

# Support Coordinator's Role in Medical Equipment and Supplies: Four Scenarios

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**BE D·B·H·D·D**

Georgia Department of Behavioral Health & Developmental Disabilities

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February 2, 2022



Reminder from last training:  
Please use Georgia Collaborative  
website to find available therapy  
providers serving the area where  
an individual lives.

# Illustrations of Support Coordinators' Differing Roles

PART 1: Wheelchairs

PART 3: Hospital Beds

PART 2: Shower Chairs

PART 4: Sensory  
Equipment/Supplies

# Part 1: Wheelchairs

# Meet Joe.

Joe is a 43-year-old man with spastic quadriplegia, including contractures at all four limbs. He uses a wheelchair for mobility and needs a mechanical lift for transfers.

During visit, you note the following:

- Since your last visit, Joe has developed skin breakdown on one of his hips.
- The brakes on the wheelchair aren't working properly.
- There are visible cracks in the material covering his wheelchair seat and back.

# What is the appropriate follow-up?

Gather the following information:

1. HOW OLD IS THE CHAIR?
2. Who delivered the existing chair?
3. Is PT or OT in place?
4. Does the individual and/or their decision-maker have a preferred DME vendor?



**CERTIFICATION OF MEDICAL NECESSITY FOR CUSTOM DURABLE MEDICAL EQUIPMENT  
PT/OT EVALUATION REQUIRED**  
(To include, but not limited to: WHEELCHAIRS, BATH CHAIRS, GAIT TRAINERS, STANDING FRAMES,  
SPECIALTY WALKERS, SIT-TO-STAND SYSTEMS, ECT.)

Certification Type/Date: INITIAL _____ / _____ / _____ REVISED _____ / _____ / _____	
Members Name: _____	Members Medicaid Number (Do Not List Mother's ID): _____
Patient DOB _____ / _____ / _____ Sex _____	HT _____ (in) WT _____ (lbs.)
Suppliers Name: _____	Suppliers Address and Telephone Number: _____
Suppliers NPI Number: _____	_____
Physicians Name: _____	Physicians Address and Telephone Number: _____
Physicians NPI Number: _____	_____
HCPCS Code(s) _____	
Place of Service _____	

Primary Diagnosis \_\_\_\_\_ ICD-10 Diagnosis Code \_\_\_\_\_  
 Secondary Diagnoses supporting medical necessity: \_\_\_\_\_  
 ICD 10 Diagnosis Code(s) \_\_\_\_\_ Length of Need \_\_\_\_\_

**PHYSICAL EXAMINATION:**

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

Ambulatory Status	Is the member ambulatory? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe in detail: _____
Ability to Self-Propel	Does the member have the ability to self-propel? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, does the member have a caregiver willing and able to assist in propelling? YES <input type="checkbox"/> NO <input type="checkbox"/>
Endurance	Describe the member's level of endurance: _____
Neck and Head Control	Describe the member's ability to control their head and neck: _____
Trunk	Provide review of exam of the member's trunk: _____

# A physician's order for the wheelchair is not sufficient.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Pelvis/Hips	Hips Provide review of exam of the member's pelvis/hips: _____
Upper Extremities:	Provide review of exam of the member's upper extremities: _____
Skin Integrity	Provide review of exam of member's skin integrity: _____

Describe the activities of daily living and associated environments in which the complex or custom equipment is required for use:

- Home (required for in-home ambulation) Percentage of time required \_\_\_\_\_
- School (member's enrolled in school either in-home or in the community):  
Enrolled at \_\_\_\_\_ Hours per Day \_\_\_\_\_
- Community Use (school, physician visits, etc.)  Other \_\_\_\_\_

Does the member have complex or custom equipment to this request issued during the following time frame?

- a) The last 5 years for members over 21?  YES  NO
- b) The last 3-5 years for members under 21?  YES  NO

**EQUIPMENT ORDERED**

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

HCPCS	BASE

Describe the specific custom equipment that is most appropriate for this member and provide a detailed rationale:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HCPCS	MODIFICATIONS, OPTIONS, ACCESSORIES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

HCPCS CONTINUED:	MODIFICATIONS, OPTIONS, ACCESSORIES

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rationale:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Ordering Physician**

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Must have occurred within 180 days prior to the order date)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Physical or Occupational Therapist (PT/OT)**

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PT/OT Printed Name \_\_\_\_\_

PT/OT GA License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Licensed DME Supplier**

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Printed Name of NRRTS Member \_\_\_\_\_

License/Certification # \_\_\_\_\_ Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Attach a copy of license or certification with prior authorization request.

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

HCPCS CONTINUED:	MODIFICATIONS, OPTIONS, ACCESSORIES

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rationale:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Ordering Physician**

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation \_\_\_\_/\_\_\_\_/\_\_\_\_ (Must have occurred within 180 days prior to the order date)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**Physical or Occupational Therapist (PT/OT)**

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PT/OT Printed Name \_\_\_\_\_

PT/OT GA License Number \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**Licensed DME Supplier**

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of NRRTS Member \_\_\_\_\_

License/Certification # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_



Attach a copy of license or certification with prior authorization request.

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**



# Summary of Support Coordinator's Role

1. REFER to qualified physical or occupational therapist.
2. MONITOR ordering and delivery of new wheelchair, wheelchair modifications, or repairs.
3. MONITOR maintenance of the wheelchair once it is delivered.

# Part 2: Shower Chairs

# Meet Renata.

Renata is new to services. She is a 32-year-old woman with significant contractures. She uses a wheelchair and lift for mobility and needs total assistance with activities of daily living.

During your first visit, you note the following:

- Renata cannot use the straight-back shower chair in the home.
- She has been getting bed baths since she moved from her family home into residential services.
- When she lived with family, they lifted and lowered her into the bathtub, but support staff in the home cannot safely help her in this way.

# What is the appropriate follow-up?

Gather the following information:

1. Has Renata had an occupational therapy assessment?
2. Has Renata ever had a bath or shower chair before?

# Decoding the DME Manual:

E0240-NU Static-back shower bench without foot support with max price of \$157.67

**COVERED BY MEDICAID REGARDLESS OF AGE**

E0240-U1 Complex, customized shower chairs

**NOT COVERED BY MEDICAID FOR MEMBERS OVER 21.**

invoice, etc. as this equipment is member specific and custom.

Note: Providers must submit separate PA's for more than one custom or complex item. All items approved on a prior authorization should be submitted on the same claim, and the date of service must be the date the items were delivered.

Bath/shower chairs are considered for reimbursement on professional claims only. (Rev. 04/18)

#### Coding Guidelines:

E0240-NU is a standard shower or bath chair which is priced from the Schedule of Maximum Allowable Payments (SMAP) for Durable Medical Equipment Services, and although it is considered complex rehab equipment, it is not custom. This item requires a standard invoice as it is not manually priced. E0240 U1 may be used to identify a custom or non-standard version of a shower/bath chair or toilet aid that requires the use of non-standard, customized equipment, and typically requires assembly prior to issue. This item requires the three (3) component invoice (MSRP, Primary Discount, and Net Cost) which is required for the approval and reimbursement of manually priced items.

**E0240- NU BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE (OFF THE SHELF)**

**E0240- U1 BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE (CUSTOMIZED, REQUIRES COMPLEX COMPONENTS, INCLUDES ASSEMBLY)**

#### Limitations and Restrictions:

**DO NOT** use E0240-U1 to submit for the prior approval or reimbursement of items that are not covered by the Department. This includes bath lifts or custom equipment for members over 21 years of age, and any item defined as noncovered in Chapter 900, Section 905. --Non-covered Services or for which there is an existing HCPCS code that is not covered by Georgia Medicaid. Beside commodes (including heavy duty, etc.) have designated HCPCS codes and should not be reported using these codes.

- These devices will be considered noncovered if all policy specific guidelines are not met.

- These devices will be considered noncovered if all requirements (a-m) on page 1, Chapter 1100 are not met.

<b>1102.2c</b>	<b>STANDING FRAME SYSTEMS (E0638) AND SIT-TO-STAND MULTI-POSITIONAL SYSTEMS (E0637)</b> (Rev. 04/15, 04/18, 10/18)
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A standing frame or sit-to-stand system may aid in digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcifications. Standers may be covered for members with neuromuscular conditions who are unable to stand

# Summary of Support Coordinator's Role

1. OBTAIN order for occupational therapy.
2. REFER to qualified occupational therapist.
3. MONITOR assessment process, OT's work with DME vendor.
4. COORDINATE two additional quotes for shower chair and physician's order.
5. SUBMIT ISP Version Change.
6. MONITOR order, delivery, and use of shower chair.

# Part 3: Hospital Beds

# Meet Albert.

Albert is a 59-year-old man who has recently suffered physical decline associated with a stroke. He can no longer walk and relies on staff to transfer him in and out of bed. Albert now has difficulty repositioning himself during the night, and has developed some excoriation on his buttocks and shoulders and sometimes reports pain during the night.

During your visit, you note the following:

- Albert is using a donated hospital bed that he's had for about a month, but the head of the bed can no longer be raised.
- The mattress on the hospital bed shows signs of significant wear.
- Albert tells you he wants his old bed back.



# What is the appropriate follow-up?

Gather the following information:

1. Does Albert have an order from his PCP for a hospital bed?
2. Is a pressure-reducing surface recommended?
3. Has Albert's provider or PCP ordered the bed from a DME provider.

# Is Albert eligible for Medicaid funding of a hospital bed and mattress? Probably.

Albert needs help with positioning in his bed. He is also reporting pain.

warranty must cover the height and weight of the member and allow for some weight increase. This should include an allowance of up to an additional 100 pounds for bariatric members.

**Hospital beds and Accessories are covered if one or more of the following criteria are met and prior approval has been granted:**

- The member requires positioning of the body in a way that cannot be achieved

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- through the use or a standard bed due to a medical condition that requires positioning to alleviate pain, prevent contractures, or avoid respiratory infections;
- The member requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration;
- The member requires special attachments or traction equipment that can only be attached to a hospital bed;
- The members weight is documented and appropriate for the hospital bed ordered:

All of the following criteria must also be met and documented:

- 1) The percentage of time the member is bed bound
- 2) The percentage of time the member is left unattended
- 3) The primary caregiver must be identified as well as the ability of the caregiver to perform the required positioning and elevation of the member
- 4) Decubitus ulcer status (none or the stage and location If applicable)
- 5) The height and weight of the member
- 6) All diagnoses supporting the order for the hospital bed and accessories
- 7) A detailed description of all items ordered

Keep in mind there are different types of hospital beds, categorized by function and capacity.

Anything more complex than a fixed height hospital bed requires the PCP to provide additional justification.

**POLICY  
1106**

**Hospital Beds and Accessories**  
(Rev. 04/13, 04/15)

Hospital beds for in-home use are a special type of furniture designed to assist in the therapeutic treatment of known medical conditions that require positioning and elevation that is not available in ordinary beds. These hospital beds come in a variety of designs and have many options and accessories available to assist and protect members. Hospital beds provide many features such as height adjustments and head and leg elevation. Hospital beds are often appropriate for members with congestive heart failure.

- a) A **fixed height hospital bed** is one with manual head and leg elevation adjustments but no height adjustment.
- b) A **variable height hospital bed** is one with manual height adjustment and with manual head and leg elevation adjustments.
- c) A **semi-electric hospital bed** is one with manual height adjustment and with electric head and leg elevation adjustments.
- d) A **total electric hospital bed** is one with electric height adjustment and with electric head and leg elevation adjustments.
- e) A **heavy-duty hospital bed** is one that supports a member who weights 350lbs-600lbs.
- f) An **extra heavy-duty hospital bed** is one that supports a member who weighs more than 600lbs.

**Coverage Guidelines:**

Hospital beds are not approved for ambulatory members. The bed bound status of the member must be described in detail. When requesting prior authorization for hospital beds, documentation must include the elevation and positioning requirements that cannot be met by use of an ordinary bed. The documentation must also indicate that the member or caretaker can perform the necessary changes in elevation and body positioning only by use of electronic controls if this option is requested.

# What is a pressure-reducing surface?

**POLICY 1111 Pressure Reducing Support Surfaces (PRSS) (Rev. 04/15)**

Pressure reducing support surfaces are mattresses or overlays designed to prevent or promote the healing of pressure ulcers by reducing or eliminating tissue pressure. Pressure ulcers, also referred to as decubitus ulcers, and are lesions caused by unrelieved pressure between a bony prominence and an external surface that results in damage or necrosis of underlying tissue. These ulcers are staged based on location and severity. Most of these devices reduce interface pressure by conforming to the body's contour so that pressure is evenly distributed over a larger surface area.

**In accordance with CMS guidelines, the staging of pressure ulcers is as follows:**

Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

- **Stage I** – Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from surrounding area.
- **Stage II** – Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
- **Stage III** – Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- **Stage IV** – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
- **Unstageable** – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the member in the supine position with the head lying flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position.

“Pressure reducing support surfaces are **mattresses or overlays** designed to prevent or promote the healing of pressure ulcers by reducing or eliminating tissue pressure.”

The presence of skin breakdown is an element of establishing medical necessity for pressure reducing surfaces.

In Albert's scenario, what is your best guess about the staging of his skin breakdown?

# Meet Albert.

Albert is a 59-year-old man who has recently suffered physical decline associated with a stroke. He can no longer walk and relies on staff to transfer him in and out of bed. Albert now has difficulty repositioning himself during the night, and has developed **some excoriation on his buttocks and shoulders** and sometimes reports pain during the night.

During your visit, you note the following:

- Albert is using a donated hospital bed that he's had for about a month, but the head of the bed can no longer be raised.
- The mattress on the hospital bed shows signs of significant wear.
- Albert tells you he wants his old bed back.

## What is the best option for Albert?

- Because of his recent loss of mobility, Albert may be eligible for services from a physical therapist. His PCP would make this decision.
- The equipment vendor may be able to recommend a safe option using just a pressure-reducing overlay with Albert's old bed.
- Wedges can be used to elevate Albert's head of bed. Bolsters can be used to support bed positioning. If his primary need is related to skin breakdown, there are some creative options that can be tried before getting a hospital bed.
- Wedges and bolsters are miscellaneous DME (not covered by Medicaid).

# Summary of Support Coordinator's Role

1. **VERIFY** that there is an order for hospital bed and/or pressure reducing surface.
2. **ASSIST** provider in getting needed education about types of beds/pressure-reducing surfaces
3. **ADVOCATE** individual's preference where possible.
4. **SUBMIT** ISP Version Change if SME needed for bed positioning support (e.g, wedges, bolsters)

Part 4:  
Sensory Equipment/Supplies



# Meet Jenny.

Jenny is a 24-year-old woman who has a diagnosis of autism. Related to this, she has severe tactile defensiveness and when she becomes uncomfortable, she will sometimes engage in property destruction and even some aggression towards others in her environment. These behaviors place Jenny and those around her at risk of harm.

Jenny's Occupational Therapist is recommending some sensory equipment to be used as part of a program to help Jenny learn some functional options when she becomes uncomfortable. The Occupational Therapist turns to you to arrange funding for these items.

# What is the appropriate follow-up?

Gather the following information:

1. The Occupational Therapist should draw up a list of all recommended sensory items and may provide where to purchase and price.
2. Then Occupational Therapist will need to draw up a plan for how the items will be used.
3. You will need to obtain a physician's order if purchasing with SMS or SME.

Will Medicaid pay for sensory items? **Generally, no.**

Sensory items are almost always listed in one of the categories of non-covered items (miscellaneous DME) in Section 905 of the DME Manual.

For example:

- Physical fitness equipment
- Personal comfort items
- Self-help devices

**BUT** there is one big exception here. If there is a tablet recommended for communication AND the individual is under the treatment of a speech therapist for communication, Medicaid will pay for the tablet.

SME or SMS? Are sensory items equipment or supplies?

IT DEPENDS on how long they are expected to last.

If the useful life of an item is two years or greater, it is considered equipment. If the item needs to be replaced in less than two years, it is considered a supply.

This means a list of several items may contain BOTH SME and SMS.

# Summary of Support Coordinator's Role

1. COLLECT supporting documentation, including OT assessment documenting need and planned use of items, list of all items and prices.
2. SUBMIT ISP VC citing DME Manual Section 905 as evidence that Waiver is payor of last resort.
3. MONITOR ordering, delivery and use of sensory items.

QUESTIONS?

Our contact information:

[nicole.arsenault@dbhdd.ga.gov](mailto:nicole.arsenault@dbhdd.ga.gov)

[karen.cawthon@dbhdd.ga.gov](mailto:karen.cawthon@dbhdd.ga.gov)



# BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities



D·B·H·D·D





**D·B·H·D·D**

Georgia Department  
of Behavioral Health  
& Developmental  
Disabilities

- BE D·B·H·D·D**
- BE COMPASSIONATE**
- BE PREPARED**
- BE RESPECTFUL**
- BE PROFESSIONAL**
- BE CARING**
- BE EXCEPTIONAL**
- BE INSPIRED**
- BE ENGAGED**
- BE ACCOUNTABLE**
- BE INFORMED**
- BE FLEXIBLE**
- BE HOPEFUL**
- BE CONNECTED**
- BE D·B·H·D·D**

# Statewide Clinical Oversight and OHW Case Study

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**BE D·B·H·D·D**

Georgia Department of Behavioral Health & Developmental Disabilities

Dana Scott, MSN, RN  
Director, Office of Health and Wellness



# Statewide Clinical Oversight

- **A formal function assigned to the Office of Health and Wellness.**
- **Purpose:** The responsibility of notification of the need for Statewide Clinical Oversight is applicable to:
  - Parties responsible for and contributing to the support of waived DD Individuals
  - Who face a heightened level of risk to environmental
  - Complexity of medical and behavioral needs
  - Health is not just medical but includes behavioral and psycho-social well being
  - Alteration from the individual's baseline can impact those realms of health

# Statewide Clinical Oversight

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- **Responsibility:** All entities that comprise the interactive team
  - Family
  - Regional Field Office
  - OHW
  - SC agencies
  - Community Service Providers

# Who can notify OHW for Statewide Clinical Oversight?

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Individuals/Family/Guardian

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Residential Providers

---

Clinical Provider (contracted/community-based)

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Support Coordination entities/personnel

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Field Office Personnel

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Stakeholders with a vested interest in overall DD Individual wellbeing

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# Qualifications for Statewide Clinical Oversight:

**Increase of  
HRST score**

**Recurring  
Serious Illness**

**Diagnosis of  
Fatal Five/  
Serious Six**

**ER Visit /  
Hospitalization**

**Outstanding  
Assessment  
(clinical)**

**Outstanding/  
Needed/ Broken  
Equipment or  
assistive  
devices**

**Life  
Threatening/  
Environment of  
Care Issue**

**Allegation of  
Abuse or  
Neglect**

# Factors indicating individual identified at heightened risk:

## Health Event/ Complexity

- ER Visit
- Hospitalization
- COVID-19 Exposure
- Weight Loss
- Falls
- Seizures

## Diagnosis of Condition Creating Increased Risk of Health Decline

- Choking & Aspiration/GERD/ Seizures/Sepsis/ Dehydration/ Constipation & Bowel Obstruction
- Diabetes/COVID-19/Cancer/ Kidney Failure

## Environmental Risk

- Destruction of home by extreme weather
- Sewage Issues
- Heating/AC Issues
- Infectious Disease Risk

## Support Risk/ Loss

- Loss of Natural Support
- Signs of Provider Burn-out
- Non-compliance with staffing
- Need to transition

# Notification of Statewide Clinical Oversight to OHW:

Send notification of the individual's need for Statewide Clinical Oversight to the following mailbox: [Statewide.ClinicalOversight@dbhdd.ga.gov](mailto:Statewide.ClinicalOversight@dbhdd.ga.gov)

Notification to include:

1. Individual Name
2. Address (if applicable)/Region
3. Reporter's relation to DD Individual (include contact information)
4. Event/Incident warranting Statewide Clinical Oversight
  - Date/Time of event/incident; Supporting/contextual information regarding event/incident; Provider action implemented to resolve/stabilize/ or mitigate individual risk.
5. Assigned ISC/SC (include contact information)
  - Date/Time of ISC/SC Notification; ISC/SC action implemented to resolve/stabilize or mitigate individual risk.
6. Assigned Field Office (include contact information)
  - Date/Time of Field Office Notification and parties notified; FO action implemented to resolve/stabilize or mitigate individual risk.



# Focus of Oversight:

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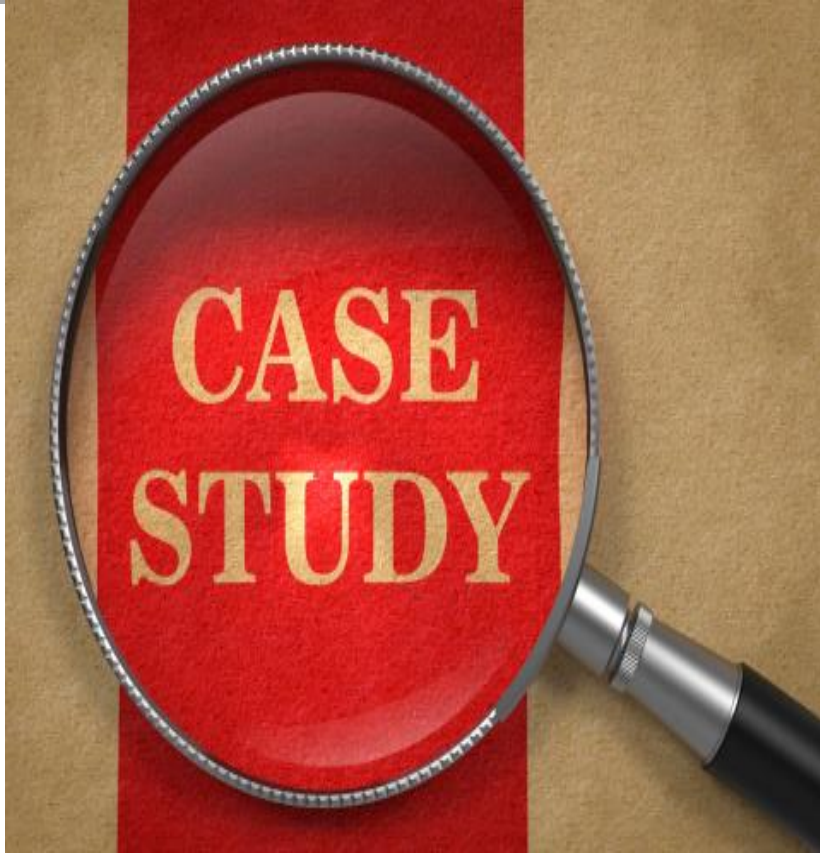
- Notification to OHW via CIRs through IMAGE, RCRs, or Emails.
- OHW will place the individual on Statewide Clinical Oversight surveillance and document in the Developmental Disabilities Clinical Oversight Application (DDCO).
- OHW will review in IDD Connects- Support Notes, Referral and Coaching, and Individual Quality Outcome Measures Review to review documentation concerning the event/incident.
- OHW will reach out to providers and ISC/SC to follow up with OHW Statewide Clinical Oversight Surveillance for each specific event/incident.

## Focus of Oversight Continued: (to include but not limited to)

OHW to reach out to providers and/or ISC/SC to ensure the following information is accurate/current: (if applicable)

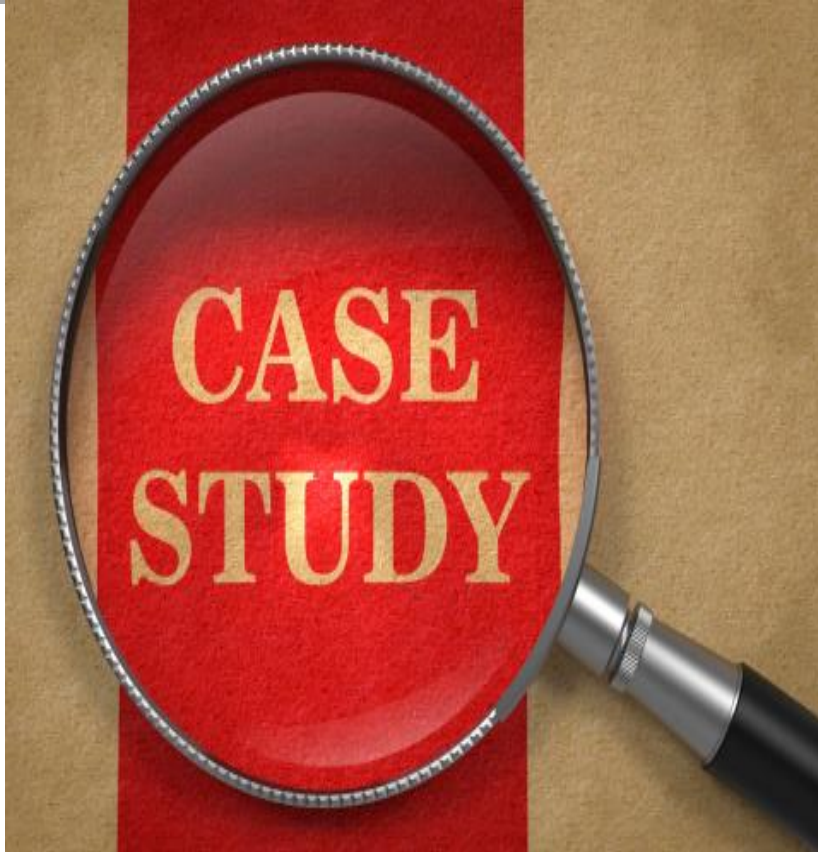
1. HRST updated in sections- Diagnosis, Medications, and/or Ratings for recent event/incident. HCPs or Risk Mitigation Documents.
2. Confirm compliance with Urgent Care/ER/Hospitalization/MD recommended treatment(s) and discharge instructions.
3. Confirm follow up appointments with PCP or referred MD were completed and indicate outcome-if new orders were written and implemented per Provider Manual policy or if the individual was released to normal activities.
4. Confirm the nursing supports that were clinically recommended by OHW have been added to the PA and the provider is implementing and documenting the supports recommended as per policy.

## Case Study:



- 58-Year-Old Female
- Resides in a 4-person CRA group home
- Authorized ISC, SMS, CAG, 5 hours RN monthly
- Profound DD, **Obesity**, **Hypothyroidism**, **Hypercalcemia**, Hyperlipidemia, HTN, **Osteoporosis**, Metabolic Syndrome, **Fibrocystic Breast Disease**, **PICA**, Microcephaly, **GERD**, Acne, Seborrheic Dermatitis Astigmatism, Myopia, **Seizure Disorder**, **Lennox-Gastaut Syndrome**, Risk for choking/aspiration (Pureed Diet), Gingivitis, Constipation, Incontinent of B/B, Onychomycosis, **SIB/Hitting**, Hx Falls, Hx Fractures, **2-person gait belt**; assist during ambulation/transfers, W/C, **hoyer lift**, hospital bed, helmet, and **lap tray**

## Case Study:



- Supported by several clinical professionals: PCP, Dentist, Neurologist, Optometrist, and Podiatry.
- Receives Proxy caregiving for medication administration.
- HCPs: Skin integrity, Neuro, Musculoskeletal, Endocrine, B/B, Cardio
- Multiple ER visits; noted gradual decline in functioning

# Substantiated ER Visits:

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- 1-10-2021 ER Visit; Seizure with fall-injury to her head- scalp contusion; CT Scan ordered. Follow up with PCP.
- 4-8-2021 Reported to have tripped on pant leg while ambulating with staff. No injury noted per ER visit. Follow up with PCP if needed.
- 5-3-2021 Individual tripped in shower and fell hitting her head; taken to ER and diagnosed with hematoma to left side of head; D/C with instructions to follow up with PCP/Neurologist to determine if falls related to drop seizures or loss of function.

# Substantiated ER Visits:

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- 8-20-2021 Taken to ER and diagnosed with constipation; prescription of MOM, D/C with instructions to follow-up with PCP within 1 week.
- 11-26-2021 Individual fell to the floor during a transfer from her bed to the wheelchair. Taken to the ER; diagnosed with contusion/bruise to right arm/side/buttock and left shoulder strain; instructed to take Tylenol PRN for pain; and to follow up with PCP. Noted PCP stated referral for cardiology consult to rule out for continued problems.

# Actions to Mitigate Further Decline of Individual:

- Was there communication with providers of clinical services to ensure awareness of multiple medical ER visits and trend of current falls?
- Was there communication with the provider to ensure recommended follow/ups with PCP/Referrals were completed and to ensure new orders were implemented?
- Was there documentation for all follow ups and outcomes until individual was medically cleared to return to normal activities?
- Was there a review of documentation? (HRST, ISP, NA, Medical Chart in group home, RN Oversight, HCP or Risk Mitigation Document)
- Was there communication to the provider to ensure the HRST was updated for new diagnoses, for medication changes, and for the rating section as related to the events/incidents?

# Actions to Mitigate Further Decline of Individual: cont.

- Was there documentation of current HCPs and completed current staff training for HCPs?
- Was there communication with providers to ensure safety environmental devices have been discussed and implemented to prevent falls; and that equipment and assistive devices (wheelchair, hooyer lift, hospital bed, gait belt, helmet, and lap tray are in good working order; and staff have received necessary training?
- Was there a review of services with the provider to determine if additional staffing or nursing would better support the individual?





Questions?



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