Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY DEVELOPMENTAL DISABILITIES PROVIDERS

OF

STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES

FISCAL YEAR 2017

Effective Date: July 1, 2016 (*Posted: June 1, 2016*)

DBHDD publishes its expectations, requirements, and standards for Community Developmental Disability Providers via policies and the State-Funded Provider Manual. This manual is updated quarterly throughout each fiscal year (July – June), and is posted one month prior to the effective date. Provider Manuals from previous fiscal years and quarters are archived on DBHDD's website at: http://dbhdd.georgia.gov/provider-manuals-archive".

INTRODUCTION

This Provider Manual has been designed as an addendum to your contract/agreement with DBHDD.

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INTRODUCTION

Welcome

Thank you for your participation as a provider in the Georgia system of services and supports for individuals with developmental disabilities. A network of providers with the ability to deliver quality state-funded services and supports is a primary asset in ensuring the ability to maintain the health, safety, welfare and quality of life for individuals with developmental disabilities residing in the communities across the state of Georgia. The Georgia Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities is glad that your agency has made the choice to participate as a provider of state-funded services and supports. We look forward to working with your agency to assist individuals with developmental disabilities in having a successful experience with community life.

Development/Update and Posting of the Provider Manual for Community Providers of State-Funded Developmental Disabilities Services

Development: This manual was developed by the staff of the Division of Developmental Disabilities in the Department of Behavioral Health and Developmental Disabilities (DBHDD) to assist community providers of state-funded developmental disabilities services. The FY 2017 Provider Manual for Community Providers of State-Funded Developmental Disabilities Services has been designed as an addendum to the provider's contract with DBHDD to provide each provider with the structure for supporting and serving individuals with developmental disabilities residing in the state of Georgia. Members of the DD Advisory Council and other stakeholders, including providers, individuals with developmental disabilities, family members and advocacy organizations, were involved in review of this manual. We extend our sincere thanks for their patience and willingness to devote time and energy to the completion of the Provider Manual for Community Providers of State-Funded Developmental Disabilities Services. If any conflict is found to exist between requirements found in this manual and requirements found in applicable state or federal law and rules and regulations, the requirement found in law and rules and regulations will prevail until resolution of the conflict is achieved.

Updates: Any updates will be made quarterly to the Provider Manual for Community Providers of State-Funded Developmental Disabilities Services. Primary responsibility for assuring updates to this provider manual rests with the DBHDD, Division of Developmental Disabilities. Ongoing input from the DD Advisory Council and other stakeholders is welcome in recommending updates to this provider manual.

Posting of Provider Manual:

Purpose of the Provider Manual

Basic Purpose: The purpose of this manual is to outline the basic principles and requirements for delivery of quality state-funded services and supports to individuals with developmental disabilities. State-funded services are intended to be temporary and/or transitional and not a permanent source of funding for individuals eligible for Medicaid waiver funding. For other individuals eligible for state-funded services and receiving these services, continued receipt of services is dependent upon available funding and continued need by the individual for the services. All community providers who participate in state-funded service delivery must have an executed DBHDD contract which requires compliance with this manual. The chapters of the manual provide the requirements for state-funded developmental disabilities services other than those in the Family Support Program.

Family Support Services: DBHDD policies for the Family Support Program are indexed in Family Supports for Developmental Disabilities Services and the Family Support, 02-401 which is located at www.gadbhdd.PolicyStat.com.

Provider Resources: There is information throughout the manual which references additional provider resources such as best practice guidelines; state and federal statutes, rules and regulations; other tools and manuals; and websites. These types of materials are available to assist providers in the development of policies and practices that meet the requirements specified in this manual and promote a good system of service delivery.

Relationships with Individuals Receiving State-Funded DD Services: The individual receiving state-funded DD services is the most important participant in the state-funded system. It is essential that providers have the ability to develop and maintain effective working relationships with individuals, their families, their legal representatives and advocates who may assist them in exercising their rights. Information in the manual outlines requirements and resources intended to promote respectful, effective relationships between individuals (and those assisting or representing them) and the providers delivering the state-funded services and supports.

Relationships with Other Providers of Services and Supports: Information included in the manual is intended to assist providers in developing relationships with other types of providers and in accessing/maximizing resources available through other programs available within the state. This information is intended to promote the ideal that individuals who participate in different programs must be treated in a holistic manner. In other words, the services and supports described in this manual will not meet all the social and health-care needs of people with developmental disabilities. It is essential that providers develop an understanding of how the state-funded DD services fit within the broader system of state healthcare, educational and social programs. Effective integration of state-funded DD services described in this manual with external services and natural supports is a goal that the state will continue to work toward.

Vision, Mission and Values

Vision: It is the vision of DBHDD that every person who participates in our services leads a satisfying, independent life with dignity and respect.

Mission: The mission of DBHDD is to provide and promote local accessibility and choice of services and programs for individuals, families and communities through partnerships, in order to create a sustainable, self-sufficient and resilient life in the community.

Values: The core values of DBHDD are respect, inclusiveness, and transparency. DBHDD believes it is critical that services, supports, treatment and care respect the vision of the individual. Each provider must incorporate this belief and practice into its service delivery to support individuals with developmental disabilities in living a meaningful life in the community. Specifically, the provider must ensure:

- Person-centered service planning and delivery that address what is important to and for individuals.
- Capacity and capabilities, including qualified and competent providers and staff.
- Individual safeguards.
- Satisfactory individual outcomes.
- Systems of care that have the infrastructure necessary to provide coordinated services, supports, treatment and care.
- Individuals rights and responsibilities.
- Individual access.

The expectations and requirements that follow are applicable to any community provider of state-funded DD services that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served. Individual self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone.*

CHAPTER 1

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT OF STATE-FUNDED SERVICES

1. INTRODUCTION

This manual provides the requirements for state-funded developmental disabilities services other than those in the Family Support Program. This chapter covers requirements for eligibility, enrollment, and disenrollment for state-funded developmental disabilities services.

The standards that follow are applicable to DBHDD or organizations that provide services to individuals that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served.

1.1 ELIGIBILITY FOR STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES

This section provides the standards for the eligibility of individuals for Developmental Disabilities State-Funded Services.

A. **Individual Eligibility and Priority for Developmental Disabilities State-Funded Services:** If a service is funded with only state funds, access to services is not guaranteed. The amount of money available for state-funded services is limited. The ability of the department to offer state funded services is dependent upon available funding and the current priorities set for these funds. Current priorities for state-funded services for individuals with developmental disabilities, in order of priority, are:

1. Bridge for individuals on the planning list for DD Waiver services; and

2. Eligible individuals with urgent, complex support needs and documented absence of other supports.

The Field Office Intake and Evaluation staff determines the individual's priority for state-funded services in accordance with the above priorities.

B. **State Funded DD Services and Waiver Eligibility:** Individuals who meet the eligibility criteria for Developmental Disabilities (DD) Home and Community Based Waiver services are eligible to receive state funded developmental disabilities services. DD waiver eligibility criteria are specified in the Department of Community Health, New Options Waiver (NOW) Program and Comprehensive Supports Waiver (COMP)

Program, Part II Policies and Procedures, Chapter 700. The NOW and COMP policies and procedures are available on the Georgia Medicaid Web Portal (www.mmis.georgia.gov).

C. **Eligibility Criteria for State Funded DD Services:** Individuals who do not meet the developmental disabilities waiver criteria or found eligible for state funded Family Support Services may receive state funded developmental disabilities services depending upon the availability of funding, if the following criteria are met:

1. **Most in Need:** The individual must demonstrate:

   a. Substantial risk of harm to self or others; **OR**

   b. Substantial inability to demonstrate community living skills at age appropriate level; **OR**

   c. Substantial need for supports to augment or replace insufficient or unavailable natural resources; **OR**

   d. High risk behavioral challenges and/or symptoms of co-occurring emotional/mental disorders and/or forensic involvement that contributes to presenting urgent, complex support needs.

   The meeting of the Most in Need criteria must be supported and documented as part of the eligibility determination by the Field Office Intake and Evaluation Office.

AND

2. **Diagnosis or Sufficient Evidence of a Developmental Disability:** The individual has an established developmental disability diagnosis or determination of sufficient evidence of a developmental disability, as assessed by a professional licensed to make the diagnosis or determination, with origin prior to the age of 22 years that resulted in substantial impairments in general intellectual functioning or adaptive behavior.

D. **Eligibility for Family Support Services:** The eligibility for Family Support Services is specified in Chapter 1 of this manual and in the DBHDD Policy Family Supports for Developmental Disabilities Services, 02-401.

E. **Lawful Presence:** Verification of lawful presence in United States is required for adults seeking DD Services from community providers of DD services. In accordance with Georgia law, all programs and services receiving funding from DBHDD or other state, federal or local funds are required to verify that adults who receive DD Services other than DD Emergency Services are lawfully present in the United States. The DBHDD Policy Verification of Lawful Presence in United States for Individuals Seeking Services and Related Discharge Procedures, 24-109.

1.2 STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES ENROLLMENT

This section provides standards for the application and enrollment for Developmental Disabilities State-Funded Services.

A. **Application for Services:** An individual or his/her representative applies for state-funded DD services by completing an application for developmental/intellectual disabilities that is available online on the DBHDD website (dbhdd.georgia.gov) or by mail or electronically (fax or email) from a DBHDD Field Office (see Appendix A for Field Office contact information). Applications may be completed in several ways:

1. Applicants may complete and submit the Application independently. Applications can be submitted via mail or electronically.

2. Applicants can complete the application over the phone with the assistance of a Field Office Intake and Evaluation representative.

3. Applicants can make arrangements to complete the application at the Field Office Intake and Evaluation Office with the assistance of a Field Office Intake and Evaluation representative.

If an individual or his/her representative contacts a provider of DD services, providers should provide the individual/representative with the contact information for the Field Intake and Evaluation (I&E) Office. The provider should inform the individual/representative that the application process is completed through the Field Intake and Evaluation Office.

A Field Intake and Evaluation Office representative provides the individual or his/her representative with an application packet upon request. All application packets include a blank Authorization for Release of Information, a Check List of what to Return with a Complete Application, and a Region by County Identification Sheet. Complete Application Packets should contain at least the following: The application, a psychological evaluation, a medical history, and a signed Authorization for Release of Information.

Once a complete application is received by the DBHDD Field Office Intake and Evaluation Office, a DD waiver eligibility determination is made by the Intake and Evaluation psychologist. As indicated above, any individual eligible for DD waiver services is eligible for state-funded DD services. These individuals are placed on the planning list, and as indicated above, a current priority for state-funded DD services is as a bridge for individuals on the planning list for DD services. Any individual determined not to be eligible for the DD waiver services is informed of fair hearing rights as indicated in the Department of Community Health, New Options Waiver (NOW) Program and Comprehensive Supports Waiver (COMP) Program, Part II Policies and Procedures, Chapter 700, which are available on the Georgia Medicaid Web Portal (www.mmis.georgia.gov).

Additional review by the Field Intake and Evaluation Office of an application for state-funded eligibility is dependent upon the following:

- Application packet includes evidence of a developmental disability and documentation supportive of most in need criteria; and
- Individual presents with urgent, complex support needs and documented absence of other supports.

The Field Intake and Evaluation Manager or designee notifies the individual or his/her representative of the determination of available funding for the individual who meets eligibility for state-funded DD services and the current state priority for services. Situations arise where an individual's need for services becomes so severe and urgent that action must be taken immediately to address significant risks to health and safety. When the Field Office learns of an individual's circumstances for which an immediate system response is required, the Intake and Evaluation Manager and Field Services Administrator for Developmental Disabilities coordinate the response. This response includes coordination with the Division of Developmental Disabilities and other agencies as applicable to the individual's situation.

B. **Review Process for Ineligibility Determination for State-Funded Developmental Disabilities**: Individuals who apply for DD waiver services and are determined to be ineligible for DD waiver services are informed in writing of their fair hearing rights as specified in NOW and COMP Part II, Chapter 700 policies, which are available on the Georgia Medicaid Web Portal (www.mmis.georgia.gov). Fair hearing rights are only applicable to ineligibility determination for DD waiver services. Individuals who apply for state-funded developmental disability services and are determined to be ineligible for the DD state-funded services may request a review of this ineligibility determination in writing to the DBHDD Regional Services Administrator for Developmental Disabilities (RSA-DD). The RSA-DD or designee coordinates a review of the ineligibility determination with Division of DD State Office staff. The findings of

the review of the ineligibility determination are provided in writing by the Field Office to the individual/representative. The decision of the review will be final.

C. **DD Waiver Eligibility and State-Funded Services:** Individuals who meet the eligibility criteria for DD Home and Community Based Waiver services are eligible to receive state-funded developmental disabilities services. State-funded services are provided to individuals who are eligible for the DD Home and Community Based Waiver Programs, the New Options Wavier Program (NOW) or the Comprehensive Supports Waiver Program (COMP), as follows:

1. Individuals on the Planning List: Available state funds may be used as a bridge for individuals on the planning list for NOW/COMP Waiver Services. The receipt of state-funded DD service not available in the State Medicaid Plan is dependent upon available funding, assessed priority, and DBHDD Field Office approval. Planning List Administrators inform individuals and their families that state-funded services may be available.

2. Individuals Receiving NOW or COMP Services: Individuals receiving NOW or COMP services are not eligible for state-funded services available in the NOW/COMP waiver programs or the State Medicaid Plan. These individuals are eligible to receive state-funded home and community based crisis services and state-funded emergency respite services. State-funded home and community based crisis services are accessed by calling the single point of entry for the Georgia Crisis Response System for Individuals with Developmental Disabilities (1-800-715-4225). State-funded emergency respite services for individuals receiving NOW or COMP services are approved by the DBHDD Field Office.

D. **State-Funded Services for Other Individuals:** Other individuals with developmental disabilities may not be eligible for Medicaid but may be eligible for state-funded services. Individuals who do not meet the DD waiver criteria may receive state-funded developmental disabilities services depending upon the availability of funding, priority of need, and meeting the Eligibility Criteria for State-Funded DD Services for individuals not eligible for NOW/COMP services listed in Item C of Section 2.1 of this chapter. The Field Office Intake and Evaluation staff determines the individual's priority for state-funded services in accordance with the priorities listed in Item A of Section 2.1 of this chapter.

E. **Referral to Planning List Administrator or State Services Coordinator:** If the individual is approved by the field office for state-funded services, a referral will be made to the Planning List Administrator when the individual is Medicaid eligible and to the State Services Coordinator when the individual is not Medicaid eligible. The Planning List Administrators coordinate the services for people who are Medicaid eligible and on the planning list and waiting for NOW or COMP services. State Services Coordinators coordinate the services for people who are not Medicaid eligible and on

the planning list and waiting for NOW or COMP services. Planning List Administrators and State Services Coordinators are assigned specific counties in which they coordinate state services for individuals with developmental disabilities determined eligible for these services and who reside in these counties. The initial contact is made by the Planning List Administrator or State Services Coordinator within ten (10) days of notification that the person has been approved to receive state services. Responsibilities of Planning List Administrators and State Services Coordinators are described in Chapter 4 of this manual.

F. **Availability of State-Funded Developmental Disabilities Services:** An individual who is determined eligible may receive state-funded developmental disabilities services depending upon the availability of funding and priority of need. The amount of money available for state-funded services is limited. The ability of DBHDD to offer state-funded services is dependent upon available funding and the current priorities set for these funds as listed in Section 2.1 of this chapter.

G. **Approval Process for Enrollment into State-Funded Services:** All individuals served by the provider should be authorized by the Field Office through the Intake and Evaluation process. Individuals authorized through the Intake and Evaluation process are provided state-funded services dependent upon available of funding and the current priorities set for these funds as listed in Section 2.1 of this chapter. With the identification of available funding for enrollment of state-funded developmental disabilities services, the individual/family is informed by the Field Office of services approved. The Field Office sends the individual/representative a list of providers servicing the area which also includes surrounding counties. The provider list must state the specific service(s) of the provider. The Field Office is responsible for reviewing the capacity of providers and for notifying providers of the specific number of individual(s) in the surrounding area with the type of approved service(s).

H. **Referral to Providers:** Referral to providers of individuals eligible for state-funded services is based on the choice of the individual or his/her representative. The Field Office obtains confirmation from the individual/representative of the choice of provider(s). Based upon individual/representative choice of provider, the Field Office makes a referral to provider(s) and notifies the provider(s) of the approved state-funded service(s) authorized for the individual by Intake and Evaluation staff. Each provider evaluates referrals to determine what area of services would be most appropriate for the individuals and the ability to meet the needs of the individuals. When able to provide services and meet the needs of the individual, the provider confirms the start date of services to the Planning List Administrator or State Services Coordinator. In case the provider cannot create an appropriate fit to successfully serve an individual, the provider should submit documentation to the Field Office of justification within ten (10) business days after receiving the referral. The Field Office reviews the documentation submitted by the provider and informs the provider in writing the results of the review. Any concerns by the Field Office about the

provider's stated reasons for refusal to serve an individual are included in the written findings of the review.

I. **Start Date Confirmation:** When the start date of services is confirmed by provider(s) to the Planning List Administrator or the State Services Coordinator, the name of the individual, provider(s), services and start date are forwarded by the Planning List Administrator or the State Services Coordinator to Operations Analyst (OA). The OA reviews and approves for contract vacancy or need for contract amendment and notifies the DBHDD State Office fiscal staff. The individual is assigned to the State Coordinator Supervisor for monitoring and follow up.

J. **Initial Individual Service Plan:** An Initial Individual Service Plan (IISP, formerly called the Temporary Individual Action Plan or TIAP) is developed prior to an individual receiving state-funded services. The IISP is developed by the provider with the required participation of the assigned Planning List Administrator to provide short-term guidelines for state-funded services planned for the individual until a comprehensive ISP is developed. The intention is to expedite the enrollment process so that the individual will receive state-funded services immediately. Comprehensive Individual Service Plan (ISP) development is described in Chapter 4 of this manual. As indicated in Chapter 4, a comprehensive ISP should be developed **90** days after the Initial ISP for individuals who will receive ongoing state-funded services.

1.3 STATE-FUNDED SERVICES REDUCTION, DISCONTINUANCE, AND DISENROLLMENT

This section provides the standards for reduction, discontinuance, and disenrollment for Developmental Disabilities State-Funded Services.

A. **Reporting of Referred Individual Receiving NOW/COMP Waiver Services:** The provider must report to the Field Office of knowledge of an individual referred to Developmental Disabilities State-Funded Services who also receives NOW/COMP Medicaid Waiver funded services.

B. **Provider Notification of Disenrollment of Individual from State-Funded DD Services:** The Provider Agency for State-Funded Services is responsible for notifying the Field Office in writing of any disenrollment of an individual from state-funded services no later than five (5) business days after the disenrollment. The written notification should provide the reason for disenrollment (e.g., movement to another state, death, family decision, etc.). The Field Office is responsible for recording the disenrollment in the information management system and following up on any needed contract amendment.

C. **Disenrollment from State-funded Services Due to NOW/COMP Waiver Enrollment:** The Field Office notifies the provider(s) of state-funded services in writing when an individual is enrolling into the NOW or COMP waiver. The Field Office facilitates

the individual's disenrollment from state-funded services and follows up on any needed contract amendments. The provider works with the Field Office in converting individuals who are eligible for the NOW/COMP Waiver from state-funded services to Waiver services.

D. **Review Process for DBHDD Field Office Discontinuation or Reduction of State-Funded Developmental Disabilities Services**: If the individual/representative requests a review of the discontinuation or reduction of state-funded developmental disabilities services, the request for the review should be sent in writing to the Field Office for a review by the Regional Services Administrator for Developmental Disabilities (RSA-DD) or designee. The decision of the review may be based on, but not limited to, a change in available funding for state developmental disabilities services, changes in individual priority of need, or NOW/COMP waiver enrollment. The Field Office Coordinator will confer with Division of DD State Office staff before providing a decision on the review. The decision of the review will be final.

CHAPTER 2
STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES

2. INTRODUCTION

There are a variety of state-funded services and supports for individuals with developmental disabilities who meet eligibility for these services and are approved for these services as outlined in Chapter 1 of this manual. This chapter provides an overview of state-funded developmental disabilities services.

2.1 STATE-FUNDED SERVICES

State-funded services may be provided to an individual with a developmental disability determined eligible for these services and depending upon the availability of funding and the current priorities for these funds in accordance with Section 1.1 of Chapter 1 of this manual. Providers under contract with DBHDD provide state-funded services in accordance with the requirements of this manual and as specified in their contract. State-funded services are provided to authorized individuals who meet the DBHDD's criteria for state-funded developmental disabilities services and who have no other means of payment of these services, including State Medicaid Plan services for those receiving Medicaid. All individuals receiving state-funded services must be authorized by the Field Office through the Intake and Evaluation process.

The following is a list of the state-funded services provided in accordance with the Individual Service Plans (ISPs) for individuals served:

A. **Routine Day Services** – These services consist of Community Access Group and Prevocational Services provided in any combination, but the Community Access Group and Prevocational Services cannot be provided at the same time to an individual. Routine Day Services are offered and made available if desired to state-funded individuals five (5) days/30 hours per week. On an exceptional basis, for individuals receiving Routine Day Services, the planned provision and utilization of services may be less frequent, but must be so indicated in the individual's ISP and approved by the Field Office. Individuals can receive additional group services (after receiving 120 hours of Routine Day Services in a month) after hours and on weekend if they are needed and included in the ISP.

   State-Funded Routine Day Services include:

   1. Direct Community Access Group and Prevocational services provided to the individual;
   2. Indirect intervention services provided specifically on the behalf of the individual as prescribed in the ISP. Indirect Intervention Services consist of design and

development of activities in any location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of a specific individual;

3. Individuals may participate in any combination of Routine Day Services, to include Community Access Group and Prevocational Services. Community Access Group and Prevocational Services are defined below.

B. **Community Access Services** – These services are individually planned to meet the person's needs and preferences for active community participation. Community Access services are provided outside the individual's place of residence. These services can occur during the day, the evenings, or weekends. Services include design of activities and environments for the individual to learn and/or use adaptive skills required for active community participation and independent functioning. These activities include training in socialization skills as well as personal assistance as indicated in the Individual Service Plan. Community Access services must not duplicate or be provided at the same time of the same day as Community Living Support, Supported Employment, or Prevocational Services.

1. **Transportation and Community Access Services**—Transportation requirements are as follows:

   a. Transportation to and from activities and settings primarily utilized by people with disabilities is included in Community Access services. This transportation is provided through Community Residential Alternative services for individuals receiving these services.

   b. Transportation provided through Community Access services is included in the cost of doing business and incorporated in the administrative overhead cost.

   c. The individual's family or representative may choose to transport an individual to a Community Access facility.

   d. Transportation is required between point of origin and activities in settings primary utilized by people with disabilities (a reasonable amount of transportation, defined as up to one hour per day, is billable). Point of origin is defined as any location that individuals are available for pick-up that is safe and appropriate for the individual based on the approved Individual Service Plan.

2. **Community Access Services** have two distinct categories, Community Access Individual and Community Access Group, as follows:

a. **Community Access Group** – Services are provided to groups of individuals. The direct care staff to individual ratio for Community Access Group services cannot exceed one (1) to ten (10) and is determined based on individual need level of the persons in the group. Community Access Group Services are designed to provide oversight, assist with daily living, socialization, communication, and mobility skills building and supports in a group. These services may include programming to reduce inappropriate and/or maladaptive behaviors. Community Access Group Services may be provided in a facility or a community as appropriate for the skill being taught or specific activity supported.

   State-Funded Community Access Group Services include the following based on the assessed need of the individual and as specified in the approved ISP:

   i. Design and development of activities in any location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which include services provided on behalf of an individual as well as direct services;

   ii. Assistance in acquiring, retaining, or improving socialization, and adaptive skills for active community participation and independent functioning outside the individual's own or family home, such as assisting the individual with money management, teaching appropriate shopping skills, using public transportation, and teaching nutrition and diet information;

   iii. Assistance in acquiring, retaining, or improving access to and use of community resources that increases participation in integrated community activities, such as training and active support to use public transportation, banks, automated tellers, and restaurants;

   iv. Provision of oversight and assistance with daily living, socialization, communication, and mobility skills building and supports in a group;

   v. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

   vi. Recreational and leisure activities that support the individual's active, local community participation and are specific to an ISP goal and therapeutic in nature, such as teaching an individual how to participate in and take

advantage of community social and recreational activities or providing active support for an individual in community recreational and leisure activities;

vii. Facilitating volunteer roles in the community and participation in self-advocacy type activities;

viii. Other related, individual-specific assistance, such as assistance with personal care and self-administration of medications, and nursing services, and health maintenance activities as indicated in the approved Individual Service Plan;

ix. Transportation is required between point of origin and activities in settings primarily utilized by people with disabilities (a reasonable amount of transportation, defined as up to one hour per day, is billable). Point of origin is defined as any location that individuals are available for pick up that is safe and appropriate for the individual based on the approved Individual Service Plan.

b. **Community Access Individual** – Services are provided to an individual, with a one-to-one staff to individual ratio. The intended outcome of Community Access Individual services is to improve the individual's access to the community through increased skills, increased natural supports, and or less paid supports. Community Access Individual Services are designed to be teaching and coaching in nature. These services assist the individual in acquiring, retaining, or improving socialization and networking, independent use of community resources, and adaptive skills required for active community participation outside the individual's place of residence. These services are not facility-based.

State-Funded Community Access Individual Services include the following based on the assessed need of the individual and as specified in the approved ISP:

i. Design and development of activities in any non-facility, community-based location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of an individual as well as direct services;

ii. Assistance in acquiring, retaining, or improving socialization, and adaptive skills for active community participation and independent functioning

outside the individual's own or family home, such as assisting the individual with money management, teaching appropriate shopping skills, using public transportation, and teaching nutrition and diet information;

iii. Assistance in acquiring, retaining, or improving socialization and networking, independent use of community resources, and adaptive skills required for active community participation outside the individual's place of residence;

iv. Individual-specific teaching and coaching of skills for access to the community, including communication, mobility, money management, and shopping skills;

v. Implementation of behavioral support plans to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

vi. Teaching and coaching an individual how to participate in and take advantage of community social and recreational activities;

vii. Facilitating volunteer roles in the community and participation in self-advocacy type activities;

viii. Other individual-specific assistance, such as assistance with personal care and self-administration of medications, and nursing services, and health maintenance activities as indicated in the approved Individual Service Plan.

C. **Prevocational Services** – These services prepare an individual for employment. These services are for individuals not expected to be able to join the general work force within one year as documented in the ISP. The direct care staff to individual ratio for facility-based Prevocational Services cannot exceed one (1) to ten (1) and is determined based on individual need level of the persons in the group. The direct care staff to individual ratio for Mobile Crew Prevocational Services cannot exceed one (1) to six (6). If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act. Prevocational Services occur at community sites outside the facility or in facility-based settings for small groups of individuals. Prevocational Services may not be delivered in an individual's own or family home or any residential setting. Prevocational Services are distinct from and do not occur at the same time of day as Community Access or Supported Employment services.

Prevocational Services include teaching individual concepts necessary for a person to perform effectively in a job in the community. The intended outcomes of these

services are to prepare an individual for employment and teach such concepts as attendance, task completion, problem solving and safety. Transportation is required to and from the facility site. This transportation is provided through Community Residential Alternative services for individuals receiving these services. The individual's family or representative may choose to transport the member to the Prevocational Services facility.

State-Funded Prevocational Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Teaching such concepts as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, and safety;

2. Instruction in appropriate social interaction skills required in the workplace;

3. Individual-specific assistance, such as assistance with personal care and self-administration of medications, as identified in the Individual Service Plan;

4. Facility-based training and/or assistance;

5. Mobile crews, which consist of a group of individuals who engage in prevocational services by performing tasks, such as cleaning or landscaping, at community sites outside the facility;

6. Transportation is required to and from the facility site (a reasonable amount of transportation, defined as up to one hour per day, is billable).

D. **Supported Employment Services** – Supported Employment Services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to work in an integrated work setting. Providers supporting any individual, who is not employed, shall have a minimum of two face-to-face contacts with the individual per month. The goal of each contact should reflect job development activities. Supported Employment Services are distinct from and do not occur at the same time of day as Community Access or Prevocational services.

The planned outcomes of Supported Employment Services are to increase the hours worked by each individual toward the goal of full-time employment (i.e., the goal of forty (40) hours per week) and to increase the wages of each individual toward the goal of increased financial independence. An individual does not have to be able to work full-time to receive Supported Employment Services because supported employment can be either full or part time work.

Supported Employment services are based on the individual's needs, preferences, and informed choice. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

State-Funded Supported Employment Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Assisting the individual to locate a job or develop a job on behalf of the individual;

2. Activities needed to sustain paid work by individuals, including supervision and training;

3. Adaptations, supervision, and training required by individuals receiving Supported Employment services as a result of their disabilities, when these services are provided in a work site where persons without disabilities are employed.

E. **Community Living Support Services** – These services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an individual's continued residence in his or her own home or family home. Community Living Supports are intended for individuals with developmental disabilities who require some residential supports to remain in the community and who require **less intensive supports** than those described in the definition of Comprehensive Residential Alternative (CRA) services. In most cases, direct support is intermittent, supporting individuals in activities such as preparing meals, managing personal finances or accessing generic community resources. However, in all cases, the type, frequency and intensity of Community Living Supports must be documented in the Individual Service Plan (ISP). Community Living Supports Services are distinct from and do not occur at the same time of day as Community Access or Supported Employment services.

- **Purpose** – Community Living Support Services are aimed at supporting individuals in having increased opportunities to participate in their own community and in exercising choice in regard to their services and daily routines.

- **Community Living Support Services and Private Home Care License** – Provider agencies that render state-funded Community Living Support Services must have a Private Home Care Provider license from the Department of Community Health, Healthcare Facility Regulation Division (HFR).

Note: State-funded CLS services do not include nursing services.

State-Funded Community Living Support Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Social and leisure skills development that assists the individual in planning and engaging in social and leisure activities as a part of home living in a community;

2. Adaptive skills development that assists the individual in community activities that are a part of home living in a community, such as community navigation, mobility, communication, understanding community signs/clues, and safety in the community;

3. Personal care and protective oversight and supervision in the person's own or family home;

4. Protective care and watchful monitoring activities of individual's functioning, the making and reminding an individual of medical appointments, intervention if a crisis arises for an individual, and supervision in the area of nutrition and self-administration of medications and other medically related services including health maintenance activities;

5. Training in and personal care/assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management;

6. Medically related services, such as basic first aid, arranging and transporting individuals to medical appointments, accompanying individuals on medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, and assisting with self-administration of medication;

7. Implementation of the behavioral support plan of an individual to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors;

8. Transportation is required for individuals living in their own home to facilitate the individual's participation in grocery or personal shopping, banking, and other community activities that support continued home living; transportation is provided as specified in the ISP for individuals living in their own home.

F. **Community Residential Alternative Services** – These services are targeted for individuals who require intense levels of support. These services are individually planned and tailored to meet the specific needs of the individual and to accommodate fluctuations in his or her needs for various services. Community Residential Alternative (CRA) services include assistance with and/or training in activities of daily

living such as bathing, dressing, grooming, and other personal hygiene, feeding, toileting, transferring and other similar tasks. These services may not be provided to persons living in their own or family homes.

1. **Provider Requirements and Community Residential Alternative Services**– The following are provider requirements:

    a. **Transportation and Community Residential Alternative Services** –The provider of Community Residential Alternative Services provides transportation of the individual to other state-funded services specified in the Individual Service Plan.

    b. **Requirements to Accompany Individuals to Emergency Rooms or Hospitals**– Community Residential Alternative provider agency staff must accompany individuals who are transported to an emergency room or hospital. A host home provider may accompany an individual to the hospital until a provider agency staff member arrives.

    c. **Requirements for Employees Residing at Employer's CRA Site:** The provider agency must abide by the Fair Labor Standards Act requirements for sleep time when employees reside at the employer's CRA site.

    d. **Relocation of Individual:** An individual must not be relocated without documented prior approval from the DBHDD Field Office, a minimum of thirty (30) days prior to the move except in documented and Field Office approved emergencies.

2. **Actions Due to Critical Health and Safety Risks**– If a CRA service site is determined by DBHDD to have critical health and safety risk, DBHDD will take immediate action to remove the individual(s).

3. **Licensure**–Provider agencies that render CRA services in a regulated setting must hold the applicable license from the Department of Community Health (DCH), Healthcare Facilities Regulation Division (HFR) as follows:

    a. For CRA services rendered in a personal care home, the provider agency must have a Personal Care Home Provider License from HFR for each individual residential site (State of Georgia Rules and Regulations 290-5-35).

    b. For CRA services, rendered in a Community Living Arrangement, the provider agency must have a Community Living Arrangement license for each individual residential site from HFR (State of Georgia Rules and Regulations 290-9-37).

c. For CRA services rendered in foster care settings for individuals under the age of 19 years, the provider agency must have a Child Placing Agencies license from HFR in accordance with the therapeutic foster care section (State of Georgia Rules and Regulations 290-9-2).

4. **State-Funded Community Residential Alternative Services** include the following based on the assessed need of the individual and as specified in the approved ISP:

   a. Assistance with, and/or training in, activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring and other similar tasks;

   b. Accompanying individuals and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities. This category includes staff to serve as interpreters and communicators and transportation costs to provide the service;

   c. Training or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care and other similar tasks;

   d. Assisting with therapeutic exercises, supervising self-administration of medication, basic first aid, arranging and transporting individuals to medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, assisting with therapeutic exercises, supervising self-administration of medication and performing other medically related services including health maintenance activities;

   e. Training and support in the areas of social, emotional, physical and special intellectual development. This category includes mobility training and programming to reduce inappropriate or maladaptive behaviors;

   f. Transportation is required to and from all state-funded services specified in the Individual Service Plan;

   g. Implementation of behavioral support plans to reduce inappropriate behavior and to acquire alternative skills and behaviors.

G. **Respite Services** – These services provide brief periods of support or relief for caregivers of individuals with disabilities or address unexpected, emergency situations that result in the need for temporary support not addressed by the Georgia Crisis Response System. Respite Services may be provided in-home (service provided in the individual's home) or out-of home (individual receives services

outside of his/her own home). Respite Services include short-term services during a day or overnight services.

1. **Categories of Respite Services:** State funds may be used to pay for the following categories of respite services:

   a. When families or the usual caretakers are in need of additional support or relief;

   b. When the individual needs relief or a break from the caretaker;

   c. When an individual is experiencing severe behavioral challenges and needing structured, short-term support beyond the crisis stabilization provided by the Georgia Crisis Response System ; or

   d. When relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.

   Note: Supports provided through the Georgia Crisis Response System are not defined as respite services.

2. **Out-of-Home Licensed Respite Home Physical Standards**: State-funded providers who provide Out-of-Home Respite Services in a licensed home meet the physical standards requirements for the homes by maintaining licensure as follows:

   a. State-funded providers who render Respite Services in a Personal Care Home meet the physical standards requirements for these homes by maintaining licensure (State of Georgia Rules and Regulations 111-8-62).

   b. State-funded providers who render Respite Services in a Community Living Arrangement meet the physical standards requirements for these homes by maintaining licensure (State of Georgia Rules and Regulations 290-9-37).

   c. State-funded providers who render Respite Services in a Child Caring Institution meet the physical standards requirements for these homes by maintaining licensure (State of Georgia Rules and Regulations 290-2-5).

   d. State-funded providers that render out-of-home Respite Services in foster care settings for individuals under the age of 19 years meet the physical standards requirements for these homes by maintaining a Child Placing Agency License (State of Georgia Rules and Regulations 290-9-2).

3. **Out-of-Home Non-Licensed Respite Home Physical Standards**: State-funded providers who render Out-of-Home Respite Services in a private residence of the employee/independent contractor providing the services must meet the

following requirements:

a. Each home must be located in a residential community not solely inhabited by persons with disabilities;

b. The home must be accessible to the individual served;

c. The home is maintained in a condition to ensure the health and safety of the individual;

d. Hazardous items are not accessible to the individual;

e. Sleeping arrangements, such that

   i. Only a bedroom is used as sleeping space for an individual;

   ii. No individual under the age of eighteen (18) years sleeps in a room with an adult;

   iii. There must be no more than two individuals per bedroom, and these individuals must be the same gender.

4. **Additional Requirements for State-Funded Respite Services**: Each Field Office maintains a list of DBHDD contracted Respite provider agencies with which the region contracts for the provision of Respite. The contracted Respite provider agency has the following responsibilities:

   a. Ensures that Respite Services are provided only in approved Respite sites that meet the specified physical standards and other requirements to provide state-funded Respite in this manual and in the DBHDD Policy State Funded Respite for Individuals with Developmental Disabilities, 02-102.

   b. Maintains a list of Approved Respite Sites and Persons Approved to Provide Respite (including addresses and contact information);

   c. Adds a site or approved person to the list ***only*** after having documentation on hand that the site or approved person meets all requirements to provide state-funded Respite Services.

      Note: State funds cannot be used to purchase or reimburse Respite Services provided by any person who is not included on the List of Persons Approved to Provide Respite.

5. **Categories of Respite Services:** The two categories of Respite Services are:

   a. **Maintenance (Scheduled or Planned) Respite** – Planned or scheduled respite

provides brief periods of support or relief for caregivers or individuals. Maintenance Respite may be provided In-Home (provider delivers services in the individual's home) or Out-Of-Home (individual receives services outside of their home, but not in a crisis home).

b. **Emergency (Unscheduled) Respite** – Unscheduled respite is intended to be a short term service for an individual who requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. Emergency Respite may be provided In-Home (provider delivers services in the individual's home) or Out-Of-Home (individual receives services outside of their home, but not in a crisis home).

6. **Emergency Respite Services Approval** — State-funded emergency respite services address urgent needs for services as approved by the Field Office. The Field Office approves Emergency Respite Services ***only*** when the current support or residential placement is unstable and/or unavailable, and no other formal or informal supports are available to the individual. A specific plan to transition the individual back to his/her permanent home is presented at the time of admission. The plan should be developed and implemented by the Planning List Administrator (PLA), Support Coordinator (SC), or Field Office designee when applicable. Individuals will NOT be placed (except in extreme emergency) without a specific plan for discharge (including date, location and responsible party).

7. **State-Funded Respite Services** include the following based on the assessed need of the individual and as specified in the approved ISP:

   a. Planned or scheduled respite (Maintenance Respite) provides brief periods of support or relief for caregivers or individuals for the following: (1) when families or the usual caretakers are in need of additional support or relief; or (2) when the individual needs relief or a break for the caretaker.

   b. Unscheduled respite (Emergency Respite) provides a period of structured support for the individual experiencing severe behavioral challenges beyond the crisis stabilization provided by the Georgia Crisis Response System or brief periods of support for an individual due to unavoidable circumstances, such as a family emergency.

   c. Planned or scheduled respite (Maintenance Respite) and Unscheduled respite (Emergency Respite) services are short-term services during a day or overnight services that include but are not limited to:

i. Individual-specific assistance, such as assistance with activities of daily living, self-administration of medications, and health maintenance activities;
ii. Direct assistance in individual's participation in community social, recreational and leisure activities;
iii. Implementation of the behavioral support plan of individual to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors.

H. **Behavioral Supports Consultation Services** – These professional consultation services assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations.

The intended outcome of Behavioral Supports Consultation Services is to increase individual skills and decrease the need to engage in challenging behaviors. The services emphasize a systems approach to behavioral interventions with an emphasis placed on early identification of problem behaviors. Specialized interventions are designed with a function-based approach that eliminates challenging behaviors and replaces them with alternative pro-social skills.

State-Funded Behavioral Supports Consultation Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Functional assessment of behavior and other diagnostic assessment of behavior.
2. Development, training, and monitoring of Behavioral Support plans with specific criteria for the acquisition and maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors.
3. Intervention modalities related to the identified behavioral needs of the individual.
4. Individual-specific skills or replacement behavior acquisition training.
5. Family education and training on Behavioral Supports.

I. **Home and Community Based Crisis Services** – The goal of the Georgia Crisis Response System (GCRS-DD) is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual

undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. The Georgia Crisis Response System is designed for individuals with developmental disabilities in need of Behavioral Health and Developmental Disabilities (BHDD) crisis services.

1. **Eligibility for Home and Community Based Crisis Services** — The Georgia Crisis Response System serves children and adults with developmental disabilities aged 5 years and above who meet eligibility criteria as defined below. A person with developmental disabilities in need of home and community based crisis services is an individual who:

    a. Has documented evidence of a diagnosis of an intellectual disability prior to age 18 years or other closely related developmental disability prior to age 22 years, for individuals currently on the planning list or in DD services; screening indicative of a developmental disability for other individuals; **AND**

    b. Presents a substantial risk of imminent harm to self or others; **AND**

    c. Is in need of immediate care, evaluation, stabilization or treatment due to the substantial risk; **AND**

    d. Is someone for whom there currently exists no available, appropriate community supports to meet the needs of the person.

2. **Components of the Georgia Crisis Response System** – This system includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis.

    a. **Intake**: Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system.

    b. **Dispatch or Referral**: The SPOE initiates the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services.

    c. **Crisis Services**: Crisis services occur through intensive on-site or off-site supports. These crisis supports are provided on a time-limited basis to ameliorate the crisis.

    Note: For additional information on the requirements of the GCRS-DD, see the Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD) in the Provider Manual for Community Developmental Disabilities Providers

located on the DBHDD website (http:dbhdd.georgia.gov, Providers tab, Community Provider tab).

3. **GCRS-DD Services** include the following:

   a. **Single Point of Entry Services** — The Georgia Crisis Response System has a single point of entry for intake and access to time-limited home and community based crisis services that support individuals with developmental disabilities in the community.

   b. **Mobile Crisis Team** — Mobile crisis teams are composed of personnel with differing levels of expertise and training. Depending on the crisis, different team compositions may be dispatched. A minimum of three team members, including a behavior specialist, licensed clinical social worker, and a direct support staff, will respond to each mobile dispatch.

   c. **Intensive In-Home Support** — Intensive In-Home Support services include, but are not limited to, the following: Implementation of behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team, safety plans, or behavioral support plans already established for the individual; provision of one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations as necessary to maintain safety; and when necessary accompanying the individual to appointments related to the crisis response. The provision of a staffing pattern up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing over 7 calendar days. Maintenance of stakeholder's involvement in the response to the crisis, in order to restore the individual to pre-crisis supports and/or provider services. Assurance of appropriate training to support crisis stabilization and the return of the individual to pre-crisis services and supports, to include: a. Demonstration of interventions to the family/caregiver and/or existing DD service provider (if applicable) **AND** b. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable).

   d. **Crisis Support Home** — A home that serves up to four (4) individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which have not responded to Intensive-In-Home Support services.

   e. **Temporary Intermediate Support (TIS) Home** — A TIS Home is to serve no more than four children ages 10 thru 17 years of age, who are diagnosed with a developmental disability and are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. Placement in a TIS home is

to only occur as a last resort and after a clinical determination for this level of placement has occurred.

f. **Intensive Case Management** — Intensive Case Management is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.

2.2 PROVIDER EXPECTATIONS RELATED TO STATE-FUNDED SERVICES

The following are provider expectations related to State-Funded Developmental Disabilities Services:

A. Ensures that State-Funded Services are delivered to individuals referred to the provider in accordance with Chapter 4 of this manual;

B. Accesses the Georgia Crisis Response Systems as a last resort and only if existing crisis procedures as part of the safety plans have been implemented unsuccessfully and/or the individual is an imminent harm to self or others and the current supports cannot maintain safety, and/or the individual is in need of immediate care, evaluation, stabilization or treatment due to risk, and the individual has no available, appropriate community supports to meet his or her needs;

C. Permits and assists as requested in a random sampling of individual records by the Department or an authorized designee to verify the eligibility of persons served, the appropriateness of State-Funded DD Services provided, and the quality of State-Funded DD Services provided;

D. Attends all Field Office Provider Meetings for the regions in which services are provided;

E. Ensures that all individuals receiving State-Funded DD Services have been identified eligible and referred for service by the Field Office, Intake and Evaluation;

F. Acknowledges that the failure to follow the Field Office process could result in denial of reimbursement or request for payback of received funds;

G. Works with the Field Office in converting individuals who are eligible for DD waiver from state funded services to Waiver services;

H. Maximizes the utilization of all capacity to serve individuals;

I. Meets quarterly with the Field Office at a meeting called by the Field Office to review utilization and address the issues related to unutilized capacity; and

J. Cooperates with the Department's Quality Improvement Organization (QIO) in its implementation of the Department's Developmental Disability Quality Management System.

CHAPTER 3
RESOURCE ALLOCATION AND INDIVIDUALIZED SERVICE PLANNING OF STATE-FUNDED SERVICES

3. INTRODUCTION

If a service is funded with only state funds, access to services is not guaranteed. The state legislature must make funding available in the state budget to initiate and ensure continuation of state-funded services. Providers may have the capacity to provide more state-funded services and there may be significant demand for state-funded services; however, the demand more frequently exceeds the availability of funding. The DBHDD, Division of Developmental Disabilities is responsible for determination of funding needs, setting priorities, and contracting and allocation of the limited state funds for services for individuals with developmental disabilities. The Division of DD is committed to carrying out these functions in concert with providers, advocacy groups, and individuals and their families. Current priorities for state-funded services for individuals with developmental disabilities are:

1. Bridge for individuals on the planning list for DD Waiver services;

2. Eligible individuals with urgent, complex support needs and documented absence of other supports.

Individuals with developmental disabilities may receive state-funded services depending on availability of funding and priority of need. State-funded emergency respite services address urgent needs for services as approved by the Field Office.

3.1 RESOURCE ALLOCATION OF STATE SERVICES FUNDS

This section provides standards for the resource allocation of state services funds by DBHDD Field Offices.

A. **Field Office Resource Allocation of State Services Funds —** Field Office resource allocation of state funds for developmental disabilities services occurs as follows:

   1. **Review of Utilization Management Data:** The Field Offices conduct ongoing review of utilization management data on state-funded services for individuals with developmental disabilities. The Field Offices currently use data from required provider reporting specified in Chapter 6 of this manual for their utilization management of state-funded services. The Division of Developmental Disabilities is in the process of adding information management system capacity to

WIS for ongoing data collection for utilization management of state-funded services.

2. **Re-distribution of State Services Resources:** Utilization management data provide the basis for decisions on the re-distribution of state services resources in accordance with the state priorities for these resources and to assure efficient use of these limited resources. State services resources also may be re-distributed due to the inability of a provider to meet contract deliverables. The Field Offices provide the Division of Developmental Disabilities with summary reports of their utilization management reviews and findings on provider contract deliverables. The Division of Developmental Disabilities reviews the Field Office summary reports prior to the development of annual provider contracts for state-funded services.

3. **Contract Amendment or Termination:** The Division of Developmental Disabilities reserves the right to amend contracts during a state fiscal year based on utilization management data, contract deliverable reports, and/or the availability of funding. If a provider does not meet the stated service outcome expectations listed in the Department's contract, the provider will be notified and may be required or permitted to develop a plan of correction. Continued underperformance may result in contract modification or other contract action, including termination of the contract.

B. **Vacancies —** State services resource allocation specifies the number of individuals to be served for specific state-funded DD services.

1. The filling of any vacancies can only occur with individuals who have been determined eligible for state-funded DD services by the Field Office Intake and Evaluation staff and prioritized for state-funded DD services by the Field Office.

2. The Field Office will make referrals of individuals on state contracted services to fill vacancies of the providers. All individuals served by the provider should be authorized by the Field Office through the Intake and Evaluation process.

C. **Field Office Referrals —** Field Offices make referral to providers as follows:

1. The Field Office makes a referral to a provider based upon the individual/representative choice of provider.

2. The Field Office's referral notifies the provider of the approved service(s) authorized by Intake and Evaluation staff.

D. **Provider Screening of Referrals —** The provider receiving a referral from a Field Office.

Office conducts a screening of the referral as follows:

1. Providers will screen all referrals to determine first, if there is a vacancy, and second, if the individual's needs can be met within the program.

2. The provider evaluates referrals to determine what area of services would be most appropriate for the individuals and the ability to meet the needs of the individuals.

3. When able to provide services and meet the needs of the individual, the provider confirms the start date of services to the Planning List Administrator or State Services Coordinator as indicated in Chapter 1 of this manual.

4. In case the provider cannot create an appropriate fit to successfully serve an individual, the provider should submit documentation to the Field Office of justification within ten (10) business days after receiving the referral.

5. The Field Office reviews the documentation submitted by the provider and informs the provider in writing the results of the review. Any concerns by the Field Office about the provider's stated reasons for refusal to serve an individual are included in the written findings of the review.

E. **Subcontracting Limitations for Community Residential Alternative Services –** The evaluation by a provider of the capacity to serve an individual should include consideration of the following subcontracting limitations:

1. Subcontracting of Community Residential Alternative Services is limited to Host Home Providers only.

2. The provider shall hold the Community Living Arrangement License or Personal Care Home Permit licensed by Healthcare Facility Regulations (HFR) for Community Residential Alternative services for all residential sites housing individuals with Developmental Disabilities.

3. Only one provider agency may provide services in any home or residential site established to provide Community Residential Alternative for individuals with Intellectual Disabilities and Related Conditions.

F. **Maximization of Provider Capacity –** The provider is expected to maximize the utilization of all capacity to serve individuals.

1. The provider conducts self-assessments of capacity to serve individuals and assists/cooperates with Field Office and state assessments of provider capacity.

2. The Field Office and the provider meet quarterly at a meeting called by the Field Office to review the utilization and address the issues related to unutilized capacity.

3. Changes may be made to adjust fund and service allocations to meet the needs of individuals based on the agreement by both parties.

3.2 INDIVIDUAL SERVICE PLANNING

This section provides standards for Individual Service Planning for state-funded developmental disabilities (DD) services.

A. **Individual Service Planning Process –** Individual Service Planning for state-funded DD services is the process through which the needs, goals, desires, and preferences of an individual are identified and strategies are developed to address those needs, goals, desires, and preferences.

1. The process for the development of the Individual Service Plan allows the individual to exercise choice and control over services and supports and assures assessment and planning for any issues of risks as applicable for the state-funded services provided;

2. Individual Service Planning should maximize the resources and supports present in the individual's life and community;

3. The planning process should enable and support the individual, and as appropriate, his or her family/representative, to fully engage in and direct the process to the extent he or she chooses;

4. Individual Service Planning assures that the individual, and as appropriate, his family/representative, has choice about how needs are met;

5. The planning process produces an organized statement of proposed services to guide the provider(s) and the individual throughout the duration of state-funded service;

6. Providers of state-funded developmental disabilities services are required to deliver services as specified in the Initial Individual Service Plan (IISP) or the Comprehensive Individual Service Plan (ISP). Compensation for services is based on the delivery of authorized services specified in the IISP or ISP.

B. **Individual Service Plan –** The organized statement, or Individual Service Plan (ISP), is the product of the Individual Service Planning.

1. The ISP is based on what is important to and for the individual; it includes the individual's hopes, dreams, and desires as well as what works and does not work for the individual;

2. The ISP captures, from the individual's point of view, decisions and choices that are being made by the individual as well as decisions with which he/she needs support and assistance.

C. **Initial Individual Service Plan –** The intention of an initial ISP is to expedite the enrollment process so that the individual will receive state funded services immediately. The standards for the Initial Individual Service Plan (IISP) are as follows:

1. An initial ISP should be developed before an individual receives state-funded services;

2. The initial ISP is developed by the provider with the required participation of the assigned Planning List Administrator to provide short-term guidelines for state-funded services planned for the individual until a comprehensive ISP is developed.

D. **Comprehensive Individual Service Plan –** The standards for the Comprehensive Individual Service Plan (ISP) are as follows:

1. A comprehensive ISP should be developed **90** days after the initial ISP for individuals who will receive ongoing state-funded services (the completion of the comprehensive ISP within 90 days is the responsibility of the Planning List Administrator or the State Services Coordinator as indicated below);

2. The ISP is developed by the Field Office Planning List Administrator or State Service Coordinator along with the provider(s) and the individual **and/or** family/representative;

3. The ISP must be person centered to maximize the individual's potential to achieve independence, community integration, and a meaningful life;

4. The goals/objectives established in the ISP must be tailored to the individual's desire and needs. Services in the ISP must reflect the individual's choices.

E. **Responsibilities of Planning List Administrators and State Services Coordinators —** The standards for the responsibilities of Planning List Administrators and State Services Coordinators are as follows:

1. Planning List Administrators in the Field Offices coordinate the services for individuals who are Medicaid eligible and waiting for waiver services.

2. State Services Coordinators in the Field Offices coordinate the services for individuals who are not Medicaid eligible and waiting for waiver services as well as for those who are approved to receive state-funded services and not eligible for waiver services.

3. Planning List Administrators and State Services Coordinators are assigned specific counties for which they are responsible for the development of the Individual Service Plans for state-funded DD services for the individuals determined eligible for these services as outlined in Chapter 1 of this manual.

4. The initial contact is made by the Planning List Administrator or State Services Coordinator within 10 days of notification that an individual has been approved to receive state services.

5. The Planning List Administrator or State Services Coordinator is responsible for the development of the comprehensive ISP **90** days after the initial ISP for individuals who will receive ongoing state-funded services.

6. Individualized Service Planning Responsibilities of the Planning List Administrator or State Services Coordinator: These responsibilities include the following:

    a. Scheduling and facilitating the development of the written, comprehensive Individual Service Plan (ISP);

    b. Ensuring the state-funded services are person centered and addressing what is important to and for the person;

    c. Meeting overall quality management standards for the ISP to include, but not be limited to, the specification of the desired outcomes of state-funded services (goals);

    d. Identifying the state-funded services and supports, including the frequency and amount, that are appropriate to meet the needs of the individual;

    e. Reviewing any identified risks and addressing those risks in the ISP;

    f. The Planning List Administrator or State Services Coordinator submits the comprehensive ISP for approval to designated Field Office staff within 10 days of the ISP meeting via the web based system.

7. ISP Review Responsibilities of the Planning List Administrator or State Services Coordinator: These responsibilities include the following:

a. Conducts review of ISP for state-funded developmental disabilities services consistent with time lines required for that plan, but no less than once annually following the initial plan development date and more often if needed;

b. Informs the Regional Services Administrator for Developmental Disabilities or designee of any urgent needs for additional services, such as Emergency Respite;

c. Provides information on changes in need and additional services requested to the Field Office committee that reviews requests for additional services based on availability of funding and priority of need and with communicated understanding to individual/family and provider that state-funded DD services are not an entitlement;

d. Amends the comprehensive ISP when a reduction in services is indicated due to change in the individual's needs;

e. Schedules the meeting for the annual ISP review no later than **45** days prior to the expiration date (the individual's birthdate) and facilitates the development of the written, comprehensive ISP;

f. Ensures services are person centered and address what is important to and for the person;

g. Reviews services and supports and revises as appropriate to meet current, individual needs;

h. Assures written, comprehensive ISP meets overall quality management standards to include, but not be limited to, the specification of the desired outcomes of state-funded services (goals);

i. Reviews current, identified risks and addresses those risks in the ISP; and

j. Submits annual ISP for approval to designated Field Office staff within 10 days of meeting via web based system.

8. Planning List Administrators and State Services Coordinators establish a working relationship with and knowledge of local community resources to support individuals with developmental disabilities and their families.

9. The Planning List Administrator or State Services Coordinator provides information to the individual/family on local community resources during the comprehensive ISP development process and ongoing as indicated by the changing needs of the individual.

10. State Services Coordinators communicate regularly with the Planning List Administrator for any individual who is currently not Medicaid eligible and receiving state-funded DD services as a bridge while waiting for Medicaid Home and Community-Based Waiver services and Medicaid eligibility.

11. The State Services Coordinator and Planning List Administrator jointly assure that individuals on the planning list and their families access available State Medicaid Plan Services while waiting for waiver services and receiving bridge state-funded services.

12. Planning List Administrators and State Services Coordinators provide the monitoring for individuals receiving state-funded DD services; additional information on monitoring is provided in Chapter 5 of this manual.

F. **State-Funded Developmental Disabilities Provider Responsibilities for Individualized Service Planning —** The provider has the following responsibilities related to the individualized service planning for persons served:

1. Ensures that direct support staff and other staff participate fully in the development of Individual Service Plans in partnership with individuals and families, Intake and Evaluation staff, and the State Services Coordinator;

2. Plans and provides services that are person centered and family centered (as appropriate) and geared to give individuals real and meaningful choices about service options;

3. Ensures that direct support staff and people who know the person best participate in any scheduled Supports Intensity Scale (SIS) interview.

4. A Health Risk Screening Tool (HRST) must be completed by the provider for an individual with an IISP prior to the meeting on the first comprehensive ISP (after the Initial ISP, formerly the TIAP).

5. Completes an HRST at least 90 days prior to the annual ISP, updates the HRST when a person experiences significant change in health and/or function, uses recommendations to provide education and training if a person's level is 3 or greater, and assures that the provider's nurse reviews and approves by signature the HRST.

6. Refers unmet individual needs to the Planning List Administrator or State Services Coordinator as indicated and/or requested by the individual served.

G. **Planning Requirements for Individuals with Identified Recurring Challenging Behavior —** When an individual has an identified recurring challenging behavior reflected in his or her Individual Service Plan (ISP) in the Health and Safety Section, a Behavioral Support Plan (BSP) that reflects positive and proactive supports must be in place to resolve the challenging behavior(s). Funding for individuals receiving State Funded Behavior Supports Consultation Services should be included or added to the contract based on a Field Office approved comprehensive ISP indicating the need for a BSP.

H. **Planning Requirements for Individuals with Identified Challenging Behavior and Health and Safety Risks —** For an individual with identified challenging behaviors that pose health and safety risks as reflected in his or her Individual Service Plan (ISP) in the Health and Safety Section, a safety plan involving crisis procedures must be in place that identifies how behavioral crisis related to the challenging behavior(s) will be safely managed. Use of 911 should not be a primary intervention in the safety plan and should only be used if crisis procedures do not ameliorate the risks. However, 911 may be necessary when high risk situations occur that cannot be safely ameliorated by use of crisis procedures such as when the individual is wielding a deadly weapon, or in the occurrence of an injury requiring emergency medical intervention.

CHAPTER 4
QUALITY MANAGEMENT OF STATE-FUNDED SERVICES

4. PURPOSE

The purpose of a Quality Management Program is to monitor and evaluate state contracted services in order to continuously improve the quality of care for all individuals served through a state-funded contract.

It is the intention of DBHDD to provide guidance to state-funded service provider agencies in developing a comprehensive and continuous quality management (QM) process to improve the quality of services for individuals with developmental disabilities. No two organizations are identical; they provide different services to different populations in different geographical areas and have different stakeholders and different organizational cultures. Providers should consider these differences when including outcomes and performance indicators in your Quality Management Plan (QMP), when deciding on data collection, and when including goals and objectives in your Quality Improvement Plan. Provider agencies are free to develop a QM plan that best serves their agency, but all QM plans should address the quality requirements found in the most recent DBHDD ***Community Service Standards for Developmental Disabilities Providers.***

4.1 WHAT IS QUALITY AND QUALITY MANAGEMENT?

The Department of Behavioral Health and Developmental Disabilities (DHBDD) defines "quality" as the degree to which a health or social service meets or exceeds establish professional standards and the needs and expectations of the individuals we serve.

Quality management is a dynamic system of processes or steps which gauge the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Quality management encompasses three functions:

- Discovery: Collecting data and direct individual experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- Remediation: Taking action to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that lead to continuous improvement in state-funded developmental disabilities services.

A. **Beginning**

The first step toward developing your organization's Quality Management Strategy is developing or reviewing your organization's vision and mission. Your organization should be clear about what it does, how it expects to improve, and the desired outcomes. Your organization may also develop a statement of values or guiding principles. Additionally, effective QMPs include establishment of an infrastructure within the organization which will support your quality enhancement efforts and stakeholder input either from your Board of Directors or through focus groups, individual interviews, or a Quality Improvement Council.

B. **Quality Improvement Council**

A Quality Improvement Council is a **mandatory, external** advisory group whose role is to assist your organization in developing meaningful outcomes and performance indicators and setting priorities for quality improvement.

Ideally, the membership of your Quality Improvement Council will be composed of stakeholder representatives. You should strive to include people to whom your organization provides services, their families, representatives from advocacy organizations, and community leaders. The exact composition is determined by the population you serve, advocacy groups that are active in your geographic area, and the interest and commitment that you can obtain from local leaders in government, business, religious, and community organizations.

The Quality Council will help you to better support people with developmental disabilities and better serve your community by assisting your organization to:

1. Identify quality outcomes and performance indicators;

2. Assess performance;

3. Prioritize quality enhancement goals and objectives; **and**

4. Evaluate implementation and effectiveness of your quality enhancement plan.

C. C. **Quality Improvement Committee**

Quality is every employee's responsibility, but each agency should designate some **internal** staff to be responsible for quality management activities and assisting other staff to fulfill their quality responsibilities. This group of staff can be referred to as an agency's "Quality Improvement Committee." The size of the committee would depend on the size of the organization. In a small organization, the committee may be one or two persons. In a large organization, there may be an entire unit or section devoted to

coordinating quality management activities.

The functions of the Quality Improvement Committee will vary somewhat from organization to organization, but typical functions include:

1. Development of various discovery methods which allow an agency to collect information and data related to the quality of its services;

2. Working with information technology staff in the development system to support the collection of information and so that data may be aggregated and analyzed for trends and patterns;

3. Analyzing data and creating reports which summarize trends and patterns that emerge;

4. Facilitating the review of quality data by internal and external groups which provide recommendations to executive management;

5. Partnering with staff who have responsibility for implementing quality improvement efforts;

6. Evaluation of the implementation of quality improvement efforts;

7. Gathering data to evaluate effectiveness of quality efforts; and

8. Providing training, technical assistance, and support to all staff on the organization's Quality Management Plan.

4.2 QUALITY OUTCOMES AND DEVELOPING PERFORMANCE INDICATORS

An important part of your Quality Management Plan is the identification of quality outcomes and performance indicators. A good place to start in this identification would be a review of the seven (7) focus areas of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. Your organization should develop a quality outcomes specific to your organization but which also address each focus area.

A. CMS Quality Framework

The CMS Quality Framework's seven (7) focus areas are:

1. Participant Access: Are the preferred services of the people that you support available to them; how quickly can they be obtained?

2. Participant-Centered Service Planning and Delivery: Do the individualized support

plans of the people that you support reflect their needs and preferences; are these services delivered?

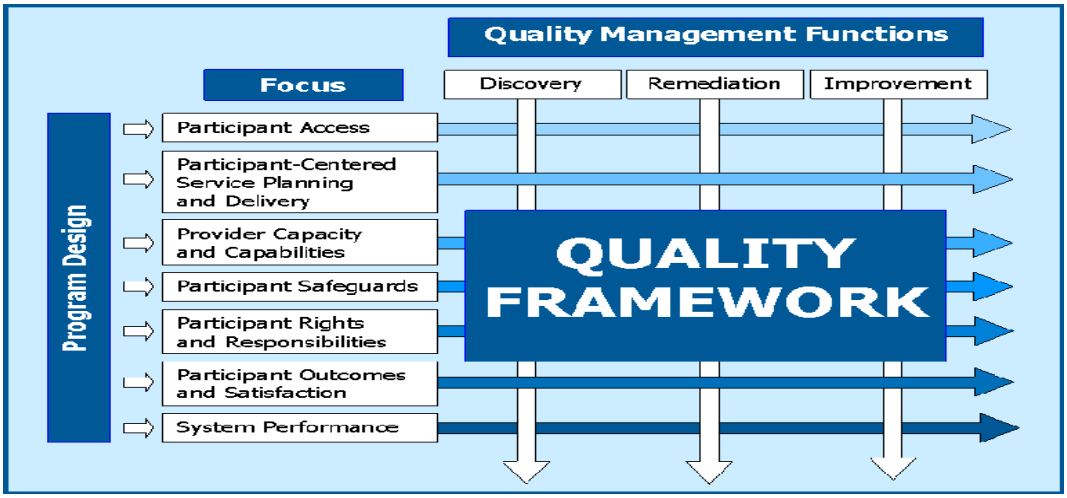
3. Provider Capacity and Capabilities: Does your organization have the capacity and capabilities to meet the needs and preferences of the people you support; does your agency meet the requirements of all applicable federal and state regulations?

4. Participant Safeguards: Are the people you support free from abuse, neglect, exploitation, and extortion; are potential risks identified and strategies developed to mitigate risks taking into account the preferences of the person receiving supports; do the people you support receive needed medications and health services?

5. Participant Rights and Responsibilities: Are the people you support informed of their rights and responsibilities; are they supported to exercise their civil rights; are all restrictions reviewed and approved by a human rights committee before implementation?

6. Participant Outcomes and Satisfaction: How satisfied are people with the services that your organization provides; are the people that you support achieving their short-term personal goals and long-term dreams; how do the people that you support fare on quality of life indicators?

7. System Performance: How efficient and effective are your services; how well does your performance align with your vision, mission, values, and guiding principles; do you keep abreast of proven and promising practices and update your practices, as appropriate?



B. **Quality Outcomes**

Quality outcomes are the results of program operations or activities and may be direct or indirect, for example, improved health vs. changed attitudes or beliefs. Performance indicators are designed to measure the extent to which performance objectives are being achieved on an ongoing basis. One outcome may be that "people have the best possible health." Performance indicators to measure how well your organization is supporting people to have the best possible health might include: number of emergency room visits, number of major illnesses or accidents, percentage of people who have a physical exam each year, percentage of people who have breast or colon cancer screenings, mortality rates, etc.

C. **Strategies for Quality Outcomes and Performance Indicators**

The following strategies will help your organization to develop quality outcomes and performance indicators:

1. Review your mission, vision, values, and guiding principles;

2. Obtain input from your Quality Improvement Council, your Board of Directors, your staff, and other stakeholders;

3. Review information about what individuals and families want from the services that your organization provides, such as results from surveys or focus groups;

4. Review requirements that you must follow, such as licensing regulations and contract requirements;

5. Determine the quality outcomes that you and your stakeholders would like to see for the individuals your agency supports and for your agency as a whole;

6. Review the seven (7) focus areas to see if you have identified quality outcomes in each area;

7. For each quality outcome, determine what your performance indicators will be; that is how you will measure how well you are doing.

D. **Other Considerations in Development of Measures**

Other considerations as you develop your measures include:

1. **Reliability:** Is your measure reliable; does it measure something consistently?

2. **Validity:** Is your measure valid; does it measure what it is supposed to measure?

3. **Sampling:** Is your sample size large enough to generalize your results within a desired confidence level, and is your sample representative of the population that your organization wants to measure?

4.3 DATA COLLECTION AND ANALYSIS (DISCOVERY)

There is a tendency for organizations to collect many various types of information and data. However, an agency should ask itself, "What am I doing with this data?" or "What is the data really telling me?" Problems arise when they do not use this information and data to learn about the quality of their services or to drive their quality enhancement efforts. The proper collection and use of data can help you build a plan and focus resources on the things that need attention.

A. **Identifying Data**
Identifying data is a two-step process:

1. Identifying existing data.

2. Identifying data that are needed.

B. **Identification of Data Sources**

After you have developed your quality outcomes and performance indicators for each outcome, your next step is to identify data sources for the performance indicators. You may already be collecting the needed data for certain indicators, but you may need to identify potential data sources and collections methods as well.

Some typical types of existing information and data may include:

1. **Satisfaction Surveys**: These may include both customer and staff satisfaction.

2. **Regulatory Reviews:** These may include licensing results or any other external monitoring that was conducted such as accreditation, standards compliance, etc.

3. **Critical Incident Reports:** These include all incidents that are required to be reported both internally and externally, including abuse, neglect, or exploitation reports.

4. **Complaints and Grievances Reports:** These include all complaints made about your services and their resolution.

5. **Internal Reviews:** These may include any assessment completed by your organization to determine how well your organization is adhering to internal policies or external regulations, e.g., chart reviews, timeline adherence, turnover information, etc.

C. **Organization of Your Data**

A list should be compiled of the data that you have currently at your disposal. The Quality Improvement Committee should review the data to determine:

1. What is it telling you?

2. Is it useful to determine the quality of your services?

3. How often is it collected?

4. Who collects the data and who submits it?

5. Where does it go?

6. Is the data aggregated and if so how often?

7. Is the data analyzed to determine patterns and trends, and if so, how often? D.

D . **Identification of Needed Data**

Your performance indicators, management, and policies and procedures will determine the information you need to collect. DBHDD and licensing standards and requirements will also determine what you collect within your organization.

E. **What Data Are Missing?**

After you determine what data you have, make a list of what information and data you need. You can then compare the list of needed data with the list of currently collected data, and determine what data is missing.

F. **Filling in the Gaps**

Once you have identified the additional data that needs to be collected, your next step is to decide:

1. How will this information be collected?

2. How will this information be stored (a database or other format) that supports analysis?

3. How will the data be used? G.

G . **Collecting Data**

Once you have identified the data that is currently available, identified the data you need (the gaps), and how to fill the gaps, you have the beginnings of a data management plan. You should regularly and frequently review your data management plan to determine if you need to make:

1. Any changes in the frequency of collection;

2. Any changes in how you collect the data;

3. Any changes in what data is to be collected; and

4. Any revisions to your data sources. H.

H . **Data Aggregation and Analysis**

The definition of "aggregate" is to gather together in a mass constituting a whole. By aggregating data, you can more easily identify areas that are not distinctive but more generally affect the quality of your services. For example, when you look at individual data (e.g., one critical incident report for a person), you respond to the immediate safety issue and initiate strategies to reduce the chance of a similar incident occurring in the future for that person. If several similar types of critical incidents are occurring for several of the people you support (a trend), you will need to take a more comprehensive approach, i.e., developing staff training programs or changing policies and procedures to prevent or reduce these types of critical incidents from reoccurring. Data analysis means to process information or data that has been collected in an effort to draw valid conclusions. It is a systemic way of applying statistical techniques to describe, summarize, and compare data using narratives, charts, graphs, and/or tables. Analyses often involve looking for trends and patterns.

I. **Trends and Patterns in Data**

Trending means examining data over a period of time to identify general tendencies for increases or decreases in the data**.** An example would be analyzing mortality rates to see if mortality rates have been decreasing or increasing over the past several years Patterns, on the other hand, signify relationships. For example, are people reporting

less satisfaction with availability of respite services in the rural areas that you serve as compared to the urban areas? Another example would be staffing patterns and the difference in the satisfaction with services that are being delivered.

4.4 ASSESSING THE QUALITY OF YOUR SERVICES (REMEDIATION)

You have determined what data is needed, collected what you could, and have analyzed your findings. Now you should be able to identify the things that your organization does well (what's working) and those things that need improvement (what's not working).

A. Making a List of What is Working and What is Not Working

Following the process for organizing our data, make a list of what is working and what is not working. Compare the lists to determine if there are conflicts between the lists. If there is a conflict, continue drilling down in the data to figure out why. Some reasons for conflicts may be:

1. The way data is collected or reported;

2. The reliability or validity of one or more of the measures; **or**

3. The sample selection methodology for one or more of the measures.

Once you determine the cause of the conflict, revise your data collection methodology and start over with the process.

B. Prioritizing Areas Needing Improvement

Now it's time to prioritize the areas you have found needing improvement. You should prioritize according to the:

1. Mission and vision of your organization;

2. Safety and well-being of the people in services; and

3. Expectations and desires of your stakeholders (which include individual, DBHDD, licensure requirements, and others).

C. Other Considerations in Prioritizing Areas Needing Improvement

While you are prioritizing, you should also consider:

1. Availability of resources to improve performance in each area;

2. Time it will take to realize improved performance; and

3. Benefits to your organization and to the people that you support**.**

4.5 DEVELOPING A QUALITY IMPROVEMENT PLAN (IMPROVEMENT)

In the preceding sections, you learned about your current data system and you prioritized your opportunities for improvement. Your next step is to develop your Quality Improvement Plan (QIP).

A. **QIP Development**

Your QIP should:

1. Provide a systematic, organized way to focus your efforts on improvement;
2. Specify desired outcomes, both at the individual level and the organizational level;
3. Assist staff in identifying and concentrating on actions needed for improvement; and
4. Provide a mechanism to communicate service delivery expectations.

B. **Questions Answered By QIP**

Your QIP should also answer the following questions. As an organization:

1. Where are we now?
2. Where do we want to be?
3. How are we going to get there?
4. When will we get there?

C. **QIP Components**

Your QIP should include the following components:

1. Goals.
2. Objectives.
3. Activities / Action Plans.
4. Benchmarks.

4.6 WRITING GOALS, OBJECTIVES, ACTION PLANS, AND BENCHMARKS

A. Goals

Goals are related to the mission and vision statements and should be based on the services and supports that your organization provides. Goals should be written in broad, general term, and project an "ideal." Goals are not specific or measurable. Goals are not the continuation of what already exists, but rather express what the organization hopes to bring about through its quality enhancement activities.

An example of a goal would be, "Our individuals will be safe and healthy."

B. Objectives

Objectives are the stepping stones that assist you in realizing your goals. Objectives are how you achieve your goals. Objectives are written in an active tense and use verbs such as "plan," "write," "conduct," "produce," as opposed to "learn," "understand," "feel." Objectives should be realistic targets for the organization and should always answer the following question, "Who is going to do what, when, why, and to what standard?" An objective for the goal above might be, "By June 20xx, organization XYZ will have a 10% reduction in the number of hospitalizations for preventable conditions."

A tool that is very helpful in writing objectives is the acronym *SMART*. *SMART* encompasses five important elements to develop valid and meaningful objectives.

1. *S*pecific – What exactly are you going to do and for whom?
   The organization states a specific outcome, or a precise, clearly defined objective to be accomplished. The outcome should be stated in numbers, percentages, frequency, reach, scientific outcome, etc.

2. *M*easurable – Is the objective measurable and can you measure it?
   The objective can be measurable and the measurement source must be identified. If the objective cannot be measured, the question of the cost of non-measurable activities must be addressed. All activities should be measurable at some level.

3. *A*chievable – Can you get reach the objective in the proposed timeframe? The objective or expectation of what will be accomplished must be realistic given your organization's capacity, time period, resources, etc.

4. *R*elevant – Will the objective lead to the desired results? The outcome or results of the objective directly supports the outcomes of the organization's plans or goals.

5. *T*ime-framed – When will you accomplish the objective?
   The target date for achieving the objective should clearly be stated. This target date will give you the capability to organize your quality activities and efforts around process improvement.

4.7 ACTIVITIES/ACTION PLANS

A. Development of Activities and Action Plans

After you have identified your objectives to achieve your goals, identify one or more activities (and action plans for each activity) to address each objective. Activities and action plans explain exactly how you are going to achieve your objective. For example, to reduce hospitalizations for preventable conditions, you might have several activities, such as developing protocols, training staff, developing tracking mechanisms, etc. The action plans for each activity will identify who does what and in what sequence.

Activities and action plans should:

1. Tell how the objective will be achieved;

2. Be specific and detailed;

3. List exactly what work needs to be done;

4. Include targeted completion dates; and

5. Identify the person(s) responsible for each action step listed.

B. **Status Reports on Implementation**

The person identified as responsible for each activity on the plan should be required to periodically provide a regularly occurring status report on implementation of the various steps. These status reports should be provided to management and communicated to all stakeholders as appropriate, so that they may be kept abreast of the implementation of the various quality improvement activities.

4.8 BENCHMARKS

Benchmarks enable you to compare progress toward achieving your benchmark (where you want to be) as compared to a baseline (where you are now). Benchmarks should be utilized to evaluate the effectiveness of your actions. Evaluation of the achievement of your objectives is critical to the success of your Quality Improvement Plan.

4.9 QUALITY IMPROVEMENT PLAN (QIP)

A. **Identifying Opportunities for Improvement**

Your QIP should provide your organization with a well thought out process to systematically identify opportunities for improvement and to resolve problems. It should also provide means to detect small or developing problems and fix them before they get out-of-hand and to detect potential problems and institute actions to prevent them from occurring at all.

B. **Implementing the QIP**

Even more important than having a Quality Improvement Plan is the implementation of that plan. A plan is just a piece of paper unless the activities and action steps on the plan are actually implemented. Implementation serves two purposes: to improve current or create new processes which will result in improved performance on quality outcomes; and to maintain a culture of quality improvement in your organization.

Each quality improvement step you take should show that quality enhancement works, how it works, why it works, and what benefits are achieved through quality improvement.

C. **Evaluating QIP Implementation**

An integral part of your Quality Management Strategy is evaluating implementation fidelity (Are you doing what your plan said you would do?) and plan effectiveness (Are you achieving your desired results?).

As implementation begins, the strategic planning for quality management and improvement has been completed. To make sure of this, ask yourself these questions:

1. Has quality been defined by all stakeholders?

2. Have outcomes been prioritized?

3. Have goals, objectives, activities and action steps, and benchmarks been developed?

4. Have valid, measurable performance indicators been selected?

5. Is my data collection process complete?

If you can answer "yes" to these questions, then implementation can begin.

4.10 EVALUATION

A. Monitoring and Evaluating the QIP

1. Evaluation involves monitoring the implementation of your QIP and determining its effectiveness. Evaluating the fidelity of your plan is just a fancy way of determining if you are doing what you said you would do. Are the activities and actions occurring according to your plan? Are you meeting your timelines? Are you collecting data so that you can measure your progress toward meeting the goals and objectives that you have established?

2. By evaluating or monitoring your plan and your data you can ascertain if you are doing better since implementing the improvement steps. Bar charts, graphs, or other statistical processes can be used to analyze data collected. Your data will help you determine your progress in achieving your objectives which will lead to meeting your goals, which ultimately will result in increased quality of the services and supports you provide.

B. Revising the QIP

Your plan should never be set in stone. If your evaluation shows that the activities and action steps within your QIP are not feasible or that they are not achieving the result

that you expected, you will need to revise your QIP. All parts of your QIP are subject to revision.

4.11 REVIEWING AND UPDATING YOUR QUALITY IMPROVEMENT PLAN

An organization's quality management and improvement strategies must be dynamic. Goals, objectives, improvement strategies, and data must be continuously reviewed and updated. Your Quality Enhancement Plan will not be an "annual" plan in the sense that it is only reviewed once a year. Each quality improvement activity should remain in your plan for as long as it takes to implement the activity and to assure the effectiveness of the activity in improving performance; this may be for several months or just a few weeks. Details of the plan (e.g., specific action plans, target dates, etc.) should be altered as needed. Steps that prove to be ineffective should be reconsidered. New goals, objectives, and activities should be added, as appropriate.

When reviewing and updating your plan, ask yourself:

A. Do we need to revisit our Outcomes and Performance Indicators?

B. Is our Quality Council working for us? Do we need to modify its functions, change membership, or alter frequency of meetings?

C. Is our quality infrastructure effective? Do we need to make any changes to better support staff in their various responsibilities related to the provision of quality services to the elderly and people with disabilities?

D. Are our discovery methods effective in providing us with the information we need to manage our organization and provide quality services?

E. Do our information technology systems meet our needs or do we need to update our systems?

F. Do we need to make any changes in the data reporting, analysis, and review processes?

G. Are our remediation and quality enhancement processes effective? Do we need to change anything?

These reviews and revisions of your Quality Improvement Plan and Quality Management Strategy will enable your quality efforts to evolve over time so that your organization will be prepared to meet new challenges and opportunities as they arise.

CHAPTER 5
REIMBURSEMENT, REPORTING AND RECORDS OF STATE-FUNDED SERVICES

5. INTRODUCTION

The provider of state-funded developmental disabilities services must have an executed, signed contract for those services with the Department prior to reimbursement for services rendered. Providers of state-funded developmental disabilities render services in accordance with the applicable *Community Service Standards for Developmental Disabilities Providers* established by the Department as defined in the most current version of the DBHDD *Provider Manual for Community Developmental Disabilities Service Providers*.

Providers of state-funded developmental disabilities services are required to deliver services as specified in the Initial Individual Service Plan (IISP) or Comprehensive Individual Service Plan (ISP). Compensation for services is based on the delivery of authorized services specified in the IISP or ISP.

This chapter specifies the procedures for reimbursement for state-funded developmental disabilities services and specific reporting and record requirements for these services in addition to the applicable standards in the most current provider manual.

5.1 REIMBURSEMENT OF STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES

The provider of state-funded developmental disabilities services submits a listing of the individuals served and the amount associated with each individual to the Field Office monthly for payment for the state-funded services. When the Waiver Information System (WIS) becomes available for reporting state-funded service information, the provider shall enter all required monthly information regarding persons receiving state-funded services into the WIS. Additional information on reporting by the provider is in the section on billing and associated reporting in this chapter.

Reimbursement for state-funded developmental disabilities services is by category as follows:

A. **Routine Day Services (UAS Budget Code – 441)**

1. Routine Day Services **(RDS)** shall be defined as:

   Community Access Group Services (CAG) (UAS Expense Code 401)
   Prevocational Services (UAS Expense Code 403)

2. **Payment Stipulations:**

   a. The Department's contract with the provider of Routine Day Services (Community Access Group and/or Prevocational Services) specifies the number of individuals to receive Routine Day Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disabilities services outlined in Chapter 1 of this manual and have no other means of payment for these services.

   b. The provider agrees that Routine Day Services will be offered and made available if desired to state-funded individuals five (5) days /30 hours per week.

   c. On an exceptional basis, for individuals receiving Routine Day Services, the planned provision and utilization of services may be less frequent, but must be so indicated in the individual's ISP and approved by the Field Office.

   d. Individuals may participate in any combination of Routine Day Services, to include Community Access Group Services and Prevocational Services.

   e. Payment requests for any one service or combination of Routine Day Services provided to any one individual shall not exceed a total monthly amount of $1,460.00, or an annual amount of $17,520.00 without prior review and authorization by the Region Office. Individuals can receive additional group services (after receiving 120 hours of Routine Day Service in a month) after hours and on weekend if they are needed and included in ISP. The provider can bill by the unit rate of $12.16 per hour. Maximum monthly reimbursement in multiple Routine Day Service categories for a single individual is prohibited.

   f. Provider payment requests for a monthly reimbursement will be limited to a single UAS Expense Code and chosen by category of greatest service, however units of service will be recorded separately.

   g. All individuals served by the provider should be authorized by the Field Office through the Intake & Evaluation process.

3. **Payment Terms:**

   The provider shall be paid $1,460.00 for Routine Day Services for each individual being served per month with full utilization of annual allocation of $17,520.00 if the individual received 90 hours or more of direct services, or the provision of

documented indirect Intervention Services specifically on behalf of the individual as prescribed in the ISP. Indirect Intervention Services consist of design and development of activities in any location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of a specific individual.

If the individual received less than 90 hours of direct services, or the provision of documented indirect Intervention Services specifically on behalf of the individual as prescribed in the ISP, the contractor shall be paid an hourly rate of $12.16 per hour.

The total annual payment for **Routine Day Services** is specified in the Department's contract with the provider.

B. **Community Individual Services (UAS Budget Code – 442):**

1. **Community Access Individual (UAS Expense Code 402):**

The Department's contract with the provider of Community Access Individual (CAI) Services specifies the number of individuals to receive CAI Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services.

For the provision of Community Access Individual Services, the provider is reimbursed $871 for each individual being served per month with full utilization of annual allocation of $10,454.00 if the individual received 24 hours or more of direct services. If the individual received less than 24 hours of direct services, the contractor shall be paid an hourly rate of $29.00 per hour.

C. **Supported Employment (UAS Budget Code – 443):**

1. **Supported Employment Services (UAS Expense Code 407)**

The Department's contract with the provider of Supported Employment Services specifies the number of individuals to receive Supported Employment Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services.

For the provision of Supported Employment Services, the provider is reimbursed $576.00 per month for each individual receiving a minimum of two face-to-face contacts for job coaching **and/or** job development **or** 60 hours of Employment Status during the month. Reimbursement for individuals receiving Supported Employment services shall not exceed the annual amount of $6,912.00.

D. **Residential Services (UAS Budget Code – 444):**

1. **Community Living Supports (CLS) Services (UAS Expense Code 412):**

The Department's contract with the provider of Community Living Supports (CLS) Services specifies the number of individuals to receive CLS Services from the provider per month either through direct services, or the provision of documented indirect intervention services specifically on behalf of the individual as prescribed in the ISP. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month. The contract also specifies the annual amount of funding.

The provider is reimbursed the $128.52 daily rate for provision of CLS Services for each individual receiving support services for eight (8) hours per day, not to exceed $3,909.00 per month. Reimbursement for Community Living Support Service shall not exceed an annual maximum amount of $46,910.00 per individual receiving support services for eight (8) hours per day. If the individual receives less than eight (8) hours of services per day, the provider is reimbursed an hourly rate of $19.72.

2. **Community Residential Alternative Service (CRA) (UAS Expense Code 411)**

The Department's contract with the provider of Community Residential Alternative Services (CRA) specifies the number of individuals to receive CRA Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month. CRA services are as indicated in the ISP.

The provider is reimbursed the $155.56 daily rate for provision of CRA Services for each individual being served per month with the monthly amount of $4,200.00. Reimbursement for Community Residential Alternative Services shall not exceed an annual maximum amount of $50,402.00 per individual.

3. **CRA Host Home Payment:**

a. Administrative Cost and Payment to Host Home Provider.

The following are requirements for administrative costs of the Community Residential Alternative (CRA) provider agency and the agency's payment to the Host Home provider:

i. Host Home Budget and Payment Details:

- The budget and agreed payment details to the Host Home provider for each individual in each Host Home enrolled by the DBHDD provider agency must support the amount of payment to the Host Home provider, which allows for the provision of the CRA services specified in the ISP of the individual and ensures the health and safety of the individual in the Host Home arrangement.
- The budget and agreed payment of the Host Home provider must be submitted to the Division of DD prior to any individual moving into a Host Home. Budget and payment details must be revised and re-submitted to the Department whenever there is an enhancement or decrease in the individual's residential allocation as well as on an annual basis (by June 30th).
- Individual budget details submitted must include, but is not limited to the individual's name and Medicaid number (if applicable), address and contact information of the Host Home.

ii. Provider agencies must comply with the DBHDD Policy Management-Supervision-Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services, 02-702. Management of Day to Day living expenses shall include but is not limited to:

- The CRA Provider provides individuals who reside in agency operated Host Homes with an agreement regarding day-to-day living expenses upon admission, annually, or as needed. This agreement shall be reviewed at the annual ISP, and shall include a statement of all associated housing and food costs; and any estimated medical, dental, and clothing fees or charges assessed to the individual, to the extent that those funds are available.

- Provider agency shall notify the individual and Host Home Provider, in writing, of any changes in living expenses, within 60 days prior to the effective date. Copies of each day-to-day living expenses agreement are maintained in the record of the individual served.

- Day-to-day living expenses agreement must be signed by the CRA Provider agency and Host Home Provider and submitted to the Division of Developmental Disabilities annually (by June 30th) or whenever there is a change of Host Home Provider or before an individual moves into the Host Home.

iii. Host Home Budget, Payment Details, and Day –to-Day Living Arrangement Agreements are submitted to the Division of Developmental Disabilities by secure email to hosthome@dbhdd.ga.gov.

E. **Support Services (UAS Budget Code 445):** Reimbursement for the category of Behavioral Supports Consultation occurs under Support Services as follows:

1. **Behavioral Supports Consultation (UAS Expense Code 421):**

   The Department's contract with the provider of Behavioral Supports Consultation Services specifies the number of individuals to receive Behavioral Supports Consultation Services from the provider during the contract year. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month.

   For the provision of Behavioral Supports Consultation Services, the provider is reimbursed an hourly rate of $94.00 per individual, not to exceed annual amount of $2,450.00 per individual. This funding covers development of the behavioral support plan and services.

F. **Respite Services (UAS Budget Code 446):**

The Department's contract with the provider of Respite Services Indicates that the provider shall be paid a monthly reimbursement of expenses for the provision of Respite Services not to exceed a specified annual amount. In addition, the Department's contract with the provider includes the following:

1. **Maintenance Respite**

   The Department's contract with the provider of Respite Services specifies the number of authorized unduplicated individuals to receive Maintenance Respite Services from the provider during the contract year. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month. Maintenance Respite Services are as indicated in the ISP.

2. **Emergency Respite**

The Department's contract with the provider of Respite Services specifies the number of authorized unduplicated individuals to receive Emergency Respite Services from the provider during the contract year. These individuals must meet the eligibility criteria for state-funded developmental disabilities outlined in Chapter 1 of this manual and have completed the I&E process, and have no other means of payment for these services during the calendar month.

The Emergency Respite Service is intended to be short term for an individual experiencing a crisis (usually behavioral) who requires a period of structured support and/or programming. Emergency Respite may also be necessitated by unavoidable circumstances, such as death of a caregiver or loss of residential placement. Emergency Respite may be provided In-Home or Out-Of-Home. The Field Office approves Emergency Respite Services ***only*** when the current support or residential placement is unstable/unavailable, and no other formal or informal supports are available to the individual. A specific plan to transition the individual back to his/her permanent home is presented at the time of admission. The plan should be developed and implemented by the Planning List Administrator (PLA), State Services Coordinator, Support Coordinator (SC), or Field Office designee when applicable. Individuals will NOT be placed (except in extreme emergency) without a specific plan for discharge (including date, location and responsible party).

G. **Other Services:**

The Department's contract with the provider of other services (e.g., crisis services and special projects) specifies the reimbursement procedures for these services. These contracts define the other services and any specific expectations for the delivery of these services beyond the general expectations for all state-funded developmental disabilities services.

5.2 STATE-FUNDED DEVELOPMENTAL DISABILITIES BILLING AND ASSOCIATED REPORTING REQUIREMENTS

A. The billing and associated reporting requirements for state-funded DD services are as follows:

1. The provider submits monthly the number and name of persons receiving state-funded DD Services by category and the payment requested for each to the Field Office Operations Analyst by the 10th day of the month subsequent to the month being reported. When the Waiver Information System (WIS) becomes available for reporting state-funded service information, the provider shall enter

all required monthly information regarding persons receiving state-funded services into the WIS by the 10th day of the month subsequent to the month being reported. The provider continues to use the standard monthly billing template developed by DBHDD before the WIS is available for reporting.

2. The provider submits the original MIER (Monthly Income and Expense Report) to the Department contract person by the 10th of the month via secure email.

3. Supported Employment providers submit monthly programmatic reports by the 10th day of the month. Reports should be submitted via secure email to the following address: **supportedemployment@dbhdd.ga.gov** until the WIS is available for reporting.

B. **Reimbursement Issues for State-Funded Developmental Disabilities Services**: The provider of state-funded developmental disabilities should notify the Field Office of any issues with reimbursement of state-funded developmental disabilities. The Field Office works with the provider to assess and rectify, as indicated, issues in the reimbursement for state-funded developmental disabilities services.

C. **Reimbursement Adjustments:** Failure to follow standards for state-funded services in this manual may result in reimbursement adjustments.

5.3 STATE-FUNDED DEVELOPMENTAL DISABILITIES SERVICES REPORTING

The provider of state-funded DD services submits reports as required and requested by the Field Office. These reports may include an annual report that provides a statistical summary of expenditures, and individual service and outcome data. Monthly reporting and other requirements of the contract between the provider and the State of Georgia, Department of Behavioral Health and Developmental Disabilities must be met.

A. **Quality Improvement Reporting –** The provider maintains a well-defined approach for assessing and improving quality as defined in Chapter 5 of this manual. An organizational quality management program should be in place to measure performance, identify deficiencies, and improve quality systematically. The provider shall have established indicators for safety, outcomes and quality of services, and individual satisfaction. The provider generates quarterly quality management reports, including measurement of quality indicators, trend analysis, and quality improvement activities. All QM plans, QIPs, and quarterly QM reports must be maintained by the provider and readily available for DBHDD quality assurance purposes. The quarterly reports must be generated following the schedule below:

Quarter	FY 16	Report Due
1st Quarter	July 1 - September 30	October 15
2nd Quarter	October 1 - December 31	January 15
3rd Quarter	January 1 - March 31	April 15
4th Quarter	April 1 - June 30	July 15

B. **Services Records —** The provider is responsible for maintaining records in accordance with the applicable standards established by the Department as defined in the most current version of the DBHDD Policy Provider Manual for Community Developmental Disabilities Service Providers, 02-1201. Records are to be maintained in an easily accessible place for monitoring/auditing purposes.

C. **Field Office Updates —** In addition to reporting requirements as specified in DBHDD policy, the Stated Funded DD Service Provider/Agency must:

1. Notify the Regional Services Administrator for Developmental Disabilities (RSA-DD) within two (2) hours of any deaths and/or high-visibility incidents (as defined in the DBHDD Policy Reporting and Investigating Deaths and Critical Incidents in Community Services, 04-106 for all individuals receiving state-funded services to the Regional Service Administrators-DD or designee and to the Individual's Planning List Administrator or State Services Coordinator. This notification is in addition to reporting requirements specified in the DBHDD policy.

2. Submit to the Field Office, the DBHDD Contracts Office, and the DBHDD Provider Network Office updated agency and/or contact information.

3. Enter accurate and/or update current required provider information in the Georgia Developmental Disabilities Provider Information website. The address of this website is as follows: www.georgiacollaborative.com.

Appendix A

FIELD OFFICE OF DBHDD CONTACT LIST

DBHDD Region 1	DBHDD Region 2	DBHDD Region 3
Allen Morgan	**Karla Brown**	**Debora Cook (Interim)**
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
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FAX (678)-947-2817	FAX(706)-792-7740	(404) 244-5056
Toll free 1-877-217-4462	Toll free 1-866-380-4835	FAX (404) 244-5179

DBHDD Region 4	DBHDD Region 5	DBHDD Region 6
Michael Bee	**Katherine McKenzie**	**Valona Baldwin**
Regional Services Administrator - DD	Regional Services Administrator - DD	Regional Services Administrator –DD
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