2. IDT with service providers
	3. Introduction to Living Choice Program	3. Review UCAT and forms	3. Locate and Secure Service Providers	3. Submit Transitional funds request
		4. Submit any additional forms	4. Provide case notes	4. Move member into community
		5. Provide case notes		5. Provide case notes

Individuals will be informed that they have the right to decide whether to accept or decline services at any time during the transition planning process. If an individual indicates that he or she does not wish to proceed further with the transition planning process, the Living Choice Project is not obligated to complete the community service plan until the individual initiates the process. If an individual chooses to live in a non-qualified community residence, the transition coordinator will document this choice and inform the person that he or she is ineligible for the Living Choice project based on his or her decision to live in a non-qualified residence.

Prior to the transition planning meeting, transition coordinators of the Living Choice project provide individuals with an orientation to the process for developing an individual transition plan. Orientation activities may include:

- sharing of information about the Living Choice project including the guiding principles and person-centered philosophy
- explaining the individual's rights, release of information forms and the requirement of informed consent
- obtaining signatures on all necessary forms, including those for release of information
- explaining to the individual, his or her family, legal guardians, or other representatives that the meetings involved in the transition planning process will be held at times and locations that are convenient for the individual and his or her transition planning team
- encouraging the individual to take time to consider and understand information provided before making decisions about the transition to the community and
- answering the individual's questions about the Living Choice Project, its components, procedures, and policies

For some individuals, it may be appropriate to provide additional training on self-direction and the self-determination. This type of training may be provided by Living Choice staff or other Living Choice Project partner agencies with experience in providing training on self-direction to persons 19 years or older with disabilities or long-term illnesses.

The transition planning team also assists the individual in obtaining or compiling documents necessary to live in the community including, as necessary, the following information:

- necessary identification cards
- a social security number and card
- medical records and documentation, including a SoonerCare card or other health care eligibility documentation
- an original copy of birth certificate
- documentation of immigration, citizenship, or naturalization (if appropriate)
- death certificates if parents are deceased
- compilation of personal belongings
- a list of known relatives, with relationships and contact information
- educational records if appropriate

Person-Centered Planning

As lead agency, the OHCA ensures that a written Person-Centered Planning will be developed for each eligible individual that wants to participate in the Living Choice project. Once an individual's assessment is complete, the individual, his or her family members, legal guardians

or other representatives will convene a person-centered planning team for the purpose of developing a person-centered plan. Members of the transition team include the individual, his or her family members, his or her legal guardians, advocates, friends, and the transition coordinator from one of the provider agencies.

The person-centered plan is based on the findings of the assessment and will help the individual with a disability or long-term illness understand the options available for transition. The person-centered plan is developed with the full participation of the individual or his or her legal guardian or other representatives.

Specifically, the person-centered plan includes the following information:

- the available options and services available for transition to the community
- the benefits and services available through the Living Choice project
- informs the individual, his or her family members, legal guardian, advocate or other representative about the benefits, risks, and alternatives to planned services
- freedom of choice to reside in a qualified community residence (A qualified community residence is defined as a home leased or owned by the individual; an apartment leased by the individual, a certified assisted living facility, or a residence in which no more than four unrelated individuals reside.)
- a source of income
- accessible health care
- transportation
- access to peer support
- access to natural supports (if available)

Additionally, the person-centered plan specifies the following:

- all services, including how and by whom they are to be provided
- service goals, including objectives and expected duration of each service element
- the individual's desired outcomes

Transition

The planning for transition of an individual from an institution is an ongoing process. Throughout the transition planning process, various interactions and meetings will occur with the individual, his or her family members, legal guardian, transition coordinator and future service providers. Prior to the actual transition date, a meeting will be held to determine and document the final plans for transitioning an individual from the institution into the community.

Suspension and Re-Application Process

The UCAT is administered during the initial visit or virtually with the member and is valid for a six-month period. If a member is unable to transition within a 180-day period due to any given reasons, the case may go into suspension status. During the suspension phase, Living Choice staff will coordinate and communicate with the transition coordinator to ensure that efforts are being made to assist the member towards community transition.

The suspension status will remain active if there is a current and clinically approved UCAT in place. If during this time no progress has been made towards community transition, the transition coordinator will submit the appropriate documentation to official close out the member's case. However, if the member's barrier(s) to transition have been addressed during this time (i.e. locating affordable and accessible housing, release from hospital, etc.) then the member may be released from suspension status and will resume the pre-transition process.

In cases where the UCAT assessment is beyond the six-month period, the member will be able to have one additional assessment. The UCAT assessment will be completed by the member's transition coordinator and reviewed by OHCA clinical staff to ensure that the member is still medically appropriate for community transition. In an event that the member is unable to transition after having the additional UCAT assessment, the case will be closed, and the member can reapply one year from the effective date of case closure.

Re-Application Process

The Living Choice Project has implemented a one-year reapplication period for members who were unable to transition through the project. If a member's case is closed due to any reasons, the member may re-apply one year from the effective date of case closure. A member is no longer eligible for assistance through the Living Choice program if the member moves from the nursing home back into the community prior to completion of all Living Choice processes. A "*Notice of Denial or Termination Letter"* is generated by Living Choice staff and provided to the member. The letter provides the reason for the case closure, and also provides an effective date (See appendix L). The member also has the right to appeal any decision that was adversely made.

Note: A copy of the "Notice of Denial or Termination Letter is included in Appendix L of the Operational Protocol. The letter provides a detailed list of common reasons for member case closure.

Re-Enrollment in the Living Choice Project

Members who return to an institution before the end of the demonstration year will be considered un-enrolled from the Living Choice Project if they remain in the institution for more than 30 days. An individual may re-enroll in the Living Choice Project without spending another 60 days in the institution upon the individual's request. The Living Choice administrative and clinical staff will determine whether the individual can safely return to the community.

In situations where an individual has a surgical procedure that will require hospitalization and convalescent care, the community- based placement will remain intact if the individual's re-institutionalization does not exceed 30 days.

Informed Consent and Guardianship

Each agency involved in the Living Choice Project has its own internal policies to obtain informed consent and how individuals 19 years or older with disabilities or long-term illnesses are assured of their rights under the Living Choice Project. Older persons with disabilities or

long- term illnesses and persons with physical disabilities utilize the Living Choice Participant Consent and Rights form. As the lead agency in the Living Choice Project, the OHCA is responsible for:

- Ensuring that all persons served are informed of their rights and responsibilities
- Provide that each individual participating in the Living Choice Project have sufficient information to make an informed choice about receiving services through the Living Choice Project.
- Ensuring the effective implementation of these protections by each public and private agency in Oklahoma that is involved in the provision of services to persons with disabilities or long-term illnesses transitioning from institutions to their own homes in the community.

Protections for persons transitioning from institutions to their own homes in the community through the Living Choice project are established through provider agreements. These provider agreements will specify the provisions or arrangements for institutional transitions for older person with disabilities or long-term illnesses.

Right to Examine Records

Any individual with a disability or long-term illness participating in the Living Choice project will be afforded the opportunity to inspect and review records relating to referrals, assessments, development and implementation of transition plans, services provided through the Living Choice project and individual complaints in any area involving records.

If an individual has a legal guardian, the legal guardian shall have the right to examine such records related to transition through the Living Choice Project.

Informed Consent

Before entering the Living Choice Project, a participant or his or her legal guardian must sign a consent form that includes the following information:

- A statement that he or she voluntarily agrees to participate
- A statement that the OHCA, as lead agency, will continue to assure home and community-based services to the individual at the conclusion of the Living Choice project
- An explanation of the purpose of the Living Choice Project
- A guarantee of confidentiality
- A clear description of possible risks of participation
- The signature of the participant or his or her legal guardian

In the Living Choice project, written, informed consent will be obtained before:

- Conducting the initial assessment for the Living Choice program

- Initiating transition planning services for the first time

In the Living Choice Project, “consent” means that:

- The individual or his or her guardian has been fully informed of all information relevant to the activities for which consent is sought in the individual’s native language or alternative method of communication
- The individual or his or her guardian understands and agrees in writing to the implementation of certain activities for which consent is sought and the consent describes the activity and lists the records (if any) that will be released and to whom
- The individual or his or her legal guardian understands that the granting of consent is voluntary on the part of the individual and may be revoked at any time

If the individual or his or her legal guardian does not provide consent with respect to a transition-related services, OHCA as the lead agency will make reasonable efforts to ensure that the individual or his or her guardian:

- Is fully aware of the nature of the services that will be available
- Understands that the individual will not be able to receive transition services through the Living Choice project unless consent is given.

Critical Incident Reporting

In the Living Choice project, a critical incident is one that meets any of the following criteria:

- If an individual participating in the Living Choice project has an injury or health related event that requires emergency care or results in the hospitalization of the individual
- If the participant in the Living Choice program dies
- If law enforcement is contacted or involved in a situation
- If abuse, neglect, financial exploitation, or sexual exploitation is suspected
- If there is harm to an individual due to physical aggression

Oklahoma statutes require any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation to make a report to either the OHS, the office of the district attorney in the county in which the suspected abuse, neglect or exploitation occurred or the local municipal police department or sheriff’s department as soon as the person is aware of the situation. If this initial report is made to the local municipal police department or sheriff’s department, such police departments or sheriff’s departments must notify the OHS-Adult Protective Services (APS) as soon as possible.

After investigation of a report, staff at the OHS-APS will forward its findings to the office of the district attorney in the county in which the suspected abuse, neglect or exploitation occurred. Confirmed findings are also forwarded to the OHS-Office of Client Advocacy (OCA) for determining as to whether the accused caretaker is subject to placement on the OHS-DDS community services worker registry, i.e., abuse registry. The OHS-OCA provides state office OHS-DDS with a copy of the investigative report that frequently contains “areas of concern” that may affect the health and safety of the individual participating in the Living Choice program.

If an incident happens to a Living Choice member, transitional coordinator will enter this information into a Critical Incident Report (CIR). Information for the CIR may come from various community entities. Critical issues related to abuse, neglect and exploitation are reported consistent with Oklahoma statutes and included in the CIR. Once the factors contributing to the incident are determined, the Living Choice project staff will work with the provider and the individual to mitigate the risk of the incident recurring.

If an incident happens to a person with intellectual disabilities or a developmental disability, OHS DDS case management staff is responsible for reviewing the report and conducting follow-up with the provider agency with respect to the areas of concern and any disciplinary action taken against the accused caretaker. Results of the case management review are forwarded to OHS-DDS state office and to the OHS-OCA. Each confirmed finding and the disciplinary action taken are also reported monthly to the Director of OHS. Non-confirmed findings are forwarded to the OHS-Quality Assurance Unit for follow-up and corrective action where appropriate. OHS-DDS state office staff maintain a database that records relevant information pertaining to each investigation, including, but not limited to the findings, the disciplinary action taken and the response to follow up conducted by OHS case management staff.

The Living Choice project requires providers serving individuals to review their Continuous Quality Improvement (CQI) plans to assess their established business and quality improvement infrastructure and determine if any additional policies, procedures or practices are required. These changes to CQI plans are submitted to the Living Choice project with an implementation plan.

Living Choice project staff maintains data on the quality performance of providers and Living Choice participant's health and welfare related to critical incidents. The frequency and type or categories of critical incidents are tracked as a quality measure.

Complaint Procedure

An individual who is not satisfied with a decision, policy or service received from a partner agency or a residential provider agency affiliated with the Living Choice project may also file a complaint in accordance with existing complaint resolution procedures at the agency. The individual may also file a complaint directly to the OHCA. Such complaints will be investigated only after the complainant has attempted to resolve the matter directly with staff of the partner agency or residential provider agency.

- A complaint must be submitted within 20 days after the person knows or should have known the matter which is the subject of the complaint.
- The preferred document for submitting a complaint is the LD-1, which is available from the Living Choice project team by calling. It can also be found on the Living Choice project's website.

A complaint must be submitted by phone, mail, or fax:

Oklahoma Health Care Authority
Legal Division
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Phone: (405) 522-7217
Fax: (405) 530-3444

The complaint must contain the following:

- A description of the complainant's interest in the matter.
- The issue(s) to be resolved and the remedy(s) requested.
- The complainant's rationale supporting the complaint, including any relevant facts and applicable law, rule or other legal authority.
- The complainant's affirmation that the facts set forth in the complaint are true.
- Staff within the OHCA legal division shall investigate of each complaint, or assign staff for such investigations, and prepare a summary of findings, recommendations, and final disposition. A copy of that summary shall be provided to the complainant and each person who was a subject of the complaint. All complaints shall be resolved in an expeditious manner.

The State Medicaid Director shall coordinate any investigation if the subject of the complaint includes the Living Choice Project Director or a LCAC member.

Documentation of Complaints

The Living Choice Project shall maintain a file on each written complaint filed with the OHCA. The file shall include:

- The name of the person who filed the complaint.
- The date the complaint was received.
- The subject matter of the complaint.
- The name of each person contacted in relation to the complaint.
- A summary of the results of the review or investigation of the complaint.
- A brief explanation of the reason that no action was taken after an investigation of the complaint.

Upon receipt of a complaint conforming to the requirements above, the Living Choice Project shall acknowledge receipt in writing to the complainant within ten working days of receipt and provide the complainant with a copy of the OHCA's policy regarding complaint investigation and resolution. All complaints will be reviewed and investigated in a confidential manner. A copy of the OHCA Living Choice complaint form is included in the appendix of this protocol.

Guardianship

If an individual participating in the Living Choice Project has a legal guardian, it is expected that the legal guardian will participate in all aspects of intake, assessment and transition planning. Staff of the Living Choice Project and its partner agencies will provide information about the Living Choice Project to the legal guardian once notified that a legal guardian exists. The legal guardian for the individual will be responsible for signing the consent form for an individual to participate in the Living Choice Project.

Some individuals in the Living Choice Project will have limited guardians for specific issues such as health care. If a person has a limited guardian responsible for health care decisions and services, this guardian will be responsible for signing the consent form for the individual to participate in the Living Choice Project.

If a case manager at OHS-DDS is concerned that a person with intellectual disabilities who

wishes to transition to the community is in need of a guardian, then the case manager will help the individual complete a guardianship assessment. If the guardianship assessment finds that the person with intellectual disabilities needs a guardian, the case manager at OHS-DDS will refer the individual to the Guardianship Coordinator. The Guardianship Coordinator will link the individual to necessary resources to help the individual find a guardian. OHS-DDS has a program that recruits and trains volunteers to serve as legal guardians for persons with intellectual disabilities.

In the absence of a legal guardian or a limited guardian, the individual who wishes to transition from the institution will be responsible for signing the consent form in order to participate in the Living Choice Project. If an individual has a representative payee for Social Security or other public benefits, the representative payee must be involved in the transition planning process so that the individual may transfer any public benefits to his or her new residence in the community.

Outreach, Marketing and Education

Strategic Plan for Marketing and Outreach

The goal of the Living Choice Project marketing and public awareness program is to educate and inform the public of the purpose, benefits, and services of the Living Choice Project. The OHCA has implemented a statewide and targeted media campaign to increase the identification of persons 19 years or older with disabilities or long-term illnesses who are capable of living in the community.

The Living Choice Project marketing and public awareness program - utilizes a systematic and purposeful set of activities to inform the public about the Living Choice Project. The Living Choice Project uses multiple resources to inform disability advocacy groups and the public regarding the needs of persons 19 years or older with disabilities or long-term illnesses that wish to live in the community. A primary focus of the marketing and public awareness program is the early identification of those individuals who have the capacity to live in the community.

The Living Choice marketing and public awareness program:

- Increases the public's knowledge of community living for persons 19 years or older with disabilities or long-term illnesses.
- Utilizes the Living Choice Advisory Committee and provider network of long-term health care providers in the identification and referral of persons with disabilities who wish to live in the community.
- Promotes community-based options and services for persons 19 years or older with disabilities or long-term illnesses.
- Provides information regarding safeguards to protect the rights of persons 19 years or older with disabilities or long-term illnesses who wish to live in the community
- Updated the existing Living Choice project brochure including the design and development of a logo associated with the Living Choice project
- Designed and produced a Living Choice project exhibit display for conferences and meetings
- Modified and updated the OHCA website to include the Living Choice project

To ensure effective marketing and outreach for all populations, staff from the Living Choice

Project prepared an invitation to bid to contract with a marketing or public relations firm to complete the following tasks:

1. Revise the brochure of the Living Choice Project using the project logo and the national Money Follows the Person logo.
2. Design a Living Choice Project scrolling banner exhibit display for conferences and meetings.
3. Design a two-page reference guide for the Living Choice Project.
4. Working with the staff of the Living Choice Project, design annual reports as required by the State of Oklahoma, the Congress of the United States for the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
5. Pay for duplication and production expenses related to all marketing and public relations materials.

The Living Choice Project Director prepared the invitation to bid and the bid was released upon the approval of the operational protocol. Once the invitation to bid was open, marketing and public relations firms had a minimum of two weeks to submit a bid. Once all completed bids were approved, the Living Choice Project Director convened a bid review team to review and score each bid submission. The marketing firm was selected and contracted by the end of December 2008. This marketing campaign promoted the Living Choice Project to the public and each of the target populations.

In order to effectively market the Living Choice Project, staff and the marketing contractor concentrated on four strategies: re-designing the Living Choice brochure, creating a Living Choice one page reference guide, designing an exhibit display and creating an annual report each year of the project. The statewide and targeted media campaigns continue to inform the public and targeted groups about the Living Choice Project.

A logo is critical to the identity of a project. The Living Choice logo is the project's unique presence in the mind of the public and what distinguishes it from other long-term care programs. Staff from the Communications division at the OHCA created a logo that is used consistently in building the identity of the Living Choice program. Along with this logo, staff from the OHCA Communications division did advise the marketing contractor on the graphic standards for all Living Choice marketing materials. These standards provided guidance for how and where the logo was used to ensure the consistent look of the Living Choice program identity.

Brochures are one of the most important printed pieces a program can use to communicate with the public. The Living Choice brochure has been professionally designed to reinforce the image of the project and to disseminate basic information about the program. Staff from the marketing or public relations firm has re-designed the Living Choice Project brochure to ensure that the message, image and effectiveness of the Living Choice project are communicated by the brochure. Staff from the marketing and or public relations firm has made suggestions to the Living Choice Project Director on how to make the brochure more dynamic. If necessary, staff from the marketing or public relations form will update or create new brochures that communicate the Living Choice image and appeal to each of the target populations.

The Living Choice project will be exploring the development of an expanded, booklet-type document that can be used for marketing to nurse facilities, transition coordination/case management agencies, families and loved ones of potential participants, and other sources of referrals that will provide a more holistic explanation of the Living Choice project. This booklet

will also include information on the waivers that participants can graduate into upon completion of the demonstration program as well as information on other state services.

Living Choice project staff will be visiting the major hospital groups in the State of Oklahoma to acquaint administrators, discharge planners, social workers, and other hospital staff with the Living Choice project and the waivers borne from it. These visits will help to ensure that when a Living choice participant or a waiver member enters their facility, they will know who to contact so that continuity of care is maintained.

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The OHCA website is designed to provide the most current information on the Living Choice Project members of the OHCA website team, the Living Choice Project Director and staff from Living Choice Project review the current OHCA website for content, graphics, readability and functionality. All Living Choice information on the OHCA website is accessible as required by the Oklahoma Electronic and Information Technology Accessibility Act. The process for updating the Living Choice project page on the OHCA website includes research and communication by the Living Choice Project Director, writing and editing website information and coordinating changes with the OHCA webmaster.

Media relations are the communication of various stories about participants in the Living Choice project to media outlets across Oklahoma. OHCA Office of Creative Media and Design (OCMD) staff continues to write and pitch stories to build public awareness of the issues that affect persons 19 years or older with disabilities or long-term illnesses. These stories will include the accomplishments of the Living Choice project. The Living Choice Project Director and the staff from the OHCA OCMD division work together to identify events, information and trends that will be of interest to the Oklahoma news media. OHCA Communications division staff develops the story angle and pitch each story to appropriate media outlets. OHCA Communications division staff also looks for news opportunities in areas of Oklahoma that lack news coverage about persons 19 years or older with disabilities or long-term illnesses.

OHCA Communications division staff has helped create a media kit to position Living Choice Project staff as subject matter experts on community based long-term care issues. Members of the media can contact both OHCA Communications staff and Living Choice staff for expertise and comments on long-term care news stories. The outcome of this outreach and marketing is to increase the visibility of the Living Choice project and highlight success stories of persons that have transitioned from institutions to their own homes in the community.

OHS-DDS staff uses the Living Choice brochures to disseminate information about the Living Choice Project to targeted disability advocacy groups, family members of residents of Greer, people with ID who are identified through the PASRR process and in need of community placement and residents/family members/guardians of private ICFs/IID. Marketing materials about the Living Choice Project include eligibility information and the benefits and services provided to individuals during the transition process.

Living Choice Project staff is also available to make presentations about the Living Choice Project at disability-related conferences statewide. Some of these conferences will include the OHS-DDS conferences and the State Conference on Aging.

Stakeholder Involvement

Purpose of the Living Choice Advisory Committee

Upon receipt of the grant award in January 2007, staff from the OHCA convened a Living Choice workgroup to assist in the development of the initial operational protocol. Following the hiring of the Living Choice Project Director in November 2007, staff at the OHCA recruited additional volunteers to serve on what would become the Living Choice Advisory Committee (LCAC). The OHCA Board convened the LCAC upon the approval of the initial version of the operational protocol. Several members of the LCAC advised the Living Choice Project Director and provided input and review of this revised operational protocol. The OHCA Board-recognized LCAC was in place by July 1, 2008. The LCAC's role includes advising and assisting the OHCA and its partner agencies in the design, development and implementation of the Living Choice program. Working within the structure of the board of the OHCA, the LCAC provides the consumer and family perspectives for the Living Choice Project.

Membership

Membership on the LCAC includes persons 19 years or older with disabilities or long-term illnesses; family members of persons with disabilities or long-term illnesses and representatives of the Living Choice Project partner agencies, local agencies, and non-profit agencies, as well as advocacy groups representing persons with disabilities or long-term illnesses. Membership on the LCAC includes not less than 50 percent representation of individuals with disabilities or long-term illnesses; parents or guardians of such individuals or immediate relatives or guardians of such individuals.

Each member has been encouraged to select one designee and only that designee may vote for the LCAC member during meetings. During the first LCAC meeting, each member notified the Living Choice Project staff of his or her designee.

The Living Choice Project staff recruits' members for the LCAC and trains LCAC members on the purpose of the LCAC and its advisory capacity for the Living Choice project. Since membership is voluntary, LCAC members know they serve through the end of the Living Choice Project. The following table lists the current and proposed members of the LCAC.

Table 1: Current members of the LCAC

Rose Ann Percival, Chair	The University of Oklahoma Health Sciences – Center for Learning and Leadership
	Consumer
	Oklahoma Healthy Aging Initiatives Network
	Oklahoma Department of Rehabilitation Services

Deborah Jenkins	Oklahoma Housing Finance Agency
	Oklahoma Dept. of Mental Health and Substance Abuse Services
	Oklahoma Dept. of Mental Health and Substance Abuse Services
	Oklahoma Durable Medical Equipment Reuse Program
	Oklahoma ABLE Tech
	Oklahoma Dept. of Human Services
	Oklahoma Dept. of Human Services OU Health and Science Center
	Oklahoma State Dept. of Health

Powers and Duties

The LCAC will engage in a variety of activities in order to achieve its purpose. The following are examples of activities that the LCAC shall undertake; however, these examples shall not constitute an exhaustive list. The LCAC, through its membership, shall:

- Monitor, review, and evaluate, not less than annually, the implementation of the Living Choice Project and suggest recommendations for action.
- Encourage and support effective coordination of activities and programs in home and community based long-term care for persons 19 years or older with disabilities or long-term illnesses.
- Recommend to the OHCA Board, other state agencies and legislators as appropriate, plans, policies, and procedures to develop effective and appropriate programs for persons 19 years or older with disabilities and/or long-term care needs.
- Study ways and means of promoting public awareness and understanding of disabilities and long-term illnesses; consider existing legislation and recommend changes and/or new laws affecting persons 19 years or older with disabilities or long-term illnesses.
- Endorse and support activities which will contribute to the goals and objectives of the Living Choice Project and the implementation of programs for persons 19 years or older with disabilities or long-term illnesses in Oklahoma.
- To the maximum extent feasible, review and comment on the Medicaid state plan and other programs within Oklahoma that relate to community based long-term care services affecting persons 19 years or older with disabilities or long-term illnesses.
- Provide a public forum for discussion of long-term care issues.

- Expand efforts to educate the public about home and community based long-term care issues and alternatives
- Establish work teams to address systems issues and barriers to community living for persons 19 years or older with disabilities or long-term illnesses
- Conduct an annual comprehensive review and analysis of Oklahoman's long-term health care services system and make recommendations to the OHCA board on how to improve the long-term health care services system

Scheduling and Conduct of LCAC Meetings

There shall be no fewer than four regularly scheduled meetings per federal fiscal year. In the case of justifiable delay, which is decided by the Living Choice Director, the meeting is held on the date, time and place designated by the Living Choice Project Director, as chosen by the membership of the LCAC.

- Prior notice of the meeting is made through the appropriate media.
- Reminders of meeting dates shall be provided at least two weeks in advance of each LCAC meeting and shall include a proposed agenda and supporting materials for that meeting.
- All LCAC meetings, including potential work team meetings shall be open and accessible to the public.
- Special meetings of the LCAC may be called by the Living Choice Project Director in consultation with the Director of the Long-Term Care Services and Supports division.

Members of the LCAC are expected to attend all scheduled meetings of the full LCAC and all relevant work team meetings. LCAC members are also expected to participate to the maximum extent feasible in other special meetings, ad hoc committee meetings, and grant review teams.

LCAC members are required to sign in at LCAC meetings. Attendance information shall be compiled and provided in each LCAC agenda package. An excused absence is one in which notification is received by phone or in writing by Living Choice Project Administrative Assistant or the Living Choice Project Director in advance of the meeting in question.

Reimbursement of Expenses Associated with Participation

LCAC members shall not be compensated for their services; however, necessary expenses incurred by LCAC members in performance of their LCAC duties shall be reimbursed in accordance with the requirements of Oklahoma travel regulations and OHCA rules. Expenses for childcare and personal care attendants may be reimbursed at appropriate rates negotiated by the providers and Living Choice project staff.

LCAC members shall be provided with updated copies of the Oklahoma travel regulations annually.

Benefits and Services within the Demonstration

Individuals in each target population will enter the Living Choice Project demonstration on the first day of their discharge from to the institution to the community through the end of the first year of their transition. Day one for a Living Choice participant will be the date of their transition

into the community. On day 366, individuals will move from the Living Choice project demonstration into one of the homes and community-based waivers or state plan services.

The Living Choice project will consist of a different mix of services for each population. Each person transitioned from an institution through the Living Choice project will have access to the following home and community-based services:

- Behavioral health and substance abuse services (outpatient)
- Case management services
- Durable medical equipment and supplies
- Home health services
- Medical supplies and equipment
- Personal care services
- Physician services, including preventive services
- Transportation services
- Respite care
- Adult day health care
- Environmental modifications
- Advanced supportive/restorative assistance
- Skilled nursing
- Prescription drugs
- Home delivered meals
- Therapy services including physical, occupational, speech, and respiratory
- Hospice care
- Personal emergency response system (PERS)
- Self-direction
- Assisted living facility services
- Private Duty Nursing
- Community transition (up to $2,400)

Through the Living Choice Project, Oklahoma is not seeking an enhanced federal matching assistance percentage for home and community-based state plan services

Living Choice Project Services

The following table lists each of the services in the Living Choice project, the billable units and rate to be paid for home and community-based services (HCBS) and demonstration services for each target population in the Living Choice project. The Living Choice project will not have any supplemental services.

Table 2: Services available in the Living Choice demonstration project (qualified and demo)

Living Choice Project					
Waiver Services	**Unit of Service**	**Unit Rate**	**Service Code**	**Modifier 1**	**Modifier 2**
Adult Day Health	15 minutes	$1.97	S5100	–	–
Advanced Supportive/Restorative	15 minutes	$4.57	T1019	TF	–
Community Transition	–	–	T2038	–	–
Direct Skilled Nursing – LPN	15 minutes	$14.61	G0300	–	–
Direct Skilled Nursing – RN	15 minutes	$14.61	G0299	–	–
Environmental Modifications	As Billed	As Prior Authorized	S5165	–	–
Home Delivered Meals	1 meal	$5.41	S5170	–	–
Hospice	1 day	$128.80	S9126	–	–
In-Home Extended Respite (8+hrs)	1 day	$179.40	S9125	–	–
In-home Respite (2 - 7 hrs)	15 minutes	$4.24	T1005	–	–
Institutional Transitional Coordination – S	15 minutes	$15.41	T1016 – S	U7	–
Institutional Transitional Coordination – VR	15 minutes	$22.06	T1016 – VR	TN	U7
NF Extended Respite (8+hrs)	1 day	As Prior Authorized	UB120	–	–
Personal Care	15 minutes	$4.24	T1019	–	–
Personal Care In Adult Day Health	1 session/day	$7.88	S5105	–	–
Personal Emergency Response System – Install	1 time	As Prior Authorized	S5160	–	–
Personal Emergency Response System – monthly	Monthly	As Prior Authorized	S5161	–	–
Prescriptions (maximum of 7 units only)	As Ordered	Avg. $76.40 each	W1111	–	–
Private Duty Nursing	15 minutes	$8.17	T1000	–	–
RN Assessment/Evaluation	15 minutes	$14.61	T1002	–	–
Specialized Medical Equipment and Supplies	As Billed	As Prior Authorized	HCPCS	–	–
Transition Coordination – S	15 minutes	$15.41	T1016	–	–
Transition Coordination – VR	15 minutes	$22.06	T1016	TN	–
THERAPY SERVICES:					
Occupational Therapy	15 minutes	$21.63	G0152	–	–
Physical Therapy	15 minutes	$21.63	G0151	–	–
Respiratory Therapy	15 minutes	$14.87	G0237	–	–
Speech/Language Therapy	15 minutes	$21.63	G0153	–	–
Therapy in Adult Day Health	1 session/day	$10.50	S5105	TG	–

SELF-DIRECTION SERVICES:					
Advanced Supportive/Restorative	15 minutes	$4.57	T1019	TF	–
Good and Services	Varied	Manual	T1999	–	–
In-Home Extended Respite (8+hrs)	1 day	$179.40	S9125	–	–
In-home Respite (2 - 7 hrs)	15 minutes	$4.24	T1005	–	–
Personal Care	15 minutes	$4.24	T1019	–	–
Assisted Living Low (Tier 1)	1 day	$49.33	T2031	–	–
Assisted Living Medium (Tier 2)	1 day	$66.57	T2031	TF	–
Assisted Living High (Tier 3)	1 day	$93.11	T2031	TG	–
INCONTINENCE SUPPLIES :					
Adult Small Brief	Each	$.80	T4521	-	-
Adult Medium Brief	Each	$.88	T4522	-	-
Adult Large Brief	Each	$.99	T4523	-	-
Adult Extra Large Brief	Each	$1.16	T4524	-	-
Adult Small Underwear	Each	$.89	T4525	-	-
Adult Medium Underwear	Each	$1.04	T4526	-	-
Adult Large Underwear	Each	$1.13	T4527	-	-
Adult Extra Large Underwear	Each	$1.29	T4528	-	-
Disposable/Guard Liner	Each	$.61	T4535	-	-
Any Size Reusuable Underpad	Each	$13.91	T4537	-	-
Chair Size Resuable Underpad	Each	$14.83	T4540	-	-
Large Disposable Underpad	Each	$.60	T4541	-	-
Small Disposable Underpad	Each	$.39	T4542	-	-
Medicaid State Plan Personal Care Program					
Prescriptions (maximum of 6 units only)	As Ordered	Avg. $76.40 each	S1111	–	–
Medicare					
Medicare Part D Prescriptions	As Ordered	Avg. $76.40 each	M1111	–	–

Legend: Services indicated as "HCBS" are currently offered through the home and community-based waivers. Services indicated as "demo" are HCBS services that will be categorized as demonstration services through the Living Choice Project.

Consumer Supports

Educational Materials

Upon the initial referral to the Living Choice project, participants will receive program materials explaining the eligibility, benefits and emergency support services available to participants in the Living Choice project. Once an individual agrees to participate in the transition to the community, the individual will receive information on the specific services available.

Service Plan Authorization

Each participant's transition plan and transition plan amendments are reviewed by Living Choice staff prior to authorization. The staff reviews every participant's transition plan and other required documentation. Living Choice works with a clinical liaison from OHCA to review the final community care plan granting approval to the prior authorizations placed on the OHCA Medicaid Management Information System (MMIS) for the participant's services. The transition coordinator is notified when approval has been received.

Transition Coordinators

The OHCA, in partnership with home health provider agencies will develop a comprehensive system of workforce development for the Living Choice project. This system of workforce development will include trainings in transition coordination, nursing facility transition, self-direction and the independent living philosophy. These trainings will also be available to case managers in the AD*vantage* waiver. Transition coordinators in the Living Choice project must complete these competency-based trainings in order to be certified as transition coordinators in the Living Choice project.

Transition coordinators will complete an orientation to the Living Choice project. Prior to working with participants in the Living Choice project transition coordinators who have not completed AD*vantage* case management training must be trained in the following areas: recognition of abuse, neglect and exploitation and required reporting and monitoring of suspected incidents.

For the Living Choice project, transition coordinators will develop the transition plan and monitor the plan during an individual's first year of the transition. Living Choice providers of case management transition coordination services must meet the following certification requirements:

1. Completion of case management training with the AD*vantage* waiver or an approved certification/training by the Oklahoma Health Care Authority; and
2. Completion of the curriculum requirements for a bachelor's degree and one year paid professional experience in aging or disability populations; or
3. Completion of a degree program as a registered nurse or licensed practical nurse and one year paid professional experience; or
4. Have at least two years paid work experience as an independent living specialist or transition specialist, or the educational equivalent, at one of the five federally recognized Centers for Independent Living in Oklahoma; and
5. Successfully complete the Living Choice Project transition coordinator training.

Case Management for Persons with intellectual disabilities

Service Plan Authorization

Case management staff at the OHS-DDS will develop a plan of care including transition-related services for persons with intellectual disabilities transitioning through the Living Choice project. This process is identical to the existing process of transitioning persons with intellectual disabilities into a residential placement. Case managers at the OHS-DDS will develop a plan of care that requests prior authorization for the service plans for individuals with intellectual disabilities transitioning through the Living Choice project. These plans of care will be prior authorized and reviewed by State Office staff at OHS-DDS.

Transition coordination

Persons with intellectual disabilities will receive the same transition planning services that exist within the Community waiver for persons with intellectual disabilities. Case managers in the Community waiver are employees of OHS-DDS and will complete all activities related to the transition of persons with intellectual disabilities from public ICFs/IID. It is expected that case managers for persons with intellectual disabilities who are transitioning from one of the public ICFs/IID will have an average caseload of 25 individuals with intellectual disabilities.

Transition coordinators

The OHS-DDS service delivery system within the Living Choice project will use case managers as transition coordinators. Case managers (with assistance from other OHS-DDS staff) will coordinate all aspects of transition for persons with intellectual disabilities. Other staff will assist the case manager and work to ensure all identified supports are in place to meet the needs of the Living Choice member prior to transition.

24-Hour Back-up Plans

During the transition planning process, case managers will develop back-up plans for the members.

In the case of an emergency, all members are advised to call the 9-1-1 emergency system. Participants in the Living Choice project will learn how to use 9-1-1 appropriately for serious medical emergencies.

The first level of the back-up plan is the system provided by each provider agency. Should the personal care attendant not show up at the scheduled time to assist the participant, then the participant is instructed to call the case management agencies scheduler number. The participant reports that the personal care attendant didn't show up and request that a substitute be sent as soon as possible.

The second level of the back-up plan is to contact the participant's informal support. If no informal support is available, the case manager will work with them to find someone to help.

The third level of the back-up plan is Oklahoma 2-1-1. 2-1-1 is available to everyone throughout the state and is an easy number to remember. 2-1-1 is free and provides a confidential resource 24 hours/7 days a week. 2-1-1 helps deliver services more efficiently by pinpointing what kind of services are needed and where. 2-1-1 has proven itself to be an invaluable resource in many situations.

Monitoring 24-Hour Back-up Plan

A series of processes and procedures are followed to monitor the participant's backup plan and mitigate any issues should the backup plan fail. For instance, Quality visits with a systematic structure that calls for our Case Managers to submit monthly Progress/Monitoring Reports are additional ways in which back-up plans are monitored. The Living Choice staff reviews the monthly reports and should any issues arise, additional documentation is requested to ensure the health and safety of the member. If there is a need for the Living Choice Staff to intervene, a Quality Visit is performed along with action plans to help address risk or failed back up plan measures. Should the back-up plan need revising to make suitable for the Living Choice Participant, that option would be explored at that time.

Direct Service Workers

Home and community based residential provider agencies are required to provide the services authorized in the participant's transition plan. The residential provider agency may utilize an alternative direct support worker to prevent a lapse in service. Back up plans addressing how the individual can continue to have their care needs met in their direct care workers absence are required for each transition plan.

Individuals in the Living Choice project who self-direct their care will also utilize the three level back up system to assure uninterrupted service. These services may be provided by friends, relatives or other arrangements. Direct support workers have safeguards that are established through specific personnel requirements such as criminal background checks and Health Information Portability and Accountability Act (HIPAA) confidentiality requirements. The residential provider agency is required to have policies and procedures addressing these requirements.

As a condition of participation in the Living Choice project, provider agencies must have 24-hour notification systems in place that can address issues specific to the services each agency provides to participants in the Living Choice project. Additionally, each participant in the Living Choice project will include a back-up plan in his or her transition plan. This back-up plan will include the risks faced by the individual and the necessary actions to be taken to prevent risks. Each back-up plan will include how staff will respond in each type of emergency.

Each home care and residential provider agency in the Living Choice project must provide staff in accordance with an individual's needs as identified in the individual's transition plan. If staff are assigned but do not show up for work, the participant may call their transition coordinator and report the issue. In the event that a back-up worker is unavailable due to unforeseen circumstances, the individual may have to rely on his or her network of informal supports to provide the care until a replacement direct service worker is available.

Older persons with disabilities or long-term illness and persons with physical disabilities who

require more supportive services will have access to enhanced personal emergency response services (PERS) with the Living Choice project. The PERS will enable an older person with a disability or long-term illness or a person with a physical disability the opportunity to press a button in an emergency and speak with a person who can address particular emergency situations.

The OHCA, as the lead agency, will establish policies that will provide for the protection of rights and for the health and safety of individuals participating in the Living Choice Project. As the lead agency, the OHCA will require each partner agency to ensure that its policies and procedures also protect the rights of and support the health and safety of individuals participating in the Living Choice Project.

Older persons and persons with physical disabilities who choose to self-direct their services will have back up plans developed with the assistance of their transition planning team as part of their individual transition plan. The back-up plan identifies roles for the individual's informal supports, friends and relatives, as well as other services and resources available. A minimum of four levels of back-up is recommended to build depth to the plan.

Transportation

Older persons with disabilities or long-term illness and persons with physical disabilities who have home and community-based services are able to access transportation to medical appointments through the state sponsored Sooner Ride Program. The individual may access this service with a toll-free number and schedule it as the need dictates. The transition coordinator is responsible for providing assistance with access to the Sooner Ride program as necessary. There is specialized transportation available for those participants who need wheelchair accessible vans. Oklahoma also has limited local transportation systems which may be used for non-medical needs. Living Choice participants will have access to both medical and non-medical transportation services. The transition coordinator will provide the individual with the necessary information on how to access the transportation services. Through the Living Choice project, non-emergency transportation will be expanded, including but not limited to taxi services, public transit services, and other modes of transportation available in the individual's community.

Access to Medical Care

Older persons and persons with physical disabilities in the Living Choice project will have access to necessary health care as needed through their Medicare benefit or through SoonerCare. The transition coordinator will be responsible for assuring the initial post transition appointments are coordinated with the individual, appropriate family members and physician. The transition coordinator will utilize these initial appointments as opportunities to evaluate and assess the individual's abilities to assume this responsibility and will revise the transition plan, if needed. Support from family members will be utilized, as appropriate, to assist in this process.

Medical Equipment

Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are being made): Many of the participants – both those with physical disabilities and those who are older persons (elderly) – in the Living Choice Project are dual eligible (they have both Medicare and Medicaid). Those participants with Medicare will be encouraged and assisted by their transition coordinators to seek repair or replacement of their durable medical and other equipment through Medicare first. In the event that Medicare cannot or will not pay, or the participant has only Medicaid, then the transition coordinator will contact the vendor about the cost of repair, the length of time the repair will take, and the means of having the item picked up for repair. The transition coordinator will also work with the vendor to obtain a loaner piece of equipment. An addendum will be submitted by the transition coordinator for up to three months of service time for the cost of a loaner piece of equipment using the DME equipment code with the appropriate modifier (LL) so that a prior authorization can be created on Oklahoma's MMIS. Prior authorization will require a physician prescription, so Living Choice team can process the prior authorization.

The Oklahoma Durable Medical Equipment Reuse Program – jointly operated by the OHCA and Oklahoma ABLE Tech – began April 2012. The program is available to all SoonerCare participants, including members of The Living Choice Program. Equipment will be provided for free. The equipment provided will come from a pool of gently used and refurbished medical equipment donated by residents of Oklahoma who no longer need the equipment. Those who wish to donate items will fill out a questionnaire that will help to determine if the item can be refurbished for further use. If it can be refurbished, then the item will be picked up from the person's home. Examples of equipment needed for the program include communication devices, CPAP machines, gait trainers, nebulizers, quad canes, shower chairs, walkers, bath benches, bedside commodes, patient lifts, standers, hospital beds, wheelchairs and scooters.

Health Management

Population care management at the OHCA are available to assist Living Choice participants with complex health needs. The population care management may assist the participant with accessing specialty health care and related services. If necessary, population care management may assist in the transition planning process for individuals with complex health needs.

In addition, all residential provider agencies are required to have a policy and procedure detailing their complaint and resolution process and provide this information to the individual. Individuals participating in the Living Choice project also have access to the OHCA member service toll-free number 888-287-2443.

In the event that a participant is denied any service they may request a hearing through the OHCA. At the hearing, the individual will have the opportunity to express his or her concerns to the hearing officer. The individual may be represented by counsel if they desire.

Direct Support Workers

For individuals that receive 24-hour residential support services, the residential provider agency is responsible for the provision of direct care services to individuals served within the Living Choice Project. The provider agency must be notified when required staff is not present for

work. The program coordinator is responsible for finding a replacement direct support worker. If the program coordinator cannot find a replacement direct support worker, then he or she must provide the care until a direct support worker can be located.

In the event that the program coordinator is not available, the individual has access to the 24 hour on-call supervisor in his or her area. The on-call supervisor has the authority to approve emergency residential care services. For individuals without 24-hour residential support services, the program coordinator of the residential provider agency is responsible for providing back-up direct support workers. Upon request by the member, natural supports may be used if available. If the program coordinator is unable to locate replacement staff, then the individual's natural supports from friends or family members may be used to care for the individual. If the event is a medical emergency, then the individual should access 911 for emergency services.

Medical Equipment

Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are being made): The appropriate funding source will be used for the repair or replacement of durable medical or other equipment. All medical equipment purchased through Medicaid funds must have a warranty and any repairs to the equipment may be subject to this warranty from the manufacturer. The case manager at OHS-DDS is responsible for assuring that a prior authorization is issued for a repair to medical equipment. The case manager will ensure that any prior equipment purchases that have been made for the individual while he or she was a resident of the ICF/ ID are discharged with the individual in the Living Choice project. The OHS-DDS case manager also has access to surplus medical equipment through each of the OHS-DDS area offices.

Self-Direction

Overview and Background of Self-Direction

Self-direction in the context of home and community based long-term care services is designed to give individuals 19 years or older with disabilities or long-term illnesses more choices and greater control over the purchase of the home and community-based services they receive. In a true self-directed service delivery model, an individual budget is designed with the individual during the person-centered planning process. The individual is able to purchase the services he or she needs with much more flexibility than traditional models in which funds flow from the Medicaid agency to a traditional home and community-based service provider agency. Using a self-directed approach, the individual has the right to make decisions about his or her personal assistance services while directing and controlling these services.

Self-direction as a model of service delivery has its roots in the independent living movement that promotes the autonomy and self-determination of individuals with disabilities.

Self-direction in Oklahoma is available as a service option in the AD*vantage* waiver and in the OHS-DDS Community Waiver and In-Home Supports Waivers for children and adults. Self-direction for older persons with disabilities or long-term illnesses and persons with physical disabilities became available in November 2012 with full implementation in Living Choice by July 2013 based on the agency's rulemaking and implementation processes. To this end, this

operational protocol indicates three models of self-direction that will be used for individuals with physical disabilities transitioning to the community through the Living Choice project.

Older Person with a Disability or Long-term Illness

Personal care has been offered as part of Oklahoma's Medicaid State Plan Program since 1970. The Individual Personal Care Service model has continued to be an option for individuals who choose to take responsibility for recruiting, hiring, and managing their personal care attendant (PCA), but not employer responsibilities related to payment of services. Payment to the PCA is made by OHCA when the PCA submits the necessary documentation of services delivered to the individual.

When the home and community based 1915(c) waiver for older persons and persons with physical disabilities was implemented in 1995, an Agency Model of State Plan Personal Assistance Services was created. In the Agency Model, it is expected that individuals participate in the care planning process and self-direct to the extent they wish, but the residential provider agency is responsible for all employer responsibilities related to the personal care service.

In 2005, the Oklahoma Legislature enacted the Oklahoma Self-Directed Care Act. This legislation directed the OHCA to establish a self-directed care program based on the principles of consumer choice and control. Through a Real Choice System Change grant, Oklahoma organized a partnership of consumer consultants and grant partners to participate in the planning of Consumer-Directed Personal Assistant Supports and Services (CD-PASS). CD-PASS was designed and implemented as a pilot in the Tulsa metropolitan area and has been chosen as the personal care service delivery model by more than 200 individuals who reside in the pilot area.

Experience gained with CD-PASS and the Individual Personal Care Service models will provide the opportunity in the Living Choice project to blend the most favorable outcomes of both into an improved self-directed model. For example, the more involved employer related responsibilities in CD-PASS and the more efficient financial management services in the individual personal care service will be included in the expanded CD-PASS model to be implemented in the Living Choice project.

This new model will be designed to allow for a range of self-directed opportunities from which the individual can choose and have responsibility for the choices and decisions that are made while working within a specified budget. This model of self-direction will provide the opportunity for participants in the Living Choice project to assume and retain responsibility for recruiting, hiring, training, and managing their service providers, and have the authority and freedom to plan their own lives and to make choices of what and how services are to be delivered. The resulting infrastructure that will be built will allow for a "cash and counseling" type of model to be considered in the future.

For self-directed services to be successful, the philosophy of self-determination and self-direction must be fully integrated into the service delivery system. The Living Choice project will provide Oklahoma with opportunities to integrate self-direction in the entire consumer experience in home and community-based services to the extent each individual wishes and will not be dependent on whether the care is delivered by residential provider agency employees or managed by the individual.

The OHCA fiscal agent contractor will be responsible for the following services:

- Monthly Statements - The contractor must provide monthly statements to the OHCA and each participant detailing the number of hours used per employee, summary of total hours used to total hours authorized per year and optional expense account status.
- Payroll Data comparison - The OHCA will receive aggregate payroll data that is compared to data in the Waiver Management Information System and claims data.
- Invoice Review - The monthly invoice received from the contractor is also reviewed prior to payment to assure only active CD-PASS members or persons with physical disabilities who choose the self-direction option are listed.

Further development of person-centered planning with self-direction principles will be accomplished and related training and ongoing learning opportunities will be delivered to individuals, their authorized representatives, and residential provider agencies. Peer counseling will be available for older persons with disabilities or long-term illnesses and persons with physical disabilities through the CILs. Peer counseling is a core service provided by each of the CIL partner agencies and will augment other services provided in the Living Choice project.

Members will have the option to self-direct their services through the Living Choice project. During the transition planning process, the transition planning team will assist the individual to determine the level of self-direction he or she may want while participating in the Living Choice project. During this process, transition coordinators will provide information and assistance to individuals with physical disabilities in order to facilitate the self-directed experience. Additionally, transition coordinators and other transition team members will assist the individual with managing an individual budget and complying with employment/payroll tasks that will be associated with self-direction.

Members will have the option to determine which level of self-direction (if any) is most appropriate for his or her living situation. The individual may select from one of the following models of service planning and provision.

Person with Intellectual Disabilities

Opportunities for self-direction will be available to persons with intellectual disabilities in the Living Choice project. In Oklahoma, persons with intellectual disabilities in the Community waiver have the opportunity to self-direct their goods and services as well as a habilitation service. All persons with intellectual disabilities transitioning as a result of the Living Choice project will enroll in the Community waiver on day 366. The demonstration services available to these individuals are equivalent to those on the Community waiver, so they will have the same opportunity to self-direct once they receive Community waiver services.
Table 3: Living Choice models of self-directed service provision

Self-direction	**Self-direction with supports**	**Agency direction service model (individual may be the co-employer)**

Individual is the employer of record	Individual with a disability is the employer of record	Either the agency or the individual is the employer of record
Individual makes all decisions including hiring, training and scheduling of personal attendants	Individuals shares responsibilities with others such as an advocate or agency. Individual directs some components of personal attendant services	Agency hires, trains and schedules the personal attendants with input from the participant
Individual has primary responsibility for his or her own back-up personal attendants while the OHCA must safeguard the health and welfare of participants	Individual (along with an advocate or an agency) are responsible for back up personal attendants.	Agency is responsible for providing services and back up personal attendants with input from the individual.
Individual has primary responsibility for checking personal and employment references. The fiscal agent contracted with the OHCA will verify provider qualifications.	Individual and their advocate or agency are responsible for checking references. Individual may contract with an agency for this service.	Agency is responsible for checking references and background checks with input from the individual.
Individual understands the budgeting process and leads in the development of the budget	Individual and their advocate or agency are responsible for developing the budget	Individual, team members and agency representatives share responsibility for budget development

Regardless of which model is selected, the transition coordinator and the individual will review the risks, added responsibilities, and liabilities of each model of supports and services. Once a service plan approach is selected, the transition coordinator will explain the service planning process for that service plan model. If self-direction or self-direction with supports is chosen, the individual and his or her transition coordinator will collaborate with the OHCA to establish an individual budget with the fiscal agent.

If individuals require training to fully self-direct their care, the transition coordinator in conjunction with the states' Fiscal Management Service Agent (FMS) will work with the individual and family to ensure that they are properly trained on the self-direction program. The individual must be able to exercise responsibility in making choices about the level of supports and services necessary to live in the community. The individual must also understand the impact of the decisions that he or she makes and assume responsibility for the results of these choices. By choosing self-direction or self-direction with supports, the individual assumes some responsibility for the hiring, training, monitoring, and training of direct support professionals. The individual must also ensure that the direct support professional work times follow the approved service plan and that all services on the plan of care are received. The following is a list of services that must be performed by the individual, his or her legal guardian, or his or her advocate:

- Recruit direct support professionals and back-up support staff
- Collect basic information for maintaining an employment file for each direct support professional. This file must also contain an application for employment.

- Select direct support professionals, assign hours within the limits of the service authorization and refer them to the payroll agent for registration
- Maintain the level of services in accordance with the plan of care. This activity also includes assigning replacement direct support professionals during absences of the assigned direct support professional
- Dismiss the direct support professional when necessary and inform the provider or payroll agent of the termination
- Training each direct support professional on the specific duties involved in providing care
- Maintain time sheets on each direct support professional working with the individual, verify hours worked and forward documentation to the payroll agent
- Notify his or her transition coordinator of any changes in his or her specific condition or needs which affect the provision of services, such as hospitalizations or need for additional hours of service
- Notify all providers if there is a desire to discontinue the option to self-direct their services

The individual, the transition coordinator, and his or her transition planning team will develop the transition plan based on the individual's strengths, assets, and goals. To assist with transition plan development, team members will review the individuals UCAT and determine the intensity, frequency, and duration of supports and services needed. For every goal that is developed, the transition panning team assists the individual with writing the steps associated with achieving each goal and the organizations or individuals that will be available to assist with achieving the goals.

Termination of Self-Direction

Members with physical disabilities may voluntarily terminate any services at any time including self-directed personal care services and self-directed supports and services. Members and case managers with additional training in self-direction will assist individuals with termination of self-directed personal care and replacement with the residential provider agency model of personal care service. The case managers will assist the member with termination of self-direction or self-direction with supports.

Involuntary termination of individual personal care services may occur if it is determined the individual can no longer effectively self-direct their personal care and their health and welfare is compromised and/or the individual does not have an authorized representative who can assume these responsibilities on the individual's behalf. Involuntary termination will also occur if there is evidence of fraudulent behavior by the individual. Members may voluntarily terminate any services at any time including self-directed personal care services and self-directed supports and services. For older persons with disabilities or long-term illnesses, the Consumer Directed Agent (CDA) who is a transition coordinator, with additional training in self-direction, assists individuals with termination of self-directed personal care and replacement with the residential provider agency model of personal care service. For persons with physical disabilities, the transition coordinator will assist the individual with termination of self-direction or self-direction with supports.

Members will be able to transition to services with a provider agency because the transition coordinator will link participants to provider agencies that are able to address their needs.

Quality Improvement Strategy

The Living Choice project will build upon the existing Quality Improvement Strategy detailed in the Home and Community-Based Waivers (HCBS); however, for the Living Choice demonstration the Level of Care for participants has already been established as verified in this protocol that states participants must meet the institutional stay requirement of 60 days in a qualified nursing facility with one day paid by state Medicaid. The Living Choice Project will incorporate the following CMS waiver assurances as indicated in the other HCBS waivers:

- Service Plan
- Qualified Providers
- Health and Welfare
- Financial Accountability
- Administrative Authority

The OHCA will include a quality framework into the design of the quality management system. Major components of the quality management program will include:

- Design: building quality into the design of the system of services and supports in HCBS through checks and balances and fail-safe systems design
- Discovery: employing various methods of obtaining current information about the consumers, providers, stakeholders, and the serviced delivery system
- Remediation: using mechanisms to identify and correct deficiencies and prevent future occurrences; and
- Systems Improvement: analyzing information to identify patterns and trends to proactively address system issues.

As the lead agency in the Living Choice project, the OHCA assures that all participants in the Living Choice project will receive the level of quality improvement activities as utilized in the HCBS Waiver programs.

The Living Choice project will utilize the quality framework outlined in Appendix H in the Application for a home and community-based waiver, version 3.5. At the conclusion of the Living Choice demonstration project, there will be continued growth in the use of home and community-based services for long term care. Enhancements will include merging existing systems, provider partners, service lines and products into an integrated and comprehensive quality management system for community based long-term support services for Oklahoma's long term care system. The quality improvement strategy was adopted by the Long-Term Care Quality Initiatives Council (LTCQIC) in March 2011 and approved by CMS.

New services in The Living Choice project include case managers, community transition services, and agency companion for members. The Living Choice project is an ideal opportunity to build upon the existing foundation as we move the long-term care system from its current state to a national model of access, cost and quality for older persons and persons with physical disabilities providing quality, consumer driven, and cost-effective services in the setting of consumers' choice.

Sampling Methodology

Oklahoma's Living Choice project currently faces a resource issue in terms of personnel and seeks to reduce the number of resources being used by revising its data collection methods. We propose to utilize the data collection of other divisions within the State Medicaid agency.

For the Qualified Provider assurance, and specifically, Oklahoma's performance measures QP 1.2 and QP 2.2, we will use the data collected by the Medicaid Enrollment unit to meeting initial licensure, certification, or waiver requirements. Simply put, one unit (i.e., Medicaid Enrollment unit) can collect and supply the data on all Medicaid enrolled providers meeting initial requirements for all programs, Living Choice and across the waivers operated by the OHCA. Thus, each program doesn't have to separately collect its own data.

Oklahoma is also going to combine operating and monitoring processes. For our performance measure HW 1.4 there is the potential to reduce data collection resources by adding the data collection of this performance measure to the service authorization process during the service plan development phase of the Living Choice project. In addition to the saved resources in data collection, it provides the added opportunity to identify proactively any Living Choice participant who has not received the abuse, neglect, and exploitation education.

The Living Choice project is going to utilize the Member Experience Survey (see below) to support the data collection for the SP 4.1 performance measure. By using both the performance review results and the responses obtained on the Member Experience Survey, a more comprehensive approach can be achieved to give a more accurate estimate of compliance. Data for the SP 4.1 is currently collected using a combination of monthly reviews, comparison of the service plans, and a review of the progress notes for each participant.

Because the waivers currently sample at 100% of member participation and previous performance reviews of agencies providing transition coordination and personal care services have consistently met the 95% confidence level, Living Choice is proposing that we be allowed to sample our participants at a 20% level. Living Choice believes this level will provide a quality measurement without losing any data fidelity.

Member Experience Survey

During the LCAC's review process, a proposal was made to create and implement a member experience survey to serve as a voice for participants who are living in the community and receiving services through the Living Choice project. The experience survey will also be used to establish a baseline of information upon which future performance reviews can be built. It was also determined that this initial survey would focus on provider agencies that provide transition coordination and home health services to Living Choice participants. This survey serves as a corollary document to the performance reviews conducted by the Living Choice project focusing on these two areas. It also functions as a secondary data source for the SP 4.1 performance measure. A copy of this member experience survey is attached as Appendix F.

The information obtained through this survey will be used to improve training with the Living Choice project transition coordinators and to assist the home health agencies providing PCAs with improving their processes for serving the participants using a best practices model.

Housing

Case managers in the Living Choice project will assist all individuals in finding an affordable qualified community residence. During the transition planning process, each case manager will inform the participant that they must reside in a qualified community residence to qualify for the Living Choice Project. Each transition case manager will document the individual's choice in the Individual Transition Plan.

Housing officials at the Oklahoma City Housing Authority (OCHA) have set aside housing vouchers each year for individuals transitioning from institutions to the community. These vouchers will be accessed by case managers working with Living Choice members to obtain housing vouchers for persons transitioning from nursing facilities to the community.

The Oklahoma Housing Finance Agency (OHFA) has partnered with the Living Choice Project to make available housing choice vouchers for members transitioning back to their communities throughout Oklahoma. These vouchers were available beginning on October 10, 2012. Case managers serving Oklahoma citizens participating in Living Choice and waiting on housing were made aware of these vouchers and strongly encouraged to begin applying for them on behalf of the participants they serve. Effective 2019, OHCA has contracted with OHFA to provide a staff resource for the Living Choice program who will continue to assist members of The Living Choice program in finding affordable housing options for transitioning members.

Living Choice has also received information from the Choctaw Nation Tribal Housing Authority that many of the projects it operates in Eastern and Southern Oklahoma are open to participants, including those who are not members of federally recognized tribes or nations enjoying sovereign nation status in Oklahoma. These sites are in Idabel, Hugo, Talihina, Calera, Hartshorne, and Poteau, Oklahoma. They comprise the Independent Elderly Housing Program of the Choctaw Nation.

Oklahoma has a variety of housing programs that will benefit individuals of all targeted populations in the Living Choice project. Several programs in Oklahoma focus on increasing the number of homeowners in Oklahoma and creating stable, livable communities within Oklahoma. Yearly, OHFA conducts a statewide affordable housing market study to determine the number of available units in each county.

To access federal housing assistance, an individual must first demonstrate need and complete an evaluation to determine if he or she is eligible for each program. Each of the housing programs listed in this operational protocol satisfy the requirements for a "qualified community residence" within the Money Follows the Person grant solicitation.

Affordable Home Ownership Opportunities for People with Disabilities

The Affordable Home Ownership Opportunities People with Disabilities (AHOOPD) program is based on the national "Home of Your Own" program. Individuals with disabilities who wish to own their own homes may access housing programs provided by local community action agencies and local community-based housing development organizations (CHDO's). The Affordable Home Ownership Opportunities for People with Disabilities (AHOOPD) Program is available through seven CHDO's statewide. Staff at each of the CHDO's will provide homebuyer education specific to the needs and capabilities of individuals with disabilities. Additionally, staff will assist the individual with a disability in determining the appropriate loan products and down payment assistance program for which he or she may qualify.
Staff at each of the CHDO's has expertise in facilitating home ownership for individuals with

disabilities. The AHOOPD program is available at the following community action agencies in the State of Oklahoma:

Big Five Community Services	Durant	Bryan, Carter, Coal, Love, and Pontotoc Counties
Community Action Agency of Oklahoma City and Oklahoma / Canadian Counties	Oklahoma City	Oklahoma and Canadian Counties
Community Action Development Corporation	Frederick	Beckham, Cotton, Jefferson, Kiowa, Roger Mills, Tillman, and Washita Counties
Community Action Resource and Development, Inc.	Claremore	Mayes, Rogers, Nowata, Wagoner, and Washington Counties
Community Development Support Association	Enid	Garfield and Grant Counties
Deep Fork Community Action Foundation	Okmulgee	McIntosh, Hughes, Okfuskee, and Okmulgee Counties
Delta Community Action Foundation	Lindsay	Garvin, McClain, and Stephens Counties
Great Plains Improvement Foundation	Lawton	Comanche County
INCA Community Services	Tishomingo	Atoka, Johnston, Marshall, and Murray Counties
KI BOIS Community Action Foundation	Stigler	Haskell, Latimer, Leflore, and Pittsburg Counties
Little Dixie Community Action Agency	Hugo	Choctaw, McCurtain, and Pushmataha Counties
Muskogee County Community Action Foundation	Muskogee	Muskogee County
Northeast Oklahoma Community Action Agency	Jay	Craig, Delaware, and Ottawa Counties
Opportunities, Inc.	Watonga	Alfalfa, Beaver, Blaine, Cimarron, Custer, Dewey, Ellis, Harper, Kingfisher, Major, Texas, Woods, and Woodward Counties
Southwest Oklahoma Community Action Group	Altus	Greer, Harmon, and Jackson Counties
United Community Action Program	Pawnee	Creek, Kay, Noble, Osage, and Pawnee Counties
Washita Valley Community Action Council	Chickasha	Grady and Caddo Counties

Figure 3: Community Housing Development Organizations Service Areas

Completion of homebuyer education is the first step to home ownership for prospective homeowners with disabilities or long-term illnesses. Once a potential homeowner is identified through the transition planning process, members of the transition planning team refer him or her to the appropriate CHDO in the county in which the individual wants to live. If there is no CHDO in the individual's area, he or she will be referred to the local public housing authority for housing assistance. If a CHDO is available and the individual wants to pursue home ownership, he or she must complete the homebuyer education program offered at the local community action agency. At the conclusion of the homebuyer education, persons 19 years or older with disabilities or long-term illnesses are referred to the appropriate federal homebuyer assistance program. The AHOOPD program also links individuals with community resources that assist with down payments, closing costs and weatherization or home rehabilitation. The AHOOPD program will be available to participants in the Living Choice program who live in the counties served by the CHDO's.

Rental Assistance

Many of the CHDO's also provide rental assistance programs through public housing authorities. Individuals transitioning through the Living Choice project may have access to federal rental assistance through the Housing Choice Voucher program (formerly the Section 8 rental assistance voucher program) administered at the local level by public housing authorities and at the state level through the Oklahoma Housing Finance Agency. The Housing Choice Voucher program is a federally funded program which assists people in paying their rent. People determined eligible will have part of their rent paid each month by a local public housing authority. Persons determined eligible for the program will receive a Housing Choice Voucher to lease a dwelling unit of their choice in the individual's community.

The Housing Choice Voucher program is a free-choice approach to assisted housing. The individual transitioning to the community through the Living Choice project is free to choose any type housing unit, if it meets the requirements of a qualified community residence and certain requirements for rent limits, rent reasonableness and housing quality standards. The landlord retains private property rights, including management, tenant selection and maintenance.

Housing options for persons with intellectual disabilities

During the transition planning process, individuals with intellectual disabilities will have the option of moving to their own residence or sharing a home with no more than three roommates. The OHS-DDS maintains a registry of individuals looking for appropriate roommates. If a roommate is available in the location where an individual wants to move, the transition case manager contacts the case manager of the individual in need of a roommate.

The individual who is transitioning will have the option of meeting with a potential roommate and his or her family members. If both individuals agree and wish to become roommates, the transition case manager arranges all necessary information for the individual to transition from the ICF/IID to a home in the community.

In the event that a roommate is not available, the individual will be able to select his or her own home based on his or her personal preferences. Depending on the level of supervision that the individual requires, he or she may be able to live by himself or herself with direct care staff providing some assistance. While individual housing placements are rare for people with intellectual disabilities, each individual's person-centered planning team should review all available housing options with each person. Should public housing assistance be available, the transition case manager will ensure that all housing applications are completed by the individual or his or her guardian prior to transition to the community.

Public Housing

Individuals transitioning to the community through the Living Choice Project may also access public housing in their communities. Public housing developments have unfurnished apartments for individuals and families. Unlike the Housing Choice Voucher program where an individual rents an apartment or home from a landlord, the public housing development is owned and operated by the local public housing authority. Individuals pay a lower cost for rent and the individual has access to a variety of social services that are available to all residents of the public housing development. In certain circumstances, individuals have the option of buying their home with federal down payment assistance. The table below shows the public housing authorities in Oklahoma and the types of programs they offer – Housing Choice Voucher, Low-Rent, or Both:

PHA NAME	PHONE	TYPE
Ada	580-436-1613	Both
Afton	918-257-4300	Low-Rent
Anadarko	405-247-3110	Low-Rent
Antlers	580-298-5542	Low-Rent
Apache	580-588-3664	Low-Rent
Atoka	580-889-7311	Low-Rent
Beggs	918-267-3211	Low-Rent
Boley	918-667-3632	Low-Rent
Boswell	580-566-2243	Low-Rent
Bristow	918-367-5558	Both
Broken Bow	580-584-6939	Both
Cache	580-429-3405	Low-Rent
Cement	405-489-3674	Low-Rent
Cheyenne	580-497-3306	Low-Rent
Clayton	918-569-4434	Low-Rent
Coalgate	580-927-2575	Both
Comanche	580-439-5333	Low-Rent
Commerce	918-675-4748	Low-Rent
Cushing	918-225-7205	Low-Rent
Cyril	580-464-2439	Low-Rent
Del City	405-672-1412	Both
Drumright	918-352-9539	Low-Rent
Elk City	580-225-0129	Low-Rent
Fort Cobb	405-643-2111	Low-Rent
Fort Gibson	918-478-2051	Both
Geary	405-884-2710	Low-Rent
Grandfield	580-479-5256	Low-Rent
Granite	580-535-2134	Low-Rent
Guthrie	405-282-3246	Low-Rent
Haileyville	918-297-3270	Low-Rent
Hartshorne	918-297-3270	Low-Rent
Heavener	918-653-2500	Low-Rent
Henryetta	918-652-9651	Both
Hobart	580-726-3121	Low-Rent
Holdenville	405-379-3375	Low-Rent
Choctaw Electric Coop (Hugo)	580-587-2485	Low-Rent
Hugo	580-326-3348	Both
Hydro	405-663-2326	Low-Rent

Idabel	580-286-9444	Low-Rent
Indiahoma	580-429-3405	Low-Rent
Keota	918-966-3202	Low-Rent
Kingston	580-564-3309	Low-Rent
Konawa	580-925-3955	Low-Rent
Krebs	918-423-4209	Low-Rent
Langston	405-466-2619	Low-Rent
Lawton	580-353-7392	Both
Lone Wolf	580-846-5401	Low-Rent
Caddo Electric Coop (Lookeba)	405-457-6323	Low-Rent
Madill	580-795-2790	Low-Rent
Mangum	580-782-3560	Low-Rent
Maud	405-374-2800	Low-Rent
McAlester	918-423-3345	Both
Cookson Hills Electric Coop (McCurtain)	918-945-7402	Low-Rent
Miami	915-542-6691	Both
Minco	405-352-4996	Low-Rent
Mountain Park	580-569-2868	Low-Rent
Mountain View	580-347-2863	Low-Rent
Muskogee	918-687-6301	Both
Newkirk	580-362-3167	Low-Rent
Norman	405-329-0933	Both
Oilton	918-862-3666	Low-Rent
Oklahoma City	405-239-7551	Both
Oklahoma Housing Finance Agency (Oklahoma City)	405-419-8299	Housing Choice Voucher
Pauls Valley	405-238-7507	Low-Rent
Osage County (Pawhuska)	918-287-2270	Low-Rent
Pawnee	918-762-3316	Low-Rent
Picher	918-673-2126	Low-Rent
Ponca City	580-762-4445	Both
Prague	405-567-3337	Low-Rent
Ringling	580-662-2227	Low-Rent
Roosevelt	580-639-2765	Low-Rent
Ryan	580-757-2390	Low-Rent
Sayre	580-928-3690	Low-Rent
Seiling	580-922-4297	Low-Rent
Seminole	405-382-3081	Both
Shawnee	405-275-6330	Both
Snyder	580-569-2827	Low-Rent
Sterling	580-365-4862	Low-Rent
Stigler	918-967-2631	Low-Rent
Stillwater	405-372-4906	Both
Stilwell	918-696-2494	Both
Stratford	580-759-3184	Low-Rent
Stroud	918-968-3485	Low-Rent
Talihina	918-567-2986	Low-Rent
Tecumseh	405-598-3244	Both
Temple	580-342-5013	Low-Rent

Terral	580-437-2433	Low-Rent
Tipton	580-667-5358	Low-Rent
Tishomingo	580-371-2543	Low-Rent
Tulsa	918-582-0021	Both
Kiamichi Electric Coop (Tuskahoma)	918-522-4436	Low-Rent
Tuttle	405-381-2721	Low-Rent
Valliant	580-933-7359	Low-Rent
Walters	580-875-2310	Low-Rent
Watonga	580-623-4623	Low-Rent
Waurika	580-228-2976	Low-Rent
Waynoka	580-824-5331	Low-Rent
Weleetka	405-786-2156	Low-Rent
Wetumka	405-452-3444	Low-Rent
Wewoka	405-257-5717	Both
Wilburton	918-465-2134	Low-Rent
Wister	918-655-3323	Low-Rent
Wynnewood	405-665-2223	Low-Rent
Yale	918-387-2181	Low-Rent

[Source: US Department of Housing and Urban Development, Public and Indian Housing, PHA Contact Information, http://www.hud.gov/offices/pih/pha/contacts/states/ok.cfm]

Housing Opportunities for Older Persons with Disabilities or Long-term Illnesses

Older persons who wish to rent their own homes may be eligible for rental assistance through the Oklahoma Housing Finance Agency or local public housing authorities (see table above). In Oklahoma, local housing organizations administer federal housing funds that provide rental assistance and public housing. Housing authorities in larger cities in Oklahoma such as Oklahoma City, Tulsa, Norman, and Lawton provide public housing specifically for low-income older persons. During the transition planning process, individuals will make application to all necessary housing programs. Individuals may access housing vouchers or move to public housing that is affordable and accessible.

Housing Options for Persons with Physical Disabilities

Transition coordinators at each CIL -maintain a database of the housing options available in each CIL service area. During the transition planning process, individuals with identify their preferred housing options and complete the necessary public housing assistance applications. Progressive Independence has a Shelter + Care grant from the U.S. Department of Housing and Urban Development to pay for housing for persons with physical disabilities transitioning from institutions to a home in the community. The Shelter + Care grant may pay up to 30 percent of housing expenses for individuals who have not been approved for Housing Choice Voucher/Section 8 rental assistance.

Continuity of Care Post Demonstration

Staff and transition coordinators of the Living Choice project will take all necessary action to ensure a seamless transition to the AD*vantage* Waiver program or a Long-Term Service on day 366.

Each person participating in the Living Choice Project will be tracked in the MMIS to ensure a timely transition from the Living Choice Project to one of the home and community based waivers. Each person will have a waiver flag in their case record within MMIS and each transition coordinator will begin the waiver transition process at least 60 days prior to the participant's one year transition date. Transition coordinators for older persons with disabilities or long-term illnesses and persons with physical disabilities will work to ensure a seamless transition from demonstration services to waiver services.

Older Person with a Disability or Long-term illness and Person with a Physical Disability

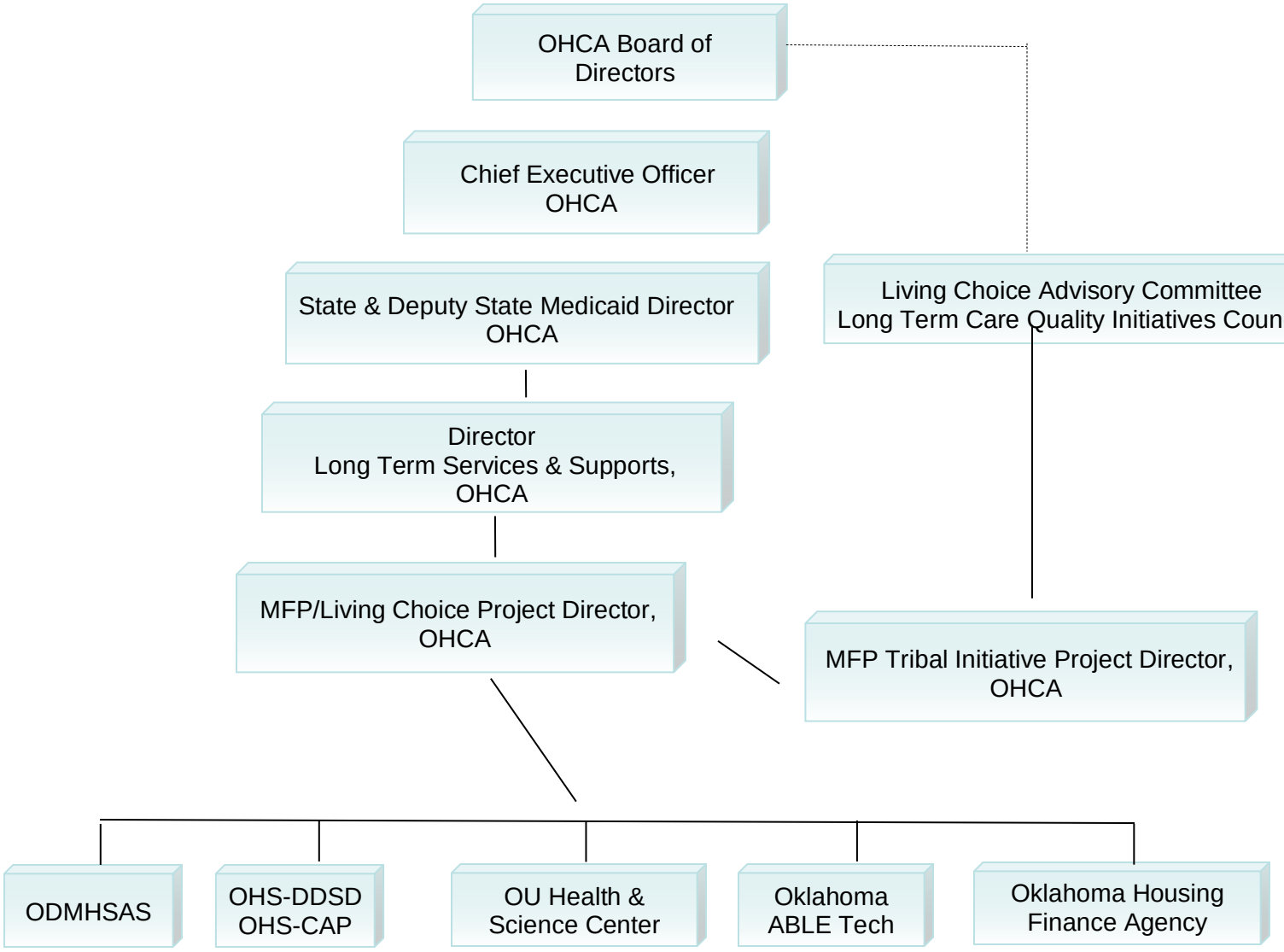
Following the implementation of activities set forth within the Living Choice project, the OHCA, in partnership with the OKDHS and the CIL's will continue facilitating nursing home transitions for each target population of the Living Choice Project. The OHCA and staff from each CIL will build upon their expertise in training transition coordinators and train existing staff at case management provider agencies in best practices in nursing facility transitions. With the necessary skills, case managers who are currently trained in the AD*vantage* waiver will learn those additional elements necessary to become transition coordinators enabling them to assist older persons with disabilities or long-term illnesses and persons with physical disabilities to move from institutions to their own homes in the community.

Older persons and persons with physical disabilities will not experience a change in service delivery as they move from the Living Choice demonstration project into the AD*vantage* waiver. The OHCA will ensure that provider agencies in the Living Choice demonstration project continue to provide services in the AD*vantage* waiver program.

ORGANIZATION AND ADMINISTRATION

Organizational structure

Living Choice Project Organizational Chart



Staffing Plan

The OHCA is the single state agency responsible for administering SoonerCare, Oklahoma's Medicaid program. The OHCA contracts with the OKDHS for eligibility determination for SoonerCare. The OHCA is responsible for ensuring that the SoonerCare program operates in compliance with state and federal laws and regulations. The State Medicaid Director oversees all aspects of long-term care within SoonerCare. The Living Choice Program operates within the Long-Term Services and Supports unit, which is part of the SoonerCare Federal and State Policy Division.

David Ward is the Director of the Long-Term Services and Supports unit. Mr. Ward oversees all aspects of Long-Term services and supports programs which includes Living Choice Operations, 1915(c) HCBS waivers, State Plan Personal Care, and Quality Assurance functions. He also serves as the liaison between the Centers for Medicare and Medicaid Services, Oklahoma Human Services, Department of Rehabilitation Services, Department of Health, other related state agencies, programs and organizations involved in the delivery of Medicaid services.

Essence McKnight is the Project Director of the MFP/Living Choice Project. In this capacity, Ms. McKnight is the state contact for the Money Follows the Person grant. Ms. McKnight provides general oversight, supervision and monitoring of the Living Choice Project including, but not limited to development of contracts for the Living Choice project, oversight of budget and of payments associated with the Living Choice Project, collaborates with project partners, stakeholders, state agencies, and CMS to maintain effective relations and develop strategies to improve programmatic processes. Ms. McKnight's resume is included in the Appendix of this operational protocol.

Russell Coker is the Project Director for the MFP Tribal Initiative. He is responsible for a wide range of complex administrative activities related to the administration and reporting of the Money Follows the Person Tribal Initiative grant. Mr. Coker will manage and oversee the Money Follows the Person Tribal Initiative grant project and all grant related activities including fiscal and administrative affairs. Mr. Coker will have direct responsibility for developing accountability measures, evaluation methods, reporting functions, developing processes for project programs, collaborating with tribal stakeholders, and coordinating with the Oklahoma Health Care Authority (OHCA) Tribal Government Relations unit.

Essence McKnight is a Research Associate of the Living Choice Project. Essence provides one-on-one assistance to the participants, transition coordinators, and other service providers. Additionally, she conducts research on Medicaid and Living Choice eligibility status, prepares administrative reports and documents, prepares prior authorizations, review service plan documentation and monthly case notes, conducts pre-transition meetings with members and associated providers, tracking and assisting with investigating critical incidents, prepares and processes invoices for alternative funds payments, and assists with conducting trainings for transitions coordinators. Ms. McKnight's resume is included in the Appendix of this operational protocol.

Patricia Harrison is a Research Analyst for the Living Choice Project. Patricia provides one-on-one assistance to the participants, transition coordinators, and other service providers. Additionally, she conducts research on Medicaid and Living Choice eligibility status, prepares administrative reports and documents, prepares prior authorizations, review service plan documentation and monthly case notes, conducts pre-transition meetings with members and associated providers, tracking and assisting with investigating critical incidents, prepares and processes invoices for alternative funds payments, and assists with conducting trainings for transitions coordinators. Ms. Harrison's resume is included in the Appendix of this operational protocol.

Natalie Boulos is a Research Analyst for the Living Choice Project. Natalie provides one-on-one assistance to the participants, transition coordinators, and other service providers. Additionally, she conducts research on Medicaid and Living Choice eligibility status, prepares administrative reports and documents, prepares prior authorizations, review service plan documentation and monthly case notes, conducts pre-transition meetings with members and associated providers,

tracking and assisting with investigating critical incidents, prepares and processes invoices for alternative funds payments, and assists with conducting trainings for transitions coordinators. Ms. Boulos's resume is included in the Appendix of this operational protocol.

Pamela Jackson is the Clinical Supervisor for the Population Care Management unit with the Oklahoma Health Care Authority (OHCA). Ms. Jackson is responsible for overseeing the Living Choice Clinical Review Analyst staff, ensuring that clinical assessments for Living Choice participants are completed in a timely manner. Additional duties include: Tracking and trending critical incidents and investigations, completing the UCAT Part III, complete all pre-transition paperwork at the member orientation, scheduling virtual assessments to assess potential Living Choice candidates, assisting with the approval of Living Choice member service plans, addendums, participating in critical incident investigations, and participation in required meetings concerning Living Choice members.

Veronica Giggers, Susan Long, and Jennifer Brown are the Living Choice Clinical Review Analysts. They are responsible for ensuring that clinical assessments for Living Choice participants are completed in a timely manner. Additional duties includes: conducting an orientation with the member and educating them on all facets of the Living Choice program, completing the UCAT Part III, completing all pre-transition paperwork at the member orientation, assessing potential Living Choice candidates through virtual platforms, assisting with the approval of Living Choice member service plan and addendums, participating in critical incident investigations, and participation in required meeting concerning Living Choice members.

Living Choice Housing Specialist - The Living Choice Housing Specialist enables the elderly and physically disabled population to apply and establish program eligibility to qualify for affordable and accessible subsidized housing through the Oklahoma Housing Finance Agency (OHFA). This staff person will coordinate with the OHFA's Section 8 Housing Choice Voucher (HCV) Program by actively increasing housing opportunities for the elderly and persons with disabilities and assists with coordinating the transition of SoonerCare members out of institutional care and into the community. This position will be housed at the Oklahoma Health Care Authority (OHCA) Long Term Supports and Services unit and will report to the Project Director of the MFP/Living Choice Project.

All members of the Living Choice Project team will work collaboratively to develop best practices for serving our participants, transition coordinators, and other service providers involved with the Living Choice Project. They must also be able to work independently when required to meet deadlines and provide the highest quality level of service to the citizens of the State of Oklahoma served by the Living Choice Project.

Training for all transition coordinators in the Living Choice project is conducted by the staff of the Living Choice Project. Project staff also provides training to individuals on how to self-direct their services. In addition to training, the staff at the Living Choice Project each manages a caseload of participants which covers the participant from their entry into Living Choice to the day they transition. They also monitor them throughout their 365-demonstration period and participate in helping them make a smooth transition into the AD*vantage* waiver.

Living Choice participants who successfully complete 365 days in the Living Choice project, graduate into the AD*vantage* waiver. All participants in this waiver must continue to meet nursing facility level of care as determined by the UCAT. Any participant who no longer meets nursing facility level of care may qualify for State Plan services or other community-based programs to meet their needs.

Living Choice participants who have transitioned from nursing facilities and are living in the community who return to a nursing facility for a period greater than 30 days (31 days or more) are considered discharged from the Living Choice project. Living Choice will allow these individuals back into the demonstration without re-establishing the 60day institutional residency requirement provided that a revised plan of care is submitted that accounts for any changes in health and psychosocial status. These participants will then have the balance of their original 365 days remaining to them to complete the demonstration.

Persons who have already transitioned through Living Choice (MFP in Oklahoma) and lived in the community for 365 days but are then re-institutionalized for a minimum of 60 days will have the opportunity to re-enroll in the Living Choice Project for an additional 365 days.
To reenroll a previous participant, Living Choice requires a re-evaluation of the previous plan of care to determine what can be changed to assist the participant with remaining independent in the community upon re-transition. The cause of re-institutionalization needs to be determined on a case-by-case basis. Once a new plan of care has been approved, the participant may be re-enrolled for a new 365-day term in the demonstration. Living Choice will track these re-enrollments, as well as the reasons for re-institutionalization and report as required.

Billing and Reimbursement Procedures

Flow of Billings

Claims for services provided through the Living Choice project are submitted by providers directly to and processed by Oklahoma's CMS-certified MMIS and are subject to all validation procedures included in the MMIS. All claims for demonstration services must be matched to an active prior authorization. Prior authorizations are created for each individual's plan of care.

All claims processed through the MMIS are subject to post-payment validation including, but not limited to the SURS unit at the OHCA. When problems with service validation are identified on a post payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payments are recouped from the provider.

Billing Validation Process

Claims for services cannot be filed for payment until after the service is rendered. Any provider who files a claim for a service that was not rendered is committing Medicaid fraud. Medicaid fraud can be detected through the post payment validation process of the OHCA.

Financial Integrity

OHCA Program Integrity staff is responsible for audits of all waiver services.

Errors in provider claims include: claims payment without corresponding documentation of service delivery and claims payment in excess of service plan authorization. Claims error incidence will be measured for each client and over all clients reviewed.

Prevalence of provider claims errors from the initial review may lead to additional sampling. If the audit detects a pattern of inappropriate billing, a referral will be made to the SURS Unit for review and further investigation of the provider's billing practices.

A final report is generated for each of the audits indicating the number of cases audited and the findings pertaining to approval of the plan of care and the financial expenditures of each person in the Living Choice project. This report is distributed to the OHCA Chief Executive Officer and the OHCA State Medicaid Director. A copy of the report is also retained in the Living Choice Unit and Audit Management Unit.

Payment for Institutional Transitional Coordination

When a Living Choice Project participant has successfully transitioned from the nursing facility to the community, the transition coordinator submits an addendum for the participant, signed by the participant, the transition coordinator, and the transition coordinator's supervisor, showing the total number of billable units used by transition coordination agency for the transition. These units begin when the transition coordinator contacts the referred participant to set up the initial Living Choice Project orientation and end on the day the participant leaves the nursing facility. Included in these units are all the various visits where the transition coordinator works with the participant to complete the paperwork required by the Living Choice Project. These units also include the time spent developing the community plan, which includes all the services the participant will access in the community to live there safely with all their needs met.

There are two different rates for this service: standard and very rural. The standard rate is paid for every zip code in the State of Oklahoma except for seven that are in the vicinity of Tulsa, Oklahoma, and others that may also be considered very rural. These seven zip codes and the others carry a *very rural* designation since they are difficult to staff and have services provided therein. The very rural rate is higher than the standard rate.

The addendum submitted for this service will carry one of two service codes depending upon whether the service is provided at the standard or very rural rate. In Oklahoma, these service codes are as follow: Standard – T1016-U3; Very Rural – T1016TN-U3. This service is coded with the beginning and ending date on the addendum that is equal to (or the same as) the date of transition. The coded service is then added to the participant's plan as an amendment and a prior authorization (PA) is created on Oklahoma's MMIS PA subsystem for the specified number of units with the required effective and end dates being the same. The PA is approved, and the amended plan is then sent to the transition coordinator by fax.

Payment for Home Establishment Expenses

The Living Choice Project has set up a process for assisting participants who are transitioning with establishing a home. Transition coordinators have a mechanism they can use to request up to – but no more than - $2,400 to assist the participant with paying deposits for rent, utilities, phone, and other types of services plus buying basic home items for the bedroom, living room, kitchen, bathroom, and other miscellaneous items such as a starter supply of food. This amount of money is a one-time allowance per participant. If all or part of it is used during their transition and then they are re-institutionalized but come out again, they have only the remainder, if any, available to them.

When the transition coordinator is reasonably certain the participant will be transitioning, he/she meets with the participant to determine what goods and home furnishings will need to be purchased and what deposits will need to be paid to create a safe home environment for the participant. The transition coordinator then proceeds to go to various stores and other places where the goods and home furnishings will be purchased and gets an estimate for all the items.

Likewise, the transition coordinator contacts the landlord/property manager of the place the participant has chosen to live to determine an estimate of the rental deposit including any security deposit and/or other fees. The transition coordinator then determines if any other expenses such as a birth certificate, state identification card, movers, or anything else is needed to help with the establishment of the participant's home.

Once the participant has transitioned to the community, the transition coordinator submits an addendum and receipt(s) for items purchased with the Transition Funds to the Living Choice staff showing the service code (in Oklahoma, T2038) for this service and the final amount. The dates for the addendum correspond to the date the transition occurred; that is, the beginning and ending date on the addendum must be the same as (equal to) the date of transition. The completed addendum is signed by the participant, the transition coordinator, his/her supervisor and then faxed to the Living Choice Project. The person whose caseload has this participant receives the addendum, enters the data on the participant's service plan, and requests the prior authorization for the approved amount from the Oklahoma Health Care Authority's MMIS prior authorization subsystem. The prior authorization number is added to the amended plan along with the approval date and the amended plan is faxed to the transition coordination agency.

Payment Process for a Failed Transition

The Living Choice Project acknowledges that every participant who enters the transition process will not transition. The transition coordination agencies working with participants spend many hours with those participants being served by their agencies endeavoring to find the resources necessary to craft a community plan ensuring a safe, successful transition to the community. Participants may decide that they do not want to transition to the community because they prefer the nursing home living environment, they may become gravely ill, suffer an injury from a fall that will extend their stay in the facility, or they may be medically denied for health reasons by one of the OHCA physicians who work with the Care Management nurses. All of these, and other unforeseen reasons, lead to failed transitions. The transition coordination agencies are able to recoup part of the money they have spent in working with the participants through the submission of an Alternative Funds Request Based on CMS policy guidance dated 10/1/2011, they may invoice the Living Choice Project for the last 180 consecutive days that they have worked with the participant. Living Choice Project policy requires submission of the case notes showing the billable units being claimed on the Alternative Funds Request. Upon receipt the Alternative Funds Request is verified for both the requested dollars and the number of units not to exceed the 180 days consecutive limitation. Once all the conditions are met, an invoice for the submitting transition coordination agency showing all of the participants for whom funds are being requested is generated. This invoice is faxed to the transition coordination agency for their review and approval. Once they sign it, they return it to the Living Choice Project Director. It is then sent to the OHCA's Finance Division for their review, approval, and processing for payment.

It should also be noted that small incidental expenses incurred by the transition coordination agencies such as the cost of a birth certificate, state identification card, housing application fees, etc. will be given consideration for payment through this method if they have occurred within the last 180 days consecutive period being paid. No other expenses such as rental deposits or similar will be reimbursed.

INDEPENDENT STATE EVALUATION

The Living Choice project will not conduct an independent program evaluation.

FINAL BUDGET

The project budget, budget narrative and 2019 supplemental budget requests are included in a separate appendix for this operational protocol. The budgetary information will also be submitted through the GrantSolutions.gov portal as required for the coming year by CMS.

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