GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Adult Day Health Care (ADHC) Waiver Manual Chapter.

Abuse – The infliction of physical or mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his/her health, self-determination, or emotional well-being is endangered. (La. R.S. 15.1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility, and eating. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

Adult Day Health Care (ADHC) – a medical program model designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based nursing center.

Adult Day Health Care Center – any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days a week.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older with functional impairments, or adults between ages 22 and 65 who have a disability according to Medicaid standards.

Advocacy – The process of assuring that recipients receive appropriate high quality services and locating additional services needed by recipients which are not readily available in the community.

Allegation of non-compliance – A claim that an event has occurred or is occurring that has the

potential for causing no more than minimal harm to a recipient or recipients. (La. R.S. 40:2009.14)

Allowable Cost – Those expenses incurred by the provider agency which are reasonable in amount and are necessary for the efficient delivery of support coordination services.

Appeal – A due process system of procedures which ensures a recipient will be notified of and have an opportunity to contest a Department of Health and Hospitals (DHH) decision.

Applicant – An individual whose written application for Medicaid or DHH funded services has been submitted to DHH but whose eligibility has not yet been determined.

Assessment – One or more processes that are used to obtain information about a person, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person requires waiver services as well as the development of the Plan of Care and an Individualized Service Plan.

Bureau of Health Services Financing (BHSF) – The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

Case Management – Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services. Activities include assessment, Plan of Care development, service monitoring and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources. Case management is also referred to as support coordination.

Center for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older, or between the ages of 21 and 65 with functional impairments, and are disabled according to Medicaid standards.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a consumer or consumers. (La. R.S. 40:2009.14).

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to

pursue opportunities to improve services, and to correct identified problems.

Confidentiality – The process of protecting a recipient's or an employee's personal information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider agency plans to take to correct identified deficiencies.

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state's Medicaid Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and addictive disorder services.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care or other direct service and support to persons with disabilities or to the elderly to enhance their well-being. This is also referred to as a Direct Service Worker.

Disabled Person – A person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his own care or protection.

Eligibility – The determination of whether or not a recipient qualifies to receive services based on meeting established criteria for the target or waiver group set by DHH.

Enrollment – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment or certification.

Exploitation – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Fiscal Intermediary – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Follow-Up – A core element of service delivery that includes oversight and monitoring of the provision of services to the recipient.

Formal Services – Another term for professional and paid services.

Good Cause – When the OAAS regional office approves a recipient's change in support coordination or provider agencies outside the timelines noted in policy if one of the following exists: the recipient is moving to another region in the state where the current provider does not provide services; the recipient and provider have unresolved difficulties and mutually agree to a transfer; the recipient's health or welfare has been compromised; or the provider has not rendered services in a manner satisfactory to the recipient.

Health Standards Section – A section of the Department of Health and Hospitals responsible for the licensure and oversight of certain individual and agency providers of services funded by the DHH.

Home and Community-Based Services Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services. The number of individuals receiving these services is limited to the number of approved and available waiver opportunities.

Individualized Service Plan – A written agreement developed by a service provider that specifies the long-range goals, short-term objectives, specific strategies or action steps, assignment of responsibility and timeframes for meeting the recipient's personal outcomes as specified in the recipient's approved Plan of Care.

Informal Services – Another term for non-professional and non-paid services provided by family, friends and community/social network.

Institutionalization – Placement of a recipient in any inpatient facility including a hospital, group home for people with developmental disabilities, nursing facility, or psychiatric hospital.

Licensed Practical Nurse (LPN) – an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

Licensure – A determination by the Medicaid Health Standards Section that a service provider agency meets the requirements of State law to provide services.

Linkage – Act of connecting a recipient to a specific support coordination or service provider agency.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the DHH. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer's activities of daily living. (La. R.S. 40:2009.14)

Neglect – The failure by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the Department of Health and Hospitals that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in DHH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (**OPH**) – The office in DHH responsible for personal and environmental health services.

Personal Outcome – Result achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of the individual's life.

Person-Centered Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized POC.

Plan of Care (POC) – A written plan developed by the recipient, his/her responsible representative and support coordinator that is based on assessment results and specifies services to be accessed and coordinated by the support coordinator on the recipient's behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Primary Care Physician – A physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the recipient or his/her personal representative as responsible for the direction of the recipient's overall medical care.

Progress Notes – Ongoing assessment of the recipient which enables the staff to update the Plan of Care and/or Individualized Service Plan in a timely, effective manner.

Provider/Provider Agency – An agency furnishing Medicaid services under a provider agreement with DHH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other DHH funding source. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other DHH funding source.

Provider Enrollment – Another term for enrollment.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and revising the overall Plan of Care and/or Individualized Service Plan.

Recipient – An individual who has been certified for medical benefits by the Medicaid program. A recipient certified for Medicaid home and community-based waiver services may also be referred to as a participant.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible recipient.

Responsible Representative – An adult who has been designated by the recipient to act on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without the recipient's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction. This is also referred to as a designated personal representative.

Self-neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Sexual abuse – Any sexual activity between a recipient and staff without regard to consent or injury; any non-consensual sexual activity between a recipient and another person; or any sexual activity between a recipient and another recipient or any other person when the recipient is not competent to give consent. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not competent to refuse.

Support Coordination – See case management.

Support Coordinator – An individual who meets the required qualifications and who is employed by a public or private entity to provide case management (support coordination) services.

Transition – The steps or activities conducted to support the passage of the recipient from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Trivial Report – A report of an allegation that an incident has occurred to a recipient or recipients that causes no physical or emotional harm and has no potential for causing harm to the

recipient or recipients. (La. R.S. 40:2009.14)

Waiver – An optional Medicaid program established under Section 1915 (c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care. See also Home and Community-Based Services Waiver.

Waiver Opportunity – An opportunity for an eligible application who meets the requirements for institutional care to receive XIX waiver services. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.