Chapter 49. Case Management

§4901. Personnel Standards

A. Staff Qualifications

1. Case managers hired or promoted on or after August 20, 1994 must meet the following criteria for education and experience:

a. bachelor's degree in a human services related field including but not limited to psychology, education, rehabilitation counseling, or counseling from an accredited institution; and one year of paid experience in a human services field providing direct consumer services or case management or

b. a licensed registered nurse; and one year of paid experience as a registered nurse in public health or a human services related field providing direct consumer services or case management; or

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education;

d. thirty hours of graduate level course credit in a human services related field may be substituted for the one year of required paid experience. Experience may be obtained before or after completion of the degree or obtaining licensure;

e. all case managers must be employees of the provider. Contracting for case managers is prohibited.

2. Case management supervisors hired or promoted on or after August 20, 1994 must meet the following qualifications for education and experience:

a. a master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education with certification in special education, occupational therapy, speech or physical therapy from an accredited institution; and two years of paid post-degree experience in a human services related field providing direct consumer services or case management; and one year of this experience must be in providing direct consumer services to the targeted population to be served; or

b. a bachelor's degree in social work from a social work program accredited by the Council on Social Work Education; and three years of paid post-degree experience in a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services to the targeted population to be served; or

c. a licensed registered nurse; and three years of paid post-licensure experience as a registered nurse in public health or a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services or case management to the target population to be served; or

d. a bachelor's degree in a human services field including but not limited to psychology, education, rehabilitation counseling, or counseling from an accredited institution; and four years of paid post-degree experience in a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services to the targeted population to be served;

e. thirty hours of graduate level course credit in the human services field may be substituted for one year of experience.

B. Training. Case managers must receive necessary orientation and periodic training on the provision of case management services arranged or provided through their agency.

1. Orientation of at least 16 hours shall be provided by the agency to all staff, volunteers and students within five working days of employment which shall include, at a minimum:

a. policies and procedures of the provider;

b. confidentiality;

c. documentation in case records;

d. consumer rights protection and reporting of violations;

e. abuse and neglect policies and procedures;

f. professional ethics;

g. emergency and safety procedures;

h. infection control including universal precautions.

2. For newly hired or promoted case managers who will provide services primarily to a specific population or sub-group, a minimum of eight hours of the orientation training must cover orientation to each target population to be served including but not limited to specific service needs and resources.

3. Routine supervision cannot be considered training.

4. In addition to the minimum 16 hours of orientation, all case managers must receive a minimum of 16 hours of training during the first 90 calendar days of employment which is related to the target population to be served and specific knowledge, skills and techniques necessary to provide case management to the target population. This training must be provided by an individual with demonstrated knowledge of the training topic and the target population. This 16 hours of training must include, at a minimum:

a. assessment techniques;

b. service planning;

c. resource identification;

d. interviewing techniques;

e. data management and record keeping;

f. communication skills.

5. No new case manager employee can be given sole responsibility for a consumer until this training is satisfactorily completed and the employee possesses adequate abilities, skills and knowledge of case management.

6. A case manager must complete a minimum of 40 hours of training per calendar year. For new employees, the orientation training cannot be counted toward the 40 hour minimum annual training requirement. The 16 hours of training for new case managers required in the first 90 days of employment may be counted toward the 40-hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required 40 hours of annual training. The following is a list of suggested additional topics for annual training:

a. the nature of the illness or disability, including symptoms and behavior;

b. pharmacology;

c. potential array of services for the population/ available local resources;

d. building natural support systems;

e. family dynamics;

f. developmental life stages;

g. crisis management;

h. first aid/CPR;

i. signs and symptoms of mental illness, alcohol and drug addiction, and mental retardation/ developmental disabilities, head injuries and/or HIV;

j. recognition of illegal substances;

k. monitoring techniques;

l. advocacy;

m. behavior management techniques;

n. developmental life stages;

o. value clarification/goals and objectives;

p. stress management/time management;

q. accessing special education services;

r. cultural diversity;

s. pregnancy and prenatal care;

t. health management;

u. team building/interagency collaboration;

v. transition/closure;

w. age-appropriate preventive health care;

x. facilitating team meetings;

y. computer skills;

z. legal issues.

7. A case management supervisor must satisfactorily complete 40 hours of training per year. A new supervisor must satisfactorily complete a minimum of 16 hours on all of the following topics prior to assuming case management supervisory responsibilities:

a. professional identification/ethics;

b. process for interviewing, screening, and hiring staff;

c. orientation/inservice training of staff;

d. evaluating staff;

e. approaches to supervision;

f. managing caseload size;

g. conflict resolution;

h. documentation.

8. Documentation of all training must be placed in the individual's personnel file. Documentation must include an agenda and the name, title, agency affiliation of the training presenter(s) and other sources of training.

C. Supervision

1. Each case management provider must have and implement a written plan for supervision of all case management staff. Supervision must occur at least once per week per case manager. Supervisors must review at least 10 percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery.

2. Supervision of individual case managers must include the following:

a. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;

b. teaching and monitoring of the application of consumer centered case management principles and practices;

c. assuring quality delivery of services;

d. managing assignment of caseloads;

e. arranging for or providing training as appropriate.

3. Supervision must be accomplished by a combination of more than one of the following means:

a. individual, face to face sessions with staff to review cases, assess performance and give feedback;

b. sessions in which the supervisor accompanies an individual staff member to meet with consumers. The supervisor assesses, teaches and gives feedback regarding the staff member's performance related to the particular consumer;

c. group face to face sessions with all case management staff to problem solve, provide feedback and support to case managers.

4. Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

a. date and content of the supervisory sessions; and

b. results of the supervisory case review which shall address, at a minimum, completeness and adequacy of records, compliance with standards, and effectiveness of services.

5. Case managers must be evaluated at least annually by their supervisor according to written policy of the provider on evaluating their performance.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:885 (August 1994).

§4903. Caseload Size Standards

A. Each full-time case manager may only have a maximum of 60 consumers in a caseload unless a lower ratio exists in DHH or other applicable controlling state or federal regulations.

B. Each case management supervisor may only have a maximum of five full-time case managers or a combination of full-time case managers and other human service staff under their direct supervision.

C. A supervisor may carry one-fifth of a caseload for each case manager supervised less than five. For example, a supervisor of three case managers may carry two-fifths of the maximum caseload.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:887 (August 1994).

§4905. Standards on Protecting Client Rights, Health, and Safety

A. All DHHR and private disability agency case managers shall conform to applicable state laws and Department of Health and Human Resources policies and procedures relative to client rights, including but not limited to those concerning confidentiality of client information and grievance procedures and client's right to appeal department decisions on service eligibility, planning, and delivery.

B. All DHHR and private disability agency case managers, if utilized, shall conform to applicable state laws and Department of Health and Human Resources policies and procedures regarding client health and safety including but not limited to those concerning transporting clients and abuse/neglect reporting.

C. Case manager initiated contact with clients shall be as specified in each client's individual plan and shall not be less frequent than 90 days.

1. A program office shall allow (if requested) surveyors of the DHHR Division of Licensing and Certification to inspect all aspects of the case management/service coordination client care (if the client agrees to the interview).

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4907. Application Procedure

A. The applicant shall submit a copy of a request for licensure to the Department of Health and Hospitals, Health Standards Section, P. O. Box 3767, Bin #27, Baton Rouge, Louisiana 70821-3767. The request shall include descriptions of:

1. the target populations to be served;

2. geographical areas (regions) to be served;

3. address(es) of the office site(s) to be used;

4. administrative file as described under §4943;

5. the provider's policies and procedures manual;

6. the requested program and services to be provided as outlined in §4953;

7. the provider's plan for staffing as outlined in §4959.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:887 (August 1994).

§4909. Review of Applications

A. The complete application request with the required fee must be received by the Health Standard Section at least 60 days prior to the date for which licensing is sought. A written response will be provided to the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4910. Types of Licenses and Expiration Dates

A. A license must be issued to an agency by geographical location (DHH region) where records and minutes of formal meetings are maintained and staff reports. When an agency has three or more staff providing case management services in another region, the agency must establish an office site in that region and request a separate license for that geographical location (unless these services are provided in parishes contiguous to the region where the agency is licensed).

B. Temporary licenses may be issued to new providers, providers who have substantially changed–either in ownership or in the services offered or in the location of the office site, or to a provider who has an identified licensing deficiency and the provider's license is expiring within 60 days. Temporary licenses expire on the date specified on the license.

C. Regular licenses expire on the date specified on the license, which will be one calendar year from the date of issue.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:308-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 August 1994).

§4911. Issuance of a License

A. The agency will not be recognized by DHH until the applicant's enrollment by geographical location (region) is approved by DHH Health Standards Section

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4913. Types of Licenses and Expiration Dates

A. New providers or providers which have substantially changed—either in the services offered or in the physical plant—are issued temporary licenses. Temporary licenses expire on the date specified on the license. Regular licenses expire on the date specified on the license which is one year or more from the date of issue. Provisional licenses are granted when the provider has deficiencies which are not a danger to the health and welfare of clients. Provisional licenses are issued for a period not to exceed 90 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4915. Reapplication

A. When a provider changes its ownership or makes any substantial changes in the services offered as outlined in §4910 or changes the location of the licensed agency, the provider must reapply for a license, beginning with a request for licensure. In the event of a change of ownership, the old license must be immediately returned to the DHH Health Standards Section. If no such changes have occurred, the regular annual reapplication must be made at least 60 days prior to the expiration of the current license. The application must be on a form prescribed by the DHH Health Standards Section and must be accompanied by the required fee. A license cannot be transferred to any location or provider other than those specified in the license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4917. Refusal, Revocation and Fair Hearing

A. A license may be revoked or refused when applicable licensing requirements are not met, as determined by the DHH Health Standards Section. Licensing decisions are subject to appeal and fair hearing in accordance with state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4919. Terms of the Licensure

A. If the provider is in compliance with the requirements of these standards, a license as a client care case management provider will be issued by the DHH Health Standards Section along with a letter enumerating that the agency is permitted to provide case management/service coordination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 12:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4921. Services for Different Handicaps

A. A provider will not be licensed to serve more than one program office type of handicapped client until the provider has been in operation and has consistently met applicable requirements for one year.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4923. Quarterly Staffing Report

A. A provider will report quarterly to the Division of Licensing and Certification, P.0. Box 3767, Baton Rouge, LA 70821 the following: The name, social security number, position and hours worked for a random seven-day period of all the staff employed by the provider. State owned and operated providers are exempt from this requirement as there are already state checks on their personnel.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4925. Licensing Inspections

A. Licensing inspections must generally be completed annually, but may occur at any time. No advance notice may be given. Licensor must be given access to the provider office site, staff members or consumers, and all relevant files and records. Licensor must explain the licensing process in an initial interview and must report orally on any deficiencies found during the inspection prior to leaving the agency. A written report of findings must be forwarded to the provider. The provider must respond to the deficiencies cited with a plan of corrective action acceptable to the secretary within 15 working days of receipt.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by

the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4927. New Construction, Renovations of Existing Facilities and Conversion of any Residential or Commercial Building for Residential Care

A. The building site shall be approved by the Division of Licensing and Certification prior to beginning of any construction. The site shall have good drainage and not subject to flooding. The site shall not be located in an area that would present a hazard to those being served. Plans and specifications must be prepared by a licensed architect or engineer. Three sets of complete plans and specifications must be submitted for approval to the Division of Licensing and Certification. The Division of Licensing and Certification will forward one set to the Office of Preventive and Public Health Services, and one set to the Office of State Fire Marshal.

B. The third set will be reviewed by the Division of Licensing and Certification. All three agencies must issue an approval of the plans and specifications prior to beginning construction. The Division of Licensing and Certification will issue the letter authorizing the start of construction after receiving approval from the Office of Preventive and Public Health Services, the Office of State Fire Marshal.

C. The Division of Licensing and Certification, the Office of Preventive and Public Health Services, and the Office of State Fire Marshal, shall have the authority to inspect the project at any stage to insure that the approved plans and specifications are being followed. Final approval of the building must be obtained from these agencies after the building is completed and before it is occupied. A license shall issued by the Division of Licensing and Certification only after these final approvals have been obtained.

D. It shall be the responsibility of the provider to obtain any approvals from local authorities (such as zoning, building, fire, etc.) that may be needed in the particular city or parish.

E. All providers must be in conformity with the ASNI standards for the handicapped.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4929. General Waiver

A. The Office of the Secretary of DHH (the secretary) must determine the adequacy of quality and protection in accordance with the provisions of these standards.

B. If, in the judgment of the secretary, application of the requirements stated in these standards would be impractical in a specified case, such requirements may be modified by the secretary to allow alternative arrangements that will secure as nearly equivalent provision of services as is practical. In no case will the modification afford less quality or protection, in the judgment of the secretary, than that which would be provided with compliance of the provisions contained in these standards.

C. At the time of each subsequent revisit, such requirement modification must be reviewed by the secretary and either continued or cancelled.

D. DHH Office of Aging and Adult Services Case Management

1. Agencies that provide case management and/or support coordination services to the DHH Office of Aging and Adult Services (OAAS) waiver programs recipients shall be exempt from licensure as a case management agency for the provision of case management services. This licensure exemption shall only be to the extent that the agency uses only DHH/OAAS trained and certified case managers to provide case management services to OAAS waiver programs in lieu of DHH licensure. Such agencies serving other populations and programs, in addition to those waiver programs operated by OAAS, shall obtain and maintain DHH licensure.

2. OAAS certification requirements shall ensure:

a. the quality of services and the care, well-being, and protection of the clients receiving services; and

b. that the delivery of case management services does not afford less quality or protection than the licensing provisions of this Chapter.

3. OAAS shall provide an attestation of meeting these requirements on an annual basis or as required by the DHH Health Standards Section.

4. OAAS case management and support coordination services will still be subject to the support coordination standards of participation rule for OAAS waiver programs, the program integrity/SURS (fraud/abuse) rules, and other applicable Medicaid rules and regulations.

E. Department of Children and Family Services Case Management

1. The Department of Children and Family Services (DCFS) shall be exempt from licensure as a case management agency for the provision of targeted case management services rendered by foster care and family services workers. The licensure exemption shall only be to the extent that DCFS uses trained and certified employees to provide case management services in lieu of DHH licensure.

2. DCFS certification requirements shall ensure:

a. the quality of services and the care, well-being, and protection of the clients receiving services; and

b. that the delivery of case management services does not afford less quality or protection than the licensing provisions of this Chapter.

3. DCFS shall provide an attestation of meeting these requirements on an annual basis.

4. DCFS case management services will still be subject to the Medicaid targeted case management rules, the

program integrity/SURS (fraud/abuse) rules and other applicable Medicaid rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2152 (October 2015).

§4931. Case Management/Service Coordination Services

A. Case management must consist of services to assist consumers in gaining access to the full range of needed services, including medical, social, educational and other support services. These must be ongoing services which must be accomplished through the following activities.

1. Intake, which must include determination of a consumer's eligibility for case management services as part of a targeted group of consumers and the determination of need for case management services. All consumers must be interviewed within 14 calendar days of referral to the provider.

2. Assessment/reassessment, which must include the collection and integration of formal/professional and informal information concerning a consumer's social, familial, medical, developmental, legal, educational, vocational, psychiatric and economic status, as appropriate, to assist in the formulation of a comprehensive, individualized written service plan.

a. The assessment process must include input from the consumer/guardian, and may include input from family members, friends, professionals, and service providers, as appropriate.

b. The assessment must focus on the individual's strengths and needs. The case manager must make a face-to-face contact with the consumer as part of the assessment process.

c. The consumer's status must be reassessed on an ongoing basis.

3. Service planning, which must include the development of a comprehensive, individualized written plan based on the needs and strengths of the consumer identified during the assessment process.

a. The consumer/guardian must actively participate with the case manager in development of the service plan with input from family members, professionals and service providers, as needed.

b. The objective of service planning must be to promote consistent, coordinated, timely and quality service provision.

c. The service plan must include, at a minimum: consumer strengths and needs; specific measurable goals and objectives with anticipated time-frames.

d. The service plan must be completed within 45 calendar days of the intake interview for case management services.

e. The written service plan must be reviewed at least 90 days to assure goals and services are appropriate to the consumer's needs identified in the assessment/reassessment process.

D. Linkage, which must assure that the consumer has access to and is receiving the most appropriate services available to meet needs as outlined in the service plan. Linkage must include, but is not limited to:

1. contacting the individual's support network including family, neighbors and friends to mobilize assistance for the individual; and

2. locating or assisting the consumer in locating formal and informal service providers;

3. advocacy, which may occur on behalf of the consumer when needed to assure the consumer has access to and receives appropriate services.

E. Monitoring/follow-up, which must include ongoing interaction with the consumer/guardian, family members and professionals (as appropriate), and service providers to ensure that the agreed upon services are provided in a coordinated and integrated manner and are adequate to meet the needs and stated goals of the service plan. The case manager must make at least monthly face-to-face contacts with the consumer/guardian as part of the linkage and monitoring/follow-up process.

F. Transition/closure, which must be a joint decision made by the case manager, consumer and/or family member, when appropriate. Closure must occur upon completion of all case management goals identified on the service plan except when case management is a required component of a service or a required service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4933. General Requirements

A. The provider must allow representatives of the state licensing authority, in the performance of their mandated duties, to inspect all aspects of the provider's functioning which impact on consumers and families and to interview any staff member or consumer (if the consumer or family agrees to said interview).

B. The provider must make available to the state licensing authority any information which the provider is required to have under the present requirements and any information reasonably related to assessment of compliance with these requirements.

C. The provider must make available to DHH any information required by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4935. Governing Body

A. The provider must have an identifiable governing body with responsibility for and authority over the policies and activities of the agency.

B. The provider must document, in writing, all members of the governing body; their addresses; their terms of membership; officers of the governing body; and terms of office of any officers.

C. When the governing body does not include consumer and family representation, written policy and procedures must be implemented to ensure consumer and family input.

D. When the governing body is comprised of more than one person, the governing body must hold formal meetings at least semi-annually to discuss agency operations, including programmatic operations.

E. When the governing body is composed of more than one person, the provider must have written minutes of all formal meetings of the governing body and bylaws specifying frequency of meetings and quorum requirements.

AUTHORITY NOTE: Promulgated in accordance with R . S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:889 (August 1994).).

§4937. Governing Body Responsibilities

A. The governing body must:

1. ensure the provider's compliance and conformity with its articles of incorporation or charter;

2. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

3. ensure that the provider shall be adequately funded and fiscally sound;

4. review and approve the provider's annual budget;

5. ensure the review and approval of an annual external audit;

6. designate a person to act as chief administrator and delegate sufficient authority to this person to manage the agency;

7. formulate and annually review, in consultation with the chief administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

8. annually evaluate the chief administrator's performance, including evaluation in the areas of quality assurance and disposition of grievances;

9. have the authority to dismiss the chief administrator;

10. notify the designated representatives of DHH prior to initiating any substantial changes in the services provided;

11. ensure that a continuous written Quality Improvement Program is in effect;

12. ensure that services are provided in a culturally sensitive manner as evidenced by staff trained in cultural awareness and related policies and procedures;

13. ensure that all business practices and staff activities conforms to the *Code of Governmental Ethics*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:889 (August 1994).

§4939. Accessibility of Executive

A. The chief administrator or a person authorized to act on behalf of the chief administrator must be accessible to staff or designated representatives of DHH during agency hours of operation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4941. Documentation of Authority to Operate

A. A provider shall have documentation of its authority to operate under state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4943. Administrative Files

A. The provider's administrative files must include at a minimum:

1. documents identifying the governing body;

2. list of members and officers of the governing body, their addresses and terms of membership;

3. minutes of formal meetings and bylaws of the governing body, if applicable;

4. documentation of the provider's authority to operate under state law;

5. functional organizational chart which depicts lines of authority;

6. all leases, contracts and purchase-of-service agreements to which the provider is a party;

7. insurance policies;

8. annual budgets and audit reports;

9. master list of all service providers used by the provider;

10. the provider's policies and procedures

11. Documentation of corrective action taken as a result of external or internal reviews.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4945. Organizational Communication

A. The provider must establish procedures to assure adequate communication among staff to provide continuity of services to the consumer.

B. The provider must establish procedures which facilitates participation and feedback from staff, consumers, families, and when appropriate, the community at large. This will be used in areas such as policy-making, planning, and program development.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4947. Financial Management

A. The provider must establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books and records in keeping with generally accepted accounting principles.

B. The provider must demonstrate fiscal accountability through regular recording of its finances and an annual external audit conducted by a certified public accountant.

C. The provider must not permit public funds to be paid, or committed to be paid, to any person to which any of the members of the governing body, administrative personnel, or members of the immediate families of members of the governing body or administrative personnel have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the provider. The provider shall have a written disclosure of any financial transaction with the provider in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

D. The provider must be capable of reporting fiscal data from July 1 through June 30.

E. The provider must have adequate and appropriate general liability insurance for the protection of its consumers, staff, facilities, and the general public.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4949. Confidentiality and Security of Records

A. A provider must have written procedures for the maintenance, security, and confidentiality of records. This must include specifying who must supervise the maintenance of records, and who must have custody of records. This procedure must also state to whom records can be released and the procedure for doing so. Records, including consumer as well as administrative, must be the property of the provider and the provider, as custodian, must secure records against loss, tampering, or unauthorized use.

B. Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the consumers or his/her family, directly or indirectly, to any unauthorized person.

C. The provider must safeguard the confidentiality of any information from which the consumer or his/her family might be identified, releasing such information only under the following conditions:

1. by court order;

2. by the consumer's written, informed consent for release of information;

a. when the consumer has been declared legally incompetent, the individual to whom the consumer's rights have devolved provides written consent.

b. when the consumer is a minor, the parent or legal guardian provides written consent.

c. in compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

D. A provider must, upon request, make available information in the case records to the consumer or legally responsible person. If, in the professional judgement of the administration of the agency, it is felt that information contained in the record would be damaging to a consumer, that information (only) may be withheld from the consumer except under court order. The provider may charge a reasonable fee for providing the above records.

E. A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's

services, or similar educational purposes, provided that names are deleted and other similar identifying information is disguised or deleted.

F. A system must be maintained that provides for the control/location of all consumer records. Consumer records must be located at the licensed site.

G. A system must be maintained that secures all records from unauthorized access and provides reasonable protection against fire, water damage, tampering, and other hazards.

H. A designated staff member must be responsible for the storage and protection of consumer records.

I. There must be a written process by which the consumer may gain access to his/her own records and receive copies upon written request.

J. Consumer records must be available to appropriate state and federal personnel at all reasonable times.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4951. Records—Administrative and Consumer

A. All provider records must be maintained in an accessible, standardized order and format and must be retained and disposed of in accordance with state laws.

B. A provider must have sufficient space, facilities and supplies for providing effective record keeping services.

C. Upon agency closure, all provider records must be maintained according to applicable laws, rules and regulations.

D. A provider must have a written record for each consumer which must minimally include:

1. identifying data recorded on a standardized form including the following:

a. name;

b. home address;

c. home telephone number;

d. date of birth;

e. sex;

f. race or ethnic origin;

g. closest living relative;

h. education;

i. marital status;

j. name and address of current employment, school, or day program, as appropriate;

k. date of initial contact;

l. court and/or legal status, including relevant legal documents;

m. names, addresses, and phone numbers of other persons or providers involved with the consumer’s service plan. This shall include the consumer's physician;

n. other identifying data as indicated;

o. date the information was gathered;

p. signature of the staff member gathering the information.

2. Interdiction Status. A notation on the inside of the front cover that the consumer has been interdicted if this information is known.

3. Limited health records including a description of any serious or life threatening medical condition of the consumer. This must include a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies.

E. A provider must ensure that all entries in records are legible, signed by the person making the entry and accompanied by the date on which the entry was made.

F. Entries must be made in consumer records when services are provided to and/or on behalf of consumer in accordance with the following:

1. All entries and forms in the consumer's record that are completed by the provider must be in ink, are legible, be dated, be signed and shall include the functional title of the person making the entry.

2. An error in the consumer's record made by staff must be corrected by drawing a line through the erroneous information. The word "error" must be written beside the correction, and the correction must be initialed.

3. Correction fluid must never be used in a consumer's record.

G. Consumer record material must be organized in a manner which encourages staff to use it as a communication tool.

1. The location of documents within the record must be consistent among all the provider's records.

2. The record must be appropriately thinned so that current material shall be easily located in the record.

H. Each record must document the need for case management services and the following, at a minimum:

1. medical, social, psychiatric, psychological and other pertinent information regarding the consumer's disability, illness, or condition which will document eligibility for case management services for the targeted population;

2. necessary assessments and other information concerning the consumer's medical, social, familial, cultural, developmental, legal, educational, vocational, psychiatric

and economic status, as appropriate, to support the initial service plan, and modifications in the service plan;

3. documentation of the need for ongoing case management and other identified services;

4. written service plan signed and dated by the case manager and the consumer and/or guardian shall be placed in the consumer's record;

5. description of all contacts, services delivered and/or action taken identifying the persons involved in service delivery, the date and place of service, the content of service delivery and the duration of the contact;

6. progress notes written at least monthly to document progress towards specified goals;

7. summary of services provided and progress towards goals, as well as the reason for the closure of the case at the time of termination; and,

8. any joint agreement with the consumer for closure.

I. The provider must utilize the tracking and/or data system for the Program Office of the targeted population being served or a comparable system which tracks the same data elements and allows reporting of data to the program office.

J. The provider must sign an agreement with the appropriate Program Office regarding the exchange of consumer-related data.

K. The record must contain at least six months of current information.

L. Information older than six months may be kept in storage but shall be available for review.

M. The records are maintained until audited and all audit questions answered or for three years from the time of payment, whichever is longer.

N. When a consumer transfers to another provider, at a minimum, copies of the following information must be sent to the requesting provider upon receipt of a release of information signed by the consumer:

1. most current service plan;

2. current assessments upon which service plan is based;

3. number of services used in the calendar year; and

4. last quarter's progress notes;

O. A nonredisclosure clause must accompany all information released to the requesting provider on all Office of Alcohol and Drug Abuse consumers;

P. The receiving provider must bear the cost of copying which shall not to exceed the community's competitive copying rate.

Q. A written policy must govern the disposal of consumer records and confidentiality of consumer information must be protected at the time of disposal.

R. A provider must have a written record for each employee which includes:

1. the application for employment and/or resume'

2. references

3. any required medical examinations

4. all required documentation of appropriate status which includes:

a. valid driver's license for operating provider vehicles or transporting consumers.

b. verification of professional credentials/certification required to hold the position including the following:

i. current licensure

ii. relevant licensure

iii. relevant education

iv. relevant training

v. relevant experience

5. periodic, at least annual, performance evaluations.

6. employee's starting and terminations dates along with salary paid.

S. An employee must have reasonable access to his/her personnel file and must be allowed to add any written statement he/she wishes to make to the file at any time.

T. A provider must not release a personnel file without the employee's written permission except in accordance with state law.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994).

§4953. Program Description

A. The provider must have a clear, concise written program description, available to the public, detailing:

1. the overall philosophy of the program;

2. the long and short term goals of the program;

3. the types of consumers to be served;

4. the intake and closure criteria;

5. there must be written eligibility criteria for each of the services/programs provided;

6. the services to be provided;

7. a schedule of any fees for service which will be charged to the consumer;

8. a method of obtaining feedback from the consumer regarding consumer satisfaction with services;

9. an inventory of existing resources (both formal and informal) has been completed that identifies services within the geographic area to address the unique needs of the population to be served. This inventory must be updated at least annually;

10. demonstrated evidence that the program coincides with or is in agreement with existing state, regional, and local comprehensive service coordination and planning for the target population.

B. The provider must make every effort to ensure that service and planning for each consumer must be a comprehensive process involving appropriate staff, representatives of other agencies, the consumer, and where appropriate, the legally responsible person, and any other person(s) significantly involved in the consumer's care on an ongoing basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994).

§4955. Transportation

A. The provider must ensure that any vehicle used by the agency staff to transport consumers must be properly maintained, inspected, and licensed according to state laws and carries a sufficient amount of liability insurance.

B. Any staff member using a vehicle to transport consumers must be properly licensed to operate that vehicle according to state laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994), amended LR 20:893 (August 1994).

§4957. External Professional Service

A. A provider shall, when necessary, give assistance to clients in obtaining any required professional services not available from employees of the provider facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4959. Staff Plan and Staff Coverage

A. A provider must have a written plan for recruitment, screening orientation, ongoing training, development and supervision and performance evaluation of staff members.

B. Sufficient staffing must be provided to ensure a safe environment and adequacy of programming with consideration given to the geography of the setting, the number and needs of individuals served, the intensity of services needed. Staff coverage must be documented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4961. Nondiscrimination

A. A provider must have a written policy to prevent discrimination and must comply with all state and federal employment practices, laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).