PRIORITY PLAN

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I. INTRODUCTION

This Priority Plan represents the longstanding and ongoing commitment of the State of Georgia and its Department of Behavioral Health and Developmental Disabilities (DBHDD) to improve quality and address gaps in the system of supports and services to people with intellectual and developmental disabilities[1] (I/DD) with a focus on capacity building, accountability and sustainability. At the highest level this Priority Plan begins to address issues and accomplish outcomes at the individual, provider and state levels. We are intentionally focused on those areas which interfere with the state's ability to meet the needs of individuals served, to minimize risk of harm, maximize provider competence and effectiveness, ensure continuous quality improvement and sustain best practice.

It is called a Priority Plan because the total task is large, comprehensive and complex. There is a need to start with priority activities and 'first steps' given the enormity of needed re-engineering of the developmental disabilities supports and services system. Consequently, the name. But this plan is more than that. This Priority Plan has been designed for multiple purposes and audiences.

This is a ***strategic plan***… intended to mobilize available resources through large scale, long range planning and development, in an effort to accomplish the outcomes identified in this Plan.

This is an ***educational plan***… intended to provide information which clearly identifies the vision and principles which will guide the provision of supports and services to people with I/DD in Georgia. It also provides direction with respect to available resources and many relevant policies and procedures designed to support people with I/DD and their families throughout the state. Information acquired from stakeholders was used to plan outcomes and identify actions which the State of Georgia will take in order to reduce or eliminate gaps in or barriers to accessing supports and services. Further discussions will take place with DBHDD partners throughout the state as this plan evolves.

This is a ***persuasive plan***… intended to influence the thoughts and actions of those who provide natural supports as well as specialized services to people with I/DD. This Plan invites stakeholders to join together with DBHDD to continue to identify desired outcomes.

This is a ***developmental plan***… intended to expand the capacity of supports and services over time. As the capacity and confidence of the systems grows, its strategies and techniques for supporting people will become more informed and effective. This will, in turn, require the Plan to change and evolve as the learning evolves.

This is a ***remedial plan***… responsive to eight recommendations identified in the Independent Reviewers' Supplemental Report filed March 24, 2014. (United States of America v. State of Georgia, 1:10-CV-249-CAP).

[1] Throughout this Plan the use of the words "people" and "Individual" will refer to people with intellectual and developmental disabilities. This choice was an intentional use of "People First" language out of respect for individuals with I/DD supported and served by the Department of Behavioral Health and Developmental Disabilities.

A. Foundation Values and Principles

The following values and principles are the foundation upon which the Outcomes and Objectives in this plan were considered and agreed. These principles are grounded in widely acknowledged best practices in the field of intellectual/developmental disabilities.

Person-Centered: The hallmark of good services is a high degree of individualization (person-centeredness). Opportunities, services and supports are designed based on the unique gifts, interests, and needs of each person being served. When done well, there is a high degree of fidelity to the individual served. "Modern approaches to quality Improvement are beginning to put individual quality of life (QOL) monitoring at the core, as it is viewed as the ultimate unit of accountability."[2] Intentional changes in practice need to translate to positive life style changes for the individuals served. "Place the individual at the center of any examination of quality. The individual's experience and response to services and supports should be the window through which quality is observed."[3]

Stakeholder[4] Partnerships and Involvement: Working closely with those people inside and outside DBHDD who have a vested interest in a problem and its solution is essential to the overall success of this plan. DBHDD has begun the process of inviting input from a wide variety of stakeholders and seeks to build long term partnerships with individuals using services, their families/networks, support coordinators, service providers, generic supports and services, neighbors, community businesses and social networks… anyone interested in identifying and eliminating barriers to healthy, engaged and productive lives for everyone in the community. In fact, this document would not be possible but for the significant and substantive input DBHDD has and will continue to receive from our stakeholders.

Model Coherency:[5] All elements of practice in a service should be in harmony with each other, and flow from a unifying set of principles. This requires people to think deeply about the identity of the people who are to be served, what it is that would be required to support people well, who could do the work well, and in what ways the work could be done with consistent, high quality. Model Coherency is a unique and very helpful tool which can be used to both conceptualize positive service designs and help designers and evaluators of services to develop a framework which increases the likelihood of a coherent match between people's identities, their most pressing needs, and the supports to actually meet those needs. It is from model coherency that many best practices, and the concept of "person-centeredness", emerged. Hence, this is a cornerstone of the quality construct proposed to remedy long-standing issues in terms of relevance, potency, effectiveness and responsiveness of services and

[2] Devlin, Steven, Robin Schweitzer, James W. Conroy and Sandra Gettel "Quality Feedback in Developmental Disabilities Service Systems: Documenting Positive Outcomes." Unpublished paper. (2013)

[3] Bradley, Valerie J. and Madeleine H. Kimmich eds. Quality Enhancement in Developmental Disabilities Brookes, 2003, Print

[4] Mason and Mitroff in their 1981 book, *Challenging Strategic Planning Assumptions* posited the following source: "The **stakeholder** concept seems to have emerged initially in the systems analysis work on organizations conducted by researchers at the Tavistock Institute in London. See Rhieman, Eric, *Industrial Democracy and Industrial Man* (London: Tavistock Institute, 1968) and Fox, Alan, *A Sociology of Work in Industry* (London: Coller MacMillan Limited, 1971). ***http://asapm.org/chgagent/where-did-the-term-stakeholder-come-from/***

[5] Wolfensberger, W. (1999). History of Normalization – 1967-1975, In R. Flynn and R. Lemay (Eds), *A Quarter Century of Normalization and Social Role Valorization: Evolution and Impact*, Ottawa, ON: University of Ottawa Press, page 75. The concept of "service specialization," which eventually became model coherency, evolved from an idea apparently presented in 1959 by Lloyd M. Dunn, chair of the Department of Special Education at George Peabody College for Teachers (since become part of Vanderbilt University) in Nashville, Tennessee, in an advanced graduate course on social and educational aspects of mental retardation which I attended. He proposed that "omnibus" institutions for the mentally retarded be replaced by smaller, more dispersed specialized institutions for specific subgroups of different identities and needs. http://www.socialrolevalorization.com/articles/journal/1996/srv-vrs-journal-1996-2-part-03.pdf

supports designed to meet the needs of individuals served. Included in this plan is a commitment to provide values based training as a foundation on which model coherency can be practiced.

***A System of Safeguards*:** This country was established based on a system of safeguards which have become well embedded as foundational components of its structure. As Americans, we believe that in order to avoid and/or solve problems we must have the diligent and continuous oversight of citizens at every level. Just as we have the Judicial, Executive and Legislatives branches of government provide checks and balances at every level, so too human service systems must have a system of internal and external safeguards at the individual, program and systems/state levels.

***Evidence Based Practices**:* This Plan places an emphasis on developing a community system of supports and services based on best practices in order to increase the likelihood of producing the intended outcomes. A strong backbone of this plan is the utilization of evidence-based practices and other practices widely accepted in the field of developmental disabilities. Such evidence based practices are used to focus on workforce development and capacity building. People who are entrusted with the care of people with disabilities need to have the evidence based knowledge, skills and demonstrated abilities to effectively carry out their duties.

Effective use of Data: Improved practices are also based on the utilization of timely and accurate information necessary to improve the quality of service delivery, to correct errors in a timely manner and to learn which practices are working or not working to produce the intended outcome. Data does not interpret itself. Since the well-being of the individual receiving services is such a basic measure of service quality it is important that the system be able to know what is precisely happening to people (monitoring) and be able to assess why (evaluation). Evaluation is always a weighing of the facts and what they mean.

"A state's quality management policies and activities should not infringe on but rather should support and enhance the personal authority and autonomy of individuals receiving publicly funded services and supports."[6] Data-based decision management is required for accountability, to stay on track, correct errors and do effective analysis of those practices that are working and those practices that are not working to produce intended outcomes. It is essential for an organization to use data as part of effective management and direction of resources.

Accountability through Transparency: The potency of intentional safeguards needs to match the potency of the vulnerabilities of the people being served. Transparency is a very powerful safeguard. People with disabilities, stakeholders, community associates and the public must be shown a clear picture of DBHDD's proposed actions and their impact on people with disabilities. The impact of these stakeholders should be solicited for guidance regarding any unintended consequences as the plan is being implemented. A potent safeguard for protecting people from harm is the presence of interested unpaid local people who want to come to know the person. Transparency works when people know, and are interested in, being part of the "effort". This allows people to consider being involved in making sure it is going as planned. Transparency is an invitation to both involvement and input from interested Georgians.

[6] Bradley, Valerie J. and Madeleine H. Kimmich eds. Quality Enhancement in Developmental Disabilities Brookes, 2003, Print

B. Individual and Systems Outcomes

In addition to foundation principles, there are high level outcomes that this plan is intended to achieve at the individual, program and systems levels. These outcomes have been identified for those individuals supported by DBHDD, their families, generic and specialized service providers, DBHDD regional and state personnel. In addition, specific outcomes are identified, topically, throughout this Plan. The outcomes which DBHDD will work to accomplish include:

What do we want as outcomes for People? (Recommendations 1-7[7])

1. People have control over their lives and the support to make meaningful choices.
2. People are able to fully exercise their rights as citizens.
3. People have the best possible health, are safe and supported as they participate in a meaningful life as defined by them.

What outcomes do we want from partnerships with Stakeholders and Participants? (Recommendations 1, 4, 6, 7 and 8)

1. People have the best possible health, are safe and supported in participating in a meaningful life as defined by them.
2. DBHDD will engage and listen to individuals using services, family members, advocates, and other stakeholders.
3. DBHDD is effective at communicating, collaborating and actively working with all stakeholders to achieve the intended outcomes.
4. DBHDD is effective at proactively managing its network and uses its resources effectively.

What do we want as outcomes for direct-service Providers? (Recommendations 2, 3, 6 & 7)

1. Providers will effectively and competently implement individualized and desired supports.
2. Providers develop and maintain positive and constructive relationships with the people they support.
3. The Providers and DBHDD establish and maintain trusting partnerships based upon collaboration and mutual respect.
4. The Provider network grows and develops to address changing needs.
5. Providers and their network are accountable to individuals they support and to the system which finances them.

What do we want as outcomes for the DBHDD (Central Office, Regional Offices and Hospitals)? (Recommendations 1, 2, 4, 5 and 6)

1. Central Office, Regional Offices, and Hospitals are partners with community providers to assure that people are safe and supported in participating in a meaningful life.

[7] These Outcomes are in harmony with the specific recommendations made by the Independent Reviewer's Supplemental Report. The recommendations which correspond are listed in parenthesis.

2. The DBHDD system is user-friendly, stable, functional, predictable, and accountable with the flexibility needed to innovate and respond to challenges and opportunities.
3. DBHDD (Central and Regional Offices) has clear expectations, purpose, values and role clarity.
4. DBHDD has the leadership, infrastructure, and resources necessary to enable them to effectively and consistently implement DBHDD policy.
5. DBHDD (Central and Regional Offices) is effective at communicating and actively working with all internal stakeholders to achieve the desired outcomes.
6. DBHDD policy and practice are guided by national best practice and reviewed by local and national experts.
7. Central Office, Regional Offices and Hospitals are partners in the development and implementation of DBHDD policy.

C. Priority Plan Organization

Definitions and narrative clarification… in sections where clarification of terms would help make the intent more clear, definitions and/or narrative are provided.

Outcome: The intended or desired result.

Objective: A step that is necessary to accomplish and in doing so brings us closer to the Outcome or expected result.

Action Steps: Steps that, when accomplished, bring us closer to the intended Objective or the expected result. Steps that will be taken at the individual, program and systems level, to accomplish the Objectives and in turn the Outcomes.

II. PROMOTING SELF DETERMINATION

Research shows that individuals with disabilities are less self-determined than their non-disabled peers. This does not reflect on the capacity of people with intellectual/developmental disabilities to become self-determined.[8] Rather, people with disabilities are provided with many fewer opportunities to make choices and express preferences across their daily lives. Multiple research studies have also found that:

- A person's self-determination status predicts higher quality of life. So, the more confident and self-determined you are, the higher your quality of life.

[8] Information regarding research into Self Determination comes from A National Gateway to Self-Determination, funded by the US Department of Health and Human Services, Administration on Developmental Disabilities, slide show developed by the Institute for Human Development, University of Missouri Kansas City; Kansas University Center on Developmental Disabilities, University of Kansas; Center on Human Development, University of Oregon, Department of Disability and Human Development, University of Illinois Chicago, Westchester Institute for Human Development, New York Medical Collage; at http://ngsd.org/sites/default/files/self-determination_and_people_with_intellectual_disabilities_and_developmental_disabilities_what_does_the_research_tell_us.pdf

- Self-determination status closely matches with positive personal and life outcomes. What this means is that the more self-determined you are the more likely you are to be employed, living more independently, being more included with non-disabled peers.

There are a number of different components to self-determination… choice making, decision making, problem solving, goal setting and attainment, self-advocacy, self-regulation, perceptions of efficacy, self-awareness and self-knowledge.

Self Determination and the skills and abilities it implies is a very important component and a key ingredient of success for individuals already living in communities throughout Georgia as well as those individuals in State Hospitals preparing to move to the community.

The Department of Behavioral Health and Developmental Disabilities understands acquiring and practicing self-determination skills is a complex life long process. Having experiences which enable people to have constant opportunities to make choices while receiving the support and respect to carry these choices out must begin early in life. Many of the people for whom this plan is intended have not had those opportunities. DBHDD further understands that government isn't always the best creator of those opportunities.

This Plan begins with an invitation to self-advocates, your families, friends and those who support you to join in dialogue with DBHDD about how to support people to be self-determined, to speak and be heard and respected. We want you to be able to say what's on your mind and hope it might include statements such as[9]…

> *I am **making choices** and setting the direction of my life. I get the support I need to make Informed decisions.*
>
> *I have the **option of using resources** (public dollars) to life my own live within a given budget. These dollars will move with me when I change my mind or the direction of my life.*
>
> *I am **experiencing** as much of life as I can; I have real life choices.*
>
> *I **express myself** and make my own choices and decisions. My opinions, choices and decisions **are respected, supported and acted on**.*
>
> ***I am supported** by competent people I trust and who will help me in areas where I need it. These people involve me in considering options, support my decisions and don't try to take decisions away from me.*
>
> *I and those I choose, **have power and control over my resources**. Those who support me are knowledgeable about changing resources.*

[9] My Choice? Ordinary Life, Community Plan for the State of Tennessee, voices of those using services and their families participating in the planning process.

*I am **involved in my community** in the areas which are important to me such as: employment, friendships, memberships and associations, spiritual development and giving back to others.*

*Even if I don't speak, those around me work to **understand and engage my thoughts** and demonstrations of behavior which express my likes and dislikes, so that I can make choices and control my life.*

***I will assume responsibility** for giving back to other people and my community, seeking employment whenever possible, and for developing my unique gifts and talents.*

What would you add? DBHDD doesn't pretend to know the answers for many things but hope you will join with us to think about how to support people using our services to be more self-determined. More than that, we hope YOU will take the lead and adopt this as YOUR initiative. One where we (DBHDD) are not in the lead but you, self-advocates, your families, friends, neighbors, communities and others step out and seize this opportunity.

III. PLANNING BASED ON INDIVIDUAL NEEDS OF INDIVIDUALS IN STATE HOSPITALS

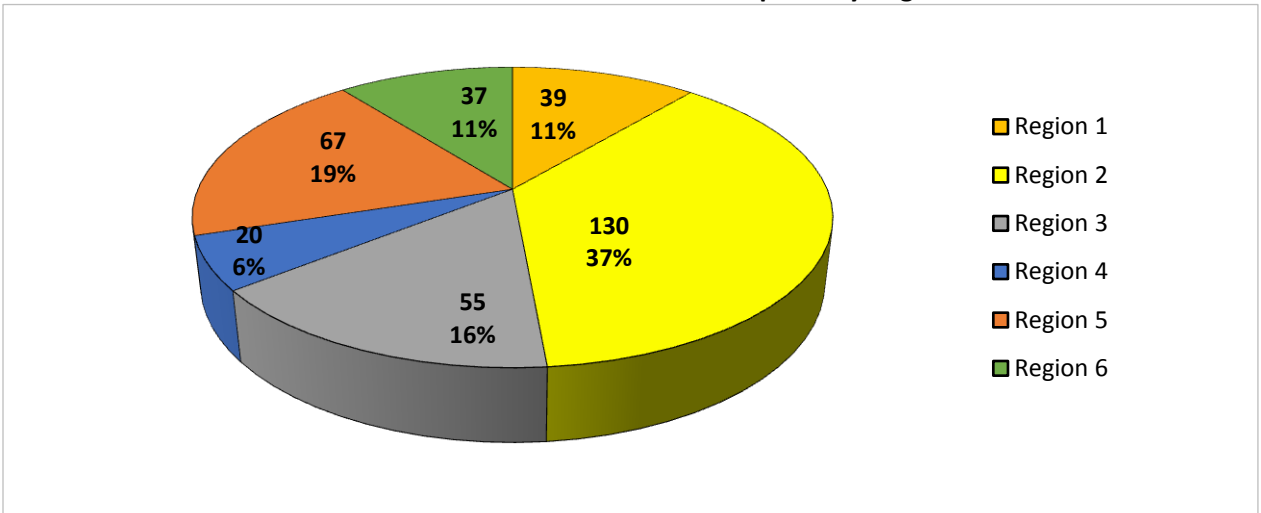
For most individuals, the path to meaningful life experiences will come from an abundance of community opportunities appropriate for their ages and interests such as school, work, leisure, home life, and friendship. Some individuals have additional needs for clinical or therapeutic supports or services, such as mental health counseling, physical and nutritional support or adaptive equipment. Although some prescriptive and clinical and therapeutic supports and services may be short-term, all individuals have lifelong needs for friends and community life with access to sustained supports in their communities.

This Plan is intended to address the needs of individuals already living in the community as well as those currently in hospitals who are planning to move to the community.

The following information provides a profile of the 348 individuals remaining in Intermediate Care Facilities for people with developmental disabilities (ICF/DDs), Skilled Nursing Facilities (SNFs), Adult Mental Health Hospital Units or Forensic Units. The following information identifies where these individuals live and what some of their needs are.

# of Individuals	Region From
39	Region 1
130	Region 2
55	Region 3
20	Region 4
67	Region 5
37	Region 6
348	Total

Chart A: Number of Individuals in Hospitals by Region

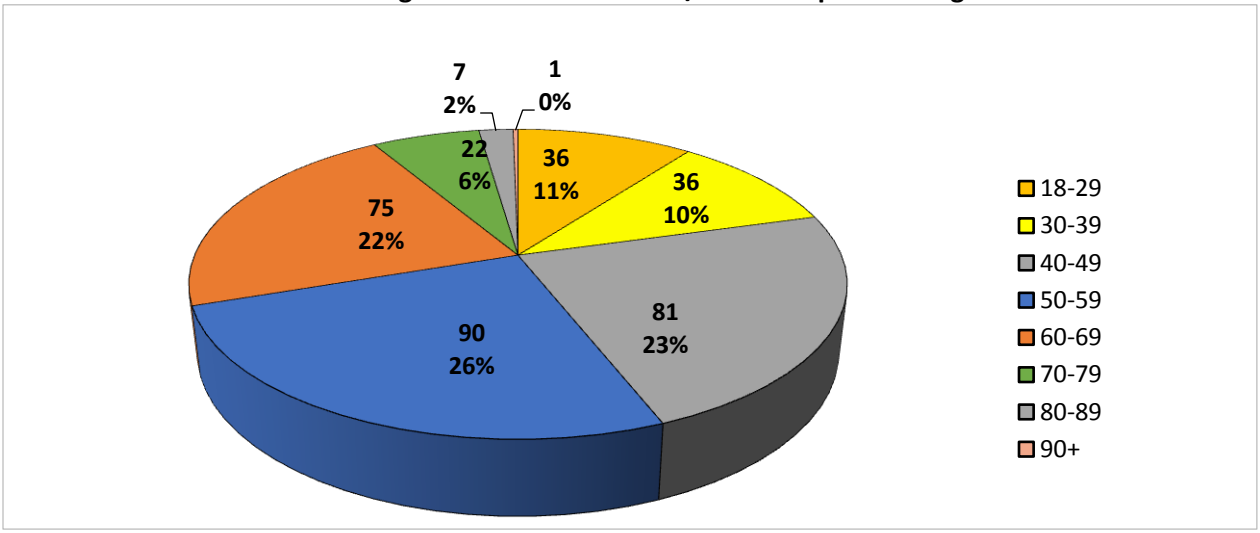


The average age of individuals living in hospitals is 51.4.[10] As the following information illustrates, there are 30 individuals age 70 or over, 72 individuals age 39 or younger, with the largest group (246) between the ages of 40 to 69.

Age	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Reg Unk	Totals
18-29	7	16	2	2	4	5	0	**36**
30-39	5	16	3	5	4	3	1	**36**
40-49	4	21	16	5	26	9	0	**81**
50-59	10	43	13	2	13	9	3	**90**
60-69	5	30	15	5	10	10	0	**75**
70-79	5	3	5	1	7	1	0	**22**
80-89	2	1	1	0	3	0	0	**7**
90+	1	0	0	0	0	0	0	**1**
Totals	**39**	**130**	**55**	**20**	**67**	**37**	**4**	**348**

[10] As of June 1, 2014.

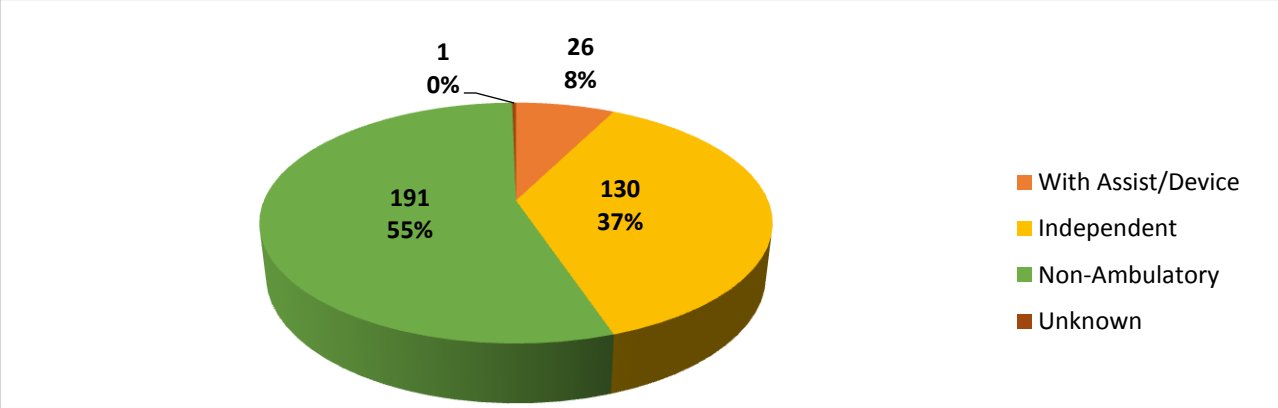
Chart B: Ages of Individuals with I/DD in Hospital Settings



In addition to being mindful of the ages and location of those remaining in hospitals, other factors are important and influence planning in terms of human and material resources. Some of those issues follow.

Chart C: Ambulation Ability

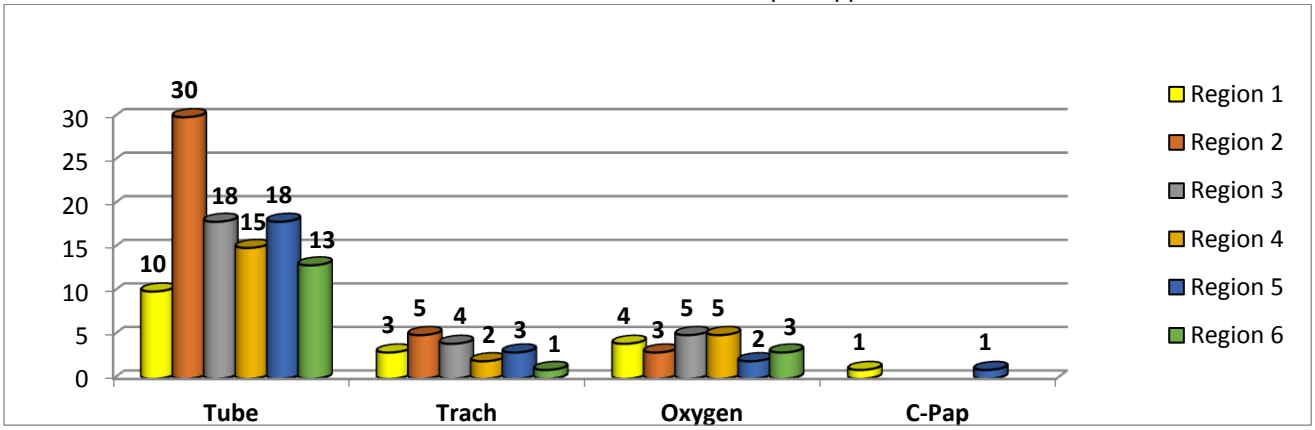
Note: Some individuals need multiple supports



Ambulation Level	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Reg Unk	Total
With Assist/Device	1	11	2	1	7	4	0	**26**
Independent	17	54	18	2	25	10	4	**130**
Non-Ambulatory	21	61	35	17	35	22	0	**191**
Unknown	0	1	0	0	0	0	0	**1**

Chart D: Individuals with Support Needs/Devices

Note: Some individuals need multiple supports



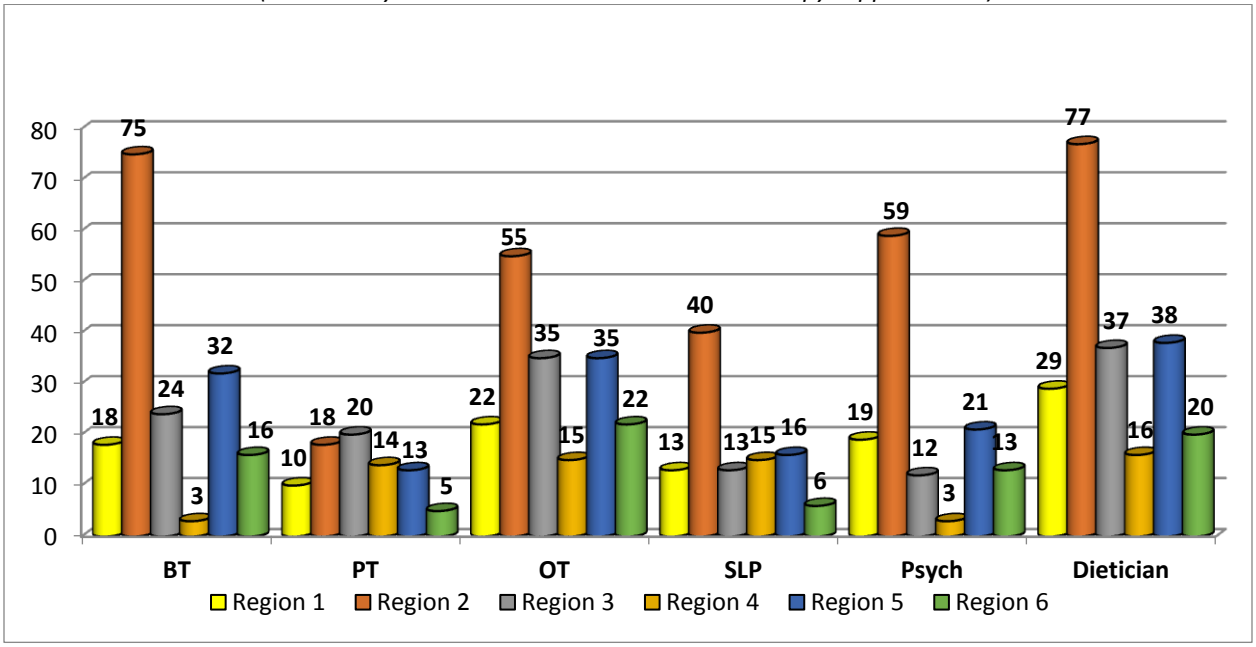
You can see from this information that very few of the individuals remaining in the hospitals are supported by a tracheostomy.[11] Nevertheless, as for all individuals living in or moving to the community, clear and effective protocols must be in place in order to meet their needs. For the 104 individuals who receive their nutrition through tubes, again, well trained staff and clear protocols must be in place and implemented.

Device	Region 1 (39 Indvs)	Region 2 (130 Indvs)	Region 3 *(55 Indvs)*	Region 4 (20 Indvs)	Region 5 (67 indvs)	Region 6 (37 indvs)	Total (348 Indvs)
Tube	10	30	18	15	18	13	104
Trach	3	5	4	2	3	1	18
Oxygen	4	3	5	5	2	3	22
C-Pap	1	0	0	0	1	0	2

[11] Tracheostomies are one of the more common, as well as the earliest recorded, surgical procedures according to the editors of Tracheostomies: The Complete Guide, Dr. Linda L. Morris and Dr. M.Sherif Affifi. A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. Medline Plus, http://www.nlm.nih.gov/medlineplus/ency/article/002955.htm

Chart E: Individuals with Support Needs/Therapy

(Note: Many individuals have more than one therapy support needs)



BT = Behavior Therapy; SLP = Speech and Language Pathology; OT = Occupational Therapy; PT = Physical Therapy

As these numbers illustrate, the demand for therapy and dietary supports for people moving to the community is widespread. Every region has significant numbers of individuals needing nutritional, psychiatric and therapeutic supports in order to live a safe and well supported life. Of the 348 individuals remaining in hospitals, 293 or 84% are reported to need therapeutic supports (BT, OT, SLP, PT).

Specialist	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Totals
BT	18	75	24	3	32	16	168
PT	10	18	20	14	13	5	80
OT	22	55	35	15	35	22	184
SLP	13	40	13	15	16	6	103
Psych	19	59	12	3	21	13	127
Dietician	29	77	37	16	38	20	217

F. Individuals with dual diagnosis

A review of the 348 individuals with a diagnosis (primary, secondary or tertiary) of mental retardation living in one of the state facilities, including ICF/DD's, SNF's, Adult Mental Health Hospital Units and Forensic Units was completed. Analysis revealed that many either had no secondary diagnosis or had a diagnosis that would not be considered an emotional or mental illness. These included issues identified

as autism, pervasive developmental disorder, pica, stereotypical movement disorder, alcohol abuse, developmental expressive language disorder, neuroleptic induced tardive dyskinesia and dementia. These were removed from the group because it was felt, based on the diagnosis that they might need behavioral services, but not necessarily psychiatric or mental health services.

The remaining number (107), were distributed as indicated below. (Those highlighted would be considered to have a diagnosis recognized by Georgia as a severe, persistent mental illness SPMI.) However, it should be noted that diagnosis which are NOS (not otherwise specified) would qualify for short-term services only, until a definitive diagnosis could be made.

Diagnosis	Facility	ICF/MR	SNF	AMH	Forensics	Totals
Adjustment Disorder with mixed disturbance of emotions + conduct	ECRH				1	1
Anxiety Disorder NOS	ECRH	1				1
Bipolar Disorder	ECRH	1		2		3
	WCGRH				2	2
Childhood or adolescent Antisocial behavior	GRH-ATL				1	1
Depressive Disorder NOS	ECRH	3				3
Dysthymic Disorder, now Persistent Depressive Disorder	ECRH				1	1
Generalized Anxiety Disorder	CSH		1			1
Impulse Control Disorder	ECRH	7	1	3	5	15
Impulse Control Disorder	GRH-SAV			1		1
Intermittent Explosive Disorder	ECRH	1			1	2
Major Depressive Disorder, Recurrent	ECRH	1				1
Mental Disorder NOS due to (indicate gen med condition)	ECRH	1				1
Mood Disorder	ECRH	2				2
Obsessive Compulsive disorder	ECRH	1				1
Organic Mental Disorder, NOS	CSH				1	1
Pedophilia	CSH				1	1
Physical/Sexual of adult abuse by other	WCGRH				1	1
Psychotic disorder due to (indicate the gen med con) w/hallucinations	ECRH	1				1
Psychotic Disorder NOS	ECRH	3			1	4
PTSD	CSH				1	1
	ECRH	2				2
Schizoaffective Disorder	ECHR			3		
	GRH-ATL			1		
	GRH-SAV			2		

Diagnosis	Facility	ICF/MR	SNF	AMH	Forensics	Totals
Schizophrenia	CSH		2		3	5
	ECHR	12	2	3	7	27
	GRH-ATL			1	1	2
	GRH-SAV			5	5	10
	WCGRH			2	7	9
Unspecified Mental Disorder (nonpsychotic)	ECRH	1				1
Totals		38	6	21	42	107

IV. INDIVIDUAL NEEDS AND COMMUNITY RESOURCES (INCR)

In order to develop and implement effective person centered plans, whether they are Transition Plans (from Hospital to the community) Individual Support Plans (while in the community); Transfer Plans (individuals transferring within the community or between regions), we must start with the person. Knowing his/her strengths, preferences, dreams, needs, and networks is foundational. This process of getting to know the person can be called many things but for the purposes of this Phase I Plan, we will refer to assessments.

Assessments: refers to the process of identifying an individual's specific preferences, family, friends and association networks, strengths, developmental needs and need for services. This should also include identification of present developmental level and health status and where possible, the cause of the disability; the expressed needs and desires of the individual and his or her family; and the environmental conditions that would facilitate or impede the individual's growth, development and performance.

The purpose of assessments and consultations is to obtain information that will assist the individual and his/her team members to establish goals, to identify the individual's capabilities and areas of need relative to those goals, and to identify the strategies and supports that are the least restrictive and likely to be effective in assisting the individual to attain his or her goals. As a part of the assessment process Teams need to be sure that:

- ✓ each person's needs and strengths have been accurately assessed and relevant input has been obtained from team members.
- ✓ assessments identify needs, strengths and preferences;
- ✓ assessments result in the identification of the person's functional needs and the assignment of each person's risk level(s) (behavioral and health);
- ✓ needs identified influence the allocation of resources (staffing, financial, equipment, etc.) which is intended to enable the person to realize his/her strengths, preferences and potential;
- ✓ recommendations made as a part of assessments are made and implemented or, if not, there is team consensus on why not.
- ✓ the assessment results, informs and guides the transition and long term planning process, the allocation of resources and the supports and services provided.

The functional assessment described here is not one document but can be composed of several individual assessments.

OUTCOME INCR1: THE INDIVIDUAL'S SUPPORT REQUIREMENTS ARE IDENTIFIED.

OBJECTIVE INCR1.A: Components of a Comprehensive Functional Needs Assessment are identified. These components are to include but not limited to:

> ***Physical development and health*** (Developmental history, Results of physical exam, Health assessment data – Medications and Nationally recognized recommendations of important health screenings (i.e. Immunization – Mammography/PAP – female, PSA/DRE – male, Vision, Dental and DNR);
> ***Nutritional status*** (Appropriateness of diet, Adequacy of total food intake, Skills associated with eating including chewing, sucking and swallowing, Food service practices, Monitoring and supervision of one's own nutritional status);
> ***Sensorimotor development*** (Motor development, Muscular, neuromuscular);
> ***Affective*** *(Emotional) development;*
> ***Speech and language*** *(communication) development;*
> ***Auditory functioning****;*
> ***Cognitive development****; to assist in understanding how the person processes information and to evaluate individual capacity for decision-making.*[12]
> ***Social Development****;*
> ***Behavioral functioning****;*
> ***Adaptive behavior/Independent Living Skills and Vocational development*** as well as other assessments that address the individual's medical and mental health conditions (i.e. aspiration, falls, fractures, osteoporosis, constipation, poly-pharmacy, seizures, challenging behaviors).

Objective INCR1.B: A unified state support requirements system is established which applies to hospitals as well as the community using data from the Comprehensive Individual Functional Assessment.

Objective INCR1.C: Individuals receive a Comprehensive Functional Needs Assessment by competent professionals in the discrete fields.

Objective INCR1.D: Each Individual's risk level is identified using the unified state risk rating system.

This information will provide a systematic way to identify the overall clinical needs of the community by region, including needed services (psychiatric, therapy, behavioral psychology, special medical services (cardiac, diabetes, gastrointestinal). It will further provide:

- consistency in assessing risk level between the hospitals and community systems.

[12] Based on information from the Comprehensive Functional Assessment and other relevant assessments, protocols outline require follow up for those individuals who may not be able to make independent (healthcare, etc.) decisions.

- a consistent and accurate tool to assist hospital and community providers in making informed decisions regarding the clinical services needed by individuals.
- Assist in the identification of available and needed supports in each region.
- Assist in the evaluation of transition plans/placements for individuals preparing to move to the community.
- Provide specific clinical indicators to include in the State's Quality Improvement data when reporting trends and changes in status at the individual, provider, regional and state levels.

OUTCOME INCR2: PHYSICAL AND NUTRITIONAL SUPPORT SERVICES ARE AVAILABLE TO EACH PERSON, IF NEEDED.

All individuals have nutritional needs. Adequate nutrition and physical wellbeing depends upon the process of specific body systems that take in and use food, fluids, and medication to benefit an individual's wellbeing. When these processes do not function well, the health and safety of an individual can be at risk. Physical and Nutritional Supports (PNS) by a team of professionals becomes necessary to support the nutritional needs for individuals as well as to reduce the person's risk in many areas including aspiration.

Physical and nutritional supports services, when provided correctly over an entire day, have proven to be of significant benefit to the person's health. In addition, such services have been demonstrated to result in significant improvements in the person's ability to move and interact with others and the environment, and with the ability to orally receive adequate nutritional intake.

Physical and nutritional support services are based upon a thorough 'interdisciplinary' assessment and evaluation of the individual. This analysis is founded in the person's specific strengths, and challenges. Based upon this analysis, the primary therapist(s) develops an individualized plan (e.g., a physical support plan for positioning or aspiration prevention). Training is then provided to individuals who work closely with the person, across all environments, to implement the plan. The therapist works with the person and family to monitor the plan to assure satisfaction and progress. The plan is monitored carefully to assure staff are trained on an on-going basis, and adjustments to the plan are made as needed.[13]

A good physical management intervention includes one or more of the following:

- therapeutic positioning (to support the person in proper alignment so that other activities can be implemented successfully to prevent deformity and skin breakdown, and to promote functional movement);
- individually designed therapeutic equipment (which, when severe challenges/deformities are present, may need to be fabricated);
- developmental interventions (to assist in increasing head and body control, improve balance, etc.);
- direct physical therapy treatments (to increase independent movement, mobility, etc.);
- collaborative physical therapy services (includes instruction and monitoring staff and care givers regarding the use of therapeutic equipment, body mechanics, proper positioning, etc.);

[13] Groves, I.D., Foster, R.E. Innovative and Exemplary Practices Leading to Effective Physical and Nutritional Management of Severely Physically Disabled Persons. O'Neal and Associates, Ltd., Florida.

Georgia has a number of clinicians providing nursing services, as well as physical, occupational, and speech services to individuals in hospitals and the community.

DBHDD places a high priority on the establishment of Physical and Nutritional Support (PNS) Team(s) at the Regional level. The state intends to implement these services through a multidimensional approach that includes: training and technical assistance to clinicians in PNS techniques; training and oversight to staff serving specific individuals with PNS plans; general PNS training to persons with I/DD, family members, support coordinators, regional monitors and providers; instruction and support in integrating these techniques throughout the person's daily routine; supporting the expansion of fabricators who can deliver custom equipment as designed; and by initiating a system of accountability at both the state and regional level.

Objective INCR2.A: The services of a Consulting Physical and Nutritional Support Team (PNS) are established.

Action Step INCR2.A.1: Identify Consulting Team members (to include):

- physical therapy (PT) with an emphasis on specialty in positioning and seating,
- occupational therapy (OT),
- speech therapy with an emphasis on oral motor facilitation; and
- additional services, if needed, for medical, nursing, nutrition/dietary and respiratory therapy.

Objective INCR2.B: Oversight and technical assistance to the hospital, Regional PNS Teams, individual providers and Support Coordinators is provided by the Consulting PNS Team.

Action Step INCR2.B.1: The Consulting Team provides oversight and technical assistance during team assessment, individual plan development, coordination with fabricators, and therapeutic interventions are provided in tandem with the Regional PNS Team;
Action Step INCR2.B.2: Assistance in the development of policies, procedures and necessary protocols to ensure consistency and sustainability;
Action Step INCR2.B.3: Timelines for fading technical assistance and oversight are provided by the Consulting PNS Team.

Objective INCR2.C: Through discussion with the Consulting PNS Team, specific roles and responsibilities for the Regional PNS Teams are identified which may include but are not limited to:

training and technical assistance to other clinicians in physical and nutritional support technology;
assistance to the person and family in identifying qualified therapists and clinicians in the community;
overseeing the transition from the services of the PNS Team in the hospital to services in the community;

assisting community therapists as they complete individual comprehensive functional needs assessments, develop individualized physical and/or nutritional support plan(s), as needed;
develop and participate in training for individuals, family, support coordinators, provider and regional staff to assure successful implementation of the physical and/or nutritional supports plan;
ongoing communication with the primary therapists, agency staff/nurses, support coordinator, and the primary care physician; and
training and mentoring individual members as well as the Regional PNS Teams collectively until they are ready to assume this responsibility.
Developing and enforcing guidelines for therapists and any person designated as a health care coordinator.

Objective INCR2.D: Hospital and community PNS Teams are established to function with oversight and technical assistance provided by the Consulting PNS Team.

Objective INCR2.E: In collaboration with the Consulting PNS Team, a Comprehensive PNS Assessment process is established which is administered by a Team of professionals, with oversight provided by the consulting team experienced in PNS services.

Objective INCR2.F. In collaboration with the (Consulting and/or Regional) PNS Team, the individual's Team, including therapists, develop and implement an individualized PNS plan, as needed.

Objective INCR2.G: Outcome Expectations regarding Physical and Nutritional Supports (PNS) for Individuals receiving PNS are established.

Objective INCR2.H: Data to be collected, reported and analyzed is identified.

Objective INCR2.I: Intervention strategies are evaluated based on data and the extent to which the identified outcomes have been accomplished.

Objective INCR2.J: Based on data analysis, modifications and improvement will be made.

Objective INCR2.K: Individuals (hospital and community) who need PNS are identified using the comprehensive PNS assessment process administered at least annually or more often, if individual circumstances change, by a Team of professionals which includes the Individual's primary therapist(s). Oversight is provided by the Consulting PNS Team

Action Step INCR2.K.1: Assess individuals using the Comprehensive PNS Assessment process administered by the PNS Team at least annually.
Action Step INCR2.K.2: Based on analysis of the Comprehensive PNS Assessment process, identify individuals who need PNS.

OUTCOME INCR3: A UNIFIED DYSPHAGIA/ASPIRATION SYSTEM IS ESTABLISHED.

Note: The responsibilities here can be assigned to the PNS Teams at the Regional Level and the Specialized Services Office since the members may be the same.
Aspiration, in this case, means breathing in a foreign object (such as sucking food into the airway)[14].

Dysphagia means difficulty swallowing[15].

The aspiration system will be a part of the PNS Team responsibilities identified above and include:

Objective INCR3.A: Roles and responsibilities regarding aspiration related assessments, plan development, implementation and monitoring are identified for, at minimum; Therapists – SLP, PT, BT, OT – Nurses, Direct Support Professionals, front line supervisors and Regional PNS Teams.[16]

Objective INCR3.B: A standardized aspiration risk screening tool is developed.

Objective INCR3.C: Individuals are evaluated using the aspiration risk screening tool at least annually or more often as needed.

Objective INCR3.D: Risk Levels are assigned

Objective INCR3.E: Levels of nurse monitoring are assigned based on level of risk. (All individuals who receive nutrition through a tube are considered high risk)

Objective INCR3.H: Therapists/BTs collaborate with the nurse and Direct Support Professionals in the completion of initial assessments and re-assessments.

Objective INCR3.J: An individual-specific aspiration risk prevention plan containing specific instructions for daily activities determined by assessment has been developed and implemented. (Food and fluid intake, meals, bathing, tooth brushing, dressing, etc.)

Objective INCR3.K: Proficiency based aspiration training has been developed and is routinely provided to hospital and community staff (provider and Support Coordinators).[17]

Objective INCR3.L: A user friendly method to document, monitor and track clinical objective data including the individual's triggers such as lung sounds, oxygen saturations, and vital signs to timely identify changes in status has been developed.

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[14] Medline Plus. http://www.nlm.nih.gov/medlineplus/ency/article/002216.htm
[15] WebMD. http://www.medicinenet.com/swallowing/article.htm#what_is_dysphagia
[16] SLP = Speech and Language Pathologist; PT = Physical Therapy; BT = Behavioral Therapy, OT = Occupational Therapy.
[17] Chomsky separates competence and performance… In short, competence involves "knowing" (something) and performance involves "doing" something with that knowledge usage. The difficulty with this construct is that it is very difficult to assess competence without assessing performance. http://www.educ.ualberta.ca/staff/olenka.bilash/best%20of%20bilash/competencyperformance.html

Objective INCR.3.P: The evaluation of the effectiveness of interventions and the accomplishment of individual outcomes is based on implementation data.

OUTCOME INCR4: A SPECIALIZED SERVICES OFFICE COORDINATES, SUPERVISES AND ENFORCES CLINICAL PROFESSIONALS PROVIDING SUPPORTS. (THIS OFFICE INCLUDES THE PNS TEAM)

OBJECTIVE INCR4.A: The Specialized Services Unit is identified. (Members Located at both Central DBHDD and Regional DBHDD Offices).

Objective INCR4.B: Specialized Services Office develops and enforces performance expectations for all therapists (BT, OT, ST, PT) and other health care professionals (nurses) providing supports.

Objective INCR4.C: Proficiency based training is identified and required of individuals providing therapy, nursing and other services as identified.

Objective INCR4.D: Guidelines for therapists which result in the integration of therapies throughout the person's day are developed, published and enforced.

> **Action Step INCR4.D.1:** Guidelines require therapists to provide training and oversight of Direct Support Professionals and others in line with therapists' requirements.

Objective INCR4.E: Guidelines for therapists, provider agencies and regional nurses which identify their roles, responsibilities and performance expectations are developed, published and enforced.

Objective INCR4.F: Guidelines clarifying who will be required to have a designated health care coordinator are established.

Objective INCR4.H: There is coordination between technical assistance provided to therapists and nurses, as well as provided by these specialists, so that consistency of message and a holistic integration of approach are achieved.

OUTCOME INCR5: THE OVERALL CLINICAL RESOURCES IN AND NEEDS OF THE COMMUNITY BY REGION HAVE BEEN EVALUATED.

Objective INCR5.A. A functional GAP analysis to determine what services are available and what services are needed by region has been conducted. Services analyzed include but are not limited to psychiatric services, therapy services (to include behavioral services, physical therapy occupational therapy, speech and language therapy nutrition.)

Objective INCR5.B: There is a plan implemented to develop services in areas as needed.

V. INDIVIDUAL PLANNING AND SUPPORT COORDINATION (SPC)

A. Transition Planning

OUTCOME SPC1: INDIVIDUALS ARE SUCCESSFULLY TRANSITIONED TO THE COMMUNITY

Objective SPC1.A: An effective Transition Planning Process has been developed.

Action Step SPC1.A.1: Develop measurable criteria which will be used to define a successful transition.
Action Step SPC1.A.2: Develop Transition Planning policies and procedures. The Policy will identify the detailed requirements before during and after the individual's move.
Action Step SPC1.A.5: Based on roles and responsibilities develop proficiency based training for the implementation of the Transition Planning Process based on roles and responsibilities for:

- *Individuals transitioning;*
- *Family members; guardians and advocates;*
- *Support Coordinators;*
- *Providers;*
- *Regional personnel;*
- *State personnel*

Action Step SPC1.A.6: Implement the strengthened Transition Planning Process.
Action Step SPC1.A.7: Re-evaluate the process formally within 3 months of the first move based on the definition of a successful transition (for the person) the data collected, and make changes as required.

Objective SPC1.H: Selected providers, including Support Coordinators, participate in Transition Planning Activities at a minimum of 60 days prior to discharge.

Objective SPC1.L: Medicaid Waiver funding is available for use by the individual retroactively to the day he/she transfers to the community.

Objective SPC1.O: Post-placement visits/monitoring have been implemented.

Objective SPC1.Q: The Transition ISP has been reviewed by the Individual's Team to make adjustments, as needed, related to the community placement no less than 30 and no more than 60 days after the move.

B. Stabilization of Those Who Have Moved

OUTCOME SPC2: INDIVIDUALS WHO HAVE MOVED TO THE COMMUNITY RECEIVE REVIEWS FOLLOWING THEIR DISCHARGE AS DEFINED BY THEIR LEVEL OF NEED.

Objective SPC2.A: Clinical Reviews of high risk individuals who have moved to the community are completed by a clinical practitioner in conjunction with the provider, Support Coordinator and house staff at the home.[18]

Action Step SPC2.A.1: All transition documentation has been reviewed, including clinical review where clinical supports are required.
Action Step SPC2.A.2: Individual is provided with the opportunities and supports to realize his/her strengths and preferences on a consistent, at least weekly, basis.
Action Step SPC2.A.3: All medical and/or mental health issues are being adequately addressed;
Action Step SPC2.A.4: Required lab work and diagnostic tests are being obtained, reviewed by the appropriate Community Practitioners, nursing staff, and house staff;
Action Step SPC2.A.5: The appropriate baseline information and transition assessments are available in the house records for future comparison;
Action Step SPC2.A.6: Medication and treatments are appropriately being administered and documented.
Action Step SPC2.A.7: Medication administration practice and procedure are in alignment with policies such as the prohibited use of "as needed" or "prn" medications;
Action Step SPC2.A.8: Appropriate plans (health care, behavioral, therapy, and/or nutritional) are in place and in alignment with the health care plan.
protocols;
Action Step SPC2.A.9: Plans addressing aspiration/Dysphagia are individual-specific and are being consistently implemented;
Action Step SPC2.A.10: Recommendations are formally requested regarding any additional training needs that staff may require.
Action Step SPC2.A.11: Providers rectify problems within timelines prescribed by the review, but within no more than 7 days.

- Procedures are developed for notification of the Region of issues, resolution and identify what to do if not resolved within 7 days.

Action Step SPC2.A.12. There are clearly defined procedures and Regional personnel identified to monitor the provider mitigation of problems.

Objective SPC2.B: The Support Coordinator and provider complete reviews in order to ensure:

- The individual is provided with daily opportunities to build on his/her strengths and preferences.
- The community PCP and therapists know the individual is now in the community.
- Individual visits specialists and others in line with prearranged appointments.
- Needed equipment is present, being consistently, appropriately used, and in good operational order;
- Staff are proficiency trained on all plans of care for the individuals for whom they are responsible.

[18] DBHDD will determine if this practitioner is a sub-contractor (there may be several per region), a regional employee (several per region) or a combination of both. This individual will do onsite visits, see the person being assessed, review the records and other activities identified and set forth in policies and procedures.

Objective SPC2.C: Support Coordinator personally visits individuals regularly after placement as evidenced by at least weekly during the first month of placement, twice monthly for the first six months and at least monthly thereafter, unless specified otherwise in the ISP.

Objective SPC2.D: Support Coordinator visits individuals in a variety of settings throughout the year (e.g., home, school/day activities, leisure locations, etc.) and across a variety of days and shifts.

Objective SPC2.E: Support Coordinator and the Individual's ISP Team meet to review the status of strengths/preferences/services/supports identified in the Transition Plan within 30 – 60 days of discharge and as necessary, as evidenced by adjustments being made as needed.

Objective SPC2.F: Support Coordinator and Provider (day and residential) review implementation data to determine consistency of implementation.

Objective SPC2.G: Support Coordinator and Provider (day and residential) review implementation data to determine status of progress and success of interventions.

Objective SPC2.H: Regional Office clinical specialists personally visits the individual at a frequency identified in his/her Transition Plan during the first 6 months of placement.

C. Individual Transfers within the Community

OUTCOME SPC3: INDIVIDUALS MOVE SUCCESSFULLY WITHIN THE COMMUNITY.

This is the process by which an individual changes his/her place of residence, the type of residential service received and/or the residential service provider. A Community move may occur as a result of:

1. The individual/guardian asks to move to another home;
2. The individual/guardian asks for a change of providers or a change in the type of residential service received;
3. The current provider is not providing or is no longer able to provide services which may mean a termination of a provider agreement or the provider is unable to assure the health and safety of the person due to a significant change in health or behavioral status.

OBJECTIVE SPC3.A: In conjunction with stakeholders, a Community Transfer Policy has been developed which Identifies what is to happen before, during and after a move.

Objective SPC3.E: Cross training, including any return demonstrations of proficiency (and other assigned tasks) is completed in advance of a planned move, as needed.

Objective SPC3.H: Responsibilities of the receiving residential provider are identified as evidenced by responsibilities set in policies and procedures.

D. Individual Support Plan (ISP)

OUTCOME SPC4: EACH PERSON HAS THE SUPPORTS/SERVICES NEEDED AS IDENTIFIED IN THE ISP

Objective SPC4.A: The Individual Support Planning Process is reviewed and revised as necessary.

Action Step SPC4.A.1: Develop methods of evaluating the new ISP process, based on data reflecting implementation practice, accuracy and content, ease of use, stakeholder satisfaction and community engagement and integration.
Action Step SPC4.A.3: Implement the process and form throughout one year, based on effective dates.
Action Step SPC4.A.4. Evaluate again, at an appropriate time after the process has been completely implemented.

Objective SPC4.B: Policies/procedures/guidelines which define the components and minimum quality expectations for Individual Support Plans (ISPs) correlated with individual assessment results) are reviewed/revised, as necessary.

Objective SPC4.C. Proficiency based training is required for providers, support coordinators and others acting as agents of DBHDD consistent with timeframes and content outlined in policies and standards.

Objective SPC4.D: Prior to the ISP meeting, the Support Coordinator (SC) meets with the person to determine what he/she wants in the ISP. A preliminary ISP will be developed to serve as the basis of planning during the meeting.

Objective SPC4.G: The ISP is consistently implemented by responsible persons.

Objective SPC4.H: Support Coordinator monitors the implementation of the ISP per Waiver Guidelines.

Objective SPC4.I. Support Coordinator reports status of ISP implementation as evidenced by action taken as required to ensure its routine implementation.

Outcome SPC4.K. The individual Plan is modified timely, consistent with changing circumstances and needs to ensure each person is safe and makes progress as identified in the ISP.

E. Support Coordination

OUTCOME SPC5: EACH PERSON HAS A SUPPORT COORDINATOR (SC) WHO ASSISTS IN IDENTIFYING AND OBTAINING DESIRED SUPPORTS AND SERVICES

Objective SPC5.A: The roles/responsibilities of the Support Coordination system have been delineated.
Note: This includes the roles and responsibilities of the Support Coordinator, The SC Supervisor, the SC Agency.

Action Step SPC5.A.1: Conduct an assessment of Support Coordinator responsibilities and proficiencies.
Action Step SPC5.A.2. Define proficiencies and responsibilities of Support Coordinators (including SC Supervisors, intensive coordination and monitoring responsibilities of individuals with high risk needs.)

Objective SPC5.B: Proficiency based training for Support Coordinators/SC Supervisors has been developed.

Objective SPC5.C: Proficiency based training to Support Coordinators/SC Supervisors (consistent with their identified roles and responsibilities) has been provided as evidenced by training provided *within 30 days of hire for new employees and within 60 days of implementation for existing employees.*

Objective SPC5.D. **Continuously evaluate additional training needs of support coordination based on evaluation of performance, changing population characteristics and add to or revise the curriculum.**

Objective SPC5.K: DBHDD has hired adequate numbers of individuals in each Regional Office whose primary responsibility is oversight of support coordination.

Objective SPC5.L. Intensive Support Coordination requirements have been developed.
Action Step SPC5.L.1. Intensive Support Coordination requirements include:
- reduced caseload,
- increased monitoring based on the individual's ISP,
- documentation and reporting responsibilities; and
- working in close conjunction with the provider agency nurse who is the Health Care coordinator.

Objective SPC5.M.: A Community Waiver Amendment shall be developed, submitted and implemented which includes increased SC rates based on new roles and responsibilities.
Action Step SPC5.M.2: Develop an amended service definition for Support Coordination focused on a team approach in the provision of enhanced support coordination associated with identified needs and risks.
Action Step SPC5.M.3: Submit amended service definition for Support Coordination focused on a team approach in provision of enhanced support coordination associated with identified needs and risks.
Action Step SPC5.M.4: Implement amended service definition for Support Coordination Focused on a team approach in the provision of enhanced support coordination associated with identified needs and risks.
Action Step SPC5.M.5: Develop population-specific elements of Georgia's transition plan.

Objective SPC5.N. The plan (between SC's, regional, state staff and others) for the newly defined roles and responsibilities for Support Coordination and Regional Offices has been implemented.

Action Step SPC5.N.1. State will develop an organization structure that reflects new roles and responsibilities that include Central Office, Region and Support Coordination.

Objective SPC5.O: Proficiency measures for Support Coordinators are defined and measurable.

Objective SPC5.P: Enforce policies/procedures for Support Coordination as evidenced by statewide consistency in Support Coordination services.

Action Step SPC5.P.1: Consistent with the preceding, develop policies and procedures for Support Coordination.

VI. COMMUNITY LIFE (CL)

A. Community Supports and Services

OUTCOME CL1: THE PERSON'S COMMUNITY SUPPORTS ARE INDIVIDUALIZED/PLANNED/COORDINATED/PROVIDED IN A TIMELY MANNER

Objective CL1.A: Each individual has a Support Coordinator who has or will assist with the move to and life in the community.

Action Step CL1.A.1 Support Coordination advocates for elements in the ISP that actively assist people in participating in the life of their communities.

Objective CL1.D: Support Coordinators promote and first utilize services available generally to all persons in the community.

Objective CL1.E: Opportunities for accomplishing personal outcomes from a variety of integrated community experiences are provided and supported regularly.

Objective CL1.I: Qualified personnel are available.

Action Step CL1.I.1. Newly hired and existing personnel have passed proficiency based training in person-centered planning and values associated with Social Role Valorization.

OUTCOME CL2: INDIVIDUALS HAVE A CHOICE OF QUALIFIED PROVIDERS

Objective CL2.B: A consumer needs/service assessment has been completed for individuals (in the hospital and those already living in the community).

Objective CL2.C. Feedback is received from providers/key stakeholders to inform decisions throughout the recruitment/retention process.

Objective CL2.D. Recruitment criteria which meets enrollment criteria enables DBHDD to enroll quality providers timely.

Objective CL2.E: DBHDD works with Provider Network Management to align activities/actions.

Objective CL2.G: Has developed a recruitment strategy.

> **Action Step CL2.G.1:** DBHDD evaluates all new providers' qualifications prior to recruiting or entering into agreements.
> **Action Step CL2.G.2:** DBHDD recruits providers to the state of Georgia, as needed.
> **Action Step CL2.G.3:** As necessary, the state contacts providers with proven/effective experience in supports and services needed;

Objective CL2.I: A retention strategy has been implemented.

> **Action Step CL2.1.2:** Implement and modify as necessary.

B. Health and Wellness

OUTCOME CL3: INDIVIDUALS RECEIVE EFFECTIVE HEALTH CARE COORDINATION

Objective CL4.A: A definition of Risk indicators is consistently used to identify level and intensity of supports and services provided. (Including, specialty, day, home, etc.)

Objective CL3.B. A unified State Risk Rating System for the community and hospitals is established as evidenced by a State Risk Rating System which addresses medical and mental health conditions (e.g., aspiration, falls, fractures, osteoporosis, constipation, poly-pharmacy, seizures, challenging behaviors.)

Objective CL3.C: Expectations for Health Care Coordination are identified as evidenced by well-defined roles and responsibilities carried out and measured at the provider, region and state level.

> **Action Step CL3.1.**: Define criteria for "high risk" individuals.

Objective CL3.D: Health Care Coordination roles/responsibilities with measurable expectations are clearly stated (in policy, standards and training materials).

Objective CL3.E: Individual health needs are routinely monitored by a nurse as evidenced by oversight, communication with Direct Support Personnel and correction which results in the achievement of health goals and timely response to changes in health status.

> **Action Step CL3.E.1**. Primary Care Nurse is assigned to each home.
> **Action Step CL3.E.2** Nursing hours (RN/LPNs) are approved for individuals based on need. As need changes, the exceptional rate assessment is completed to secure needed services and supports.

Objective CL3.H: Recommendations of accurately informed health care professionals are followed (or if not, decisions are justified, reviewed and documented).

OUTCOME CL5: INDIVIDUALS RECEIVE EFFECTIVE RESPONSE TO CHANGING HEALTH NEEDS

Objective CL5.E: When an individual is receiving health care in an out of home setting, appropriate supports (discharge planning begins the day of admission and a smooth transition home occurs as soon as medically feasible) will be provided.

OUTCOME CL6: INDIVIDUALS RECEIVE COMPETENT CARE IN LINE WITH BEST PRACTICE

Objective CL6.C: Quality Improvement information is used to improve health outcomes.

OUTCOME CL7: INDIVIDUALS WHO CHALLENGE SERVICES RECEIVE EFFECTIVE COMMUNITY SUPPORTS

This section deals with the needs of those viewed as challenging specifically, people with significantly delayed cognitive ability and limited motor and verbal communication; and those individuals whose violent or disruptive behaviors and/or mental health needs challenge services. For purposes of this plan, we are referring to individuals whose challenges include:

> ***Multiple disabilities;*** that is, individuals who have severe cognitive challenges, communication limitations, and other disabilities which have limited their ability to move, sit, or balance themselves, eat on their own, express themselves in traditional verbal ways, see and/or hear, focus their attention, and remember, acquire and maintain new skills.
>
> **Or**
>
> "***Behaviors*** of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behavior which is likely to seriously limit or delay access to and use of ordinary community facilities."[19]

Every situation provides an opportunity to learn; behavior occurs all the time. Therefore, personnel supporting people whose abilities or behavior are challenging must understand that every interaction has the potential to be positive and therapeutic.

The priority is to listen and understand behavior, observe and structure the environment so it too is therapeutic and understanding. Environmental conditions and stimulation need to be considered as a priority when determining potential causes of inappropriate or disruptive behaviors. Who you live with, the noise level at home, consistent staffing, ability to be alone are all examples of issues we would all consider when understanding behavior.

[19] Mansell, J.L. Services for People with Learning Disabilities and Challenging Behavior or Mental Health Needs, HMSO, London.

Behavioral services are a broad ranging set of possibilities, not limited exclusively to behavioral therapy. Behavioral services may include other forms of intervention designed to address the underlying issue(s) identified. If the person has restricted access to the community, no or few relationships, and limited vision for potential in growth because of the persons behavior and the team has not addressed these issues, then the person needs behavioral services.

If the person presents behavior that exceeds the ability of the Team to successfully implement the ISP/or the person to attain skills and accomplish goals; and/or if the person is on psychotropic medication for behavioral or mental health issues, behavioral supports are needed.

Objective CL7.A: Individuals receive skill development and/or behavioral services consistent with their needs.

Action Step CL7.A.1: Individuals receive adequate assessments (skill and/or behaviorally related), as needed.
Action Step CL7.A.2: Assessments will add to the team's knowledge of what motivates, sustains or improves skills and/or changes behaviors.
Action Step CL7.A.3: Assessments will provide a baseline and provide anecdotal as well as data based information.
Action Step CL7.A.4: Assessments identify the factors that contribute to skill building and/or the occurrence of challenging behavior. (These factors may be environmental, personal, biological, social, developmental, psychological, past trauma/abuse, interpersonal or other internal or external stimuli.)

Objective CL7.B: ISPs and/or Transition Plans will incorporate information specifically related to those individuals whose abilities or behaviors challenge services.

Action Step CL7.B.1: Individually planned interventions to increase skills and/or reduce the person's need to use challenging behaviors are implemented.
Action Step CL7.B.2: Procedures will be developed and implemented to review the progress of each person semiannually or as needed.
Action Step CL7.B.3: Progress of each individual will be reviewed to ascertain the adequacy and effectiveness of the positive skill building training.
Action Step CL7.B.4: For those individuals who are being supported to reduce aggressive, self-injurious, or dangerous behaviors, the progress review will take place at least monthly or as needed.
Action Step CL7.B.5: Those approaches (instructional/environmental) which are found to need revisions, will be modified within (10) working days of the review.

Objective CL7.C: Those who develop the Plan thoroughly know/understand the individual and his/her experiences.

C. Behavioral and Mental Health

OUTCOME CL9. PEOPLE HAVE ACCESS TO COMPREHENSIVE BEHAVIORAL/MENTAL HEALTH SUPPORTS/SERVICES

Objective CL9.A: The Behavioral/mental health support system will include, at least, the following components:

- *prevention, early intervention and ongoing support.* these services, at a minimum include:
    - include proactive strategies where specialist's services work alongside informal, generic and contracted provider services to promote physical, emotional and psychological well-being.
    - the timely provision of supports designed to meet the specific needs of the individual;
    - the timely development of coordinated services to manage important transition(s) including change in significant relationships, day services, employment, residential, etc.;
    - ongoing efforts to help the person communicate[20] their needs and wants; and
    - the ongoing provision of services in a manner which respects each person's wants, desires, and needs.
- *reactive strategies which require services to take corrective action soon after a potential problem is identified, before it becomes an emergency with a view to systems improvement and prevention*.

  This requires:
    - the development of individually tailored strategies;
    - the development of policies and procedures; complemented by
    - proficiency based training initiatives;
    - staff who provide day to day services are prepared to meet the challenges provided by the person's mental/psychiatric issues;
    - staff of local community health and mental health organizations are prepared to meet the additional challenges posed by Intellectual disability; and
    - a provider capacity to respond effectively in unexpected situations.
- *crisis management includes service responses which are timely, safe and effective.*
    - Provider agency response systems should be supplemented for people who require them based on plans designed specifically for the individual which are minimally intrusive and maximally effective.

[20] This requires the availability of communication assessments, speech therapy and augmentative communication devices coupled with Direct Support Professionals who consistently enable the person to use these communication aids and respond to them.

- Given that crisis may develop rapidly and under entirely unexpected circumstances, services and therapists must be flexible and adaptive.

Objective CL9.C: Sufficient numbers of qualified behavior analysts (BA) and behavior specialists (BS) are available in each region. These specialists work with local BA and BS to:

Action Plan CL9.C.1: to assess individual needs;
Action Plan CL9.C.2: write individualized behavior support plans;
Action Plan CL9.C.3: provide proficiency based training to staff to ensure accurate and consistent implementation of these plans;
Action Plan CL9.C.4. monitor the effectiveness of the plans; and
Action Plan CL9.C.5. revise the individual plans and training, as needed when the individual's status has changed.

Objective CL9.D: Transition guidelines and practices including mental health supports are in place for individuals transitioning to the community prior to their move.

Objective CL9.E: Proficiency based training is provided to community personnel.

Objective CL9.F: Out-of Home solutions to crisis intervention is minimized.[21]

Action Step CL9.F.1. A plan for managing crisis is in place regionally.
Action Step CL9.F.4: Successful and unsuccessful interventions are evaluated and practice is improved based on this analysis.
Action Step CL9.F.5: Changes in practice based on analysis are shared region-to-region so improved practice is consistent statewide.

Objective CL9.K. Best practice assessment and treatment approaches and protocols for individuals with dual diagnosis are in place.

VII: BUILDING COMPETENCE, KNOWLEDGABLE PERFORMANCE AND SUSTAINABILITY (BCS)

Competency – Proficiency – Sustainability Training Model: addresses competency which is "knowing" the subject matter; Proficiency to ensure that staff are skilled in identified areas demonstrating the ability to apply that knowledge; and return reviews of continued proficiency to ensure sustainability.

Proficiency based training referenced in this document requires knowledge, demonstration of proficiency and sustainability as a product of internal continuous monitoring and feedback loop.

[21] Effectiveness extends beyond the ability to provide an immediate solution to a presenting problem. For example, physical and social dislocation are undesirable side effects of most out-of-home/facility-based solutions. . These must be known and accessible to those people who may need or use them.

OUTCOME BCC1: INDIVIDUALS RECEIVE SERVICES FROM PROVIDERS WITH DEMONSTRATED ABILITIES

Objective BCC1.A: Services are provided by competent personnel as evidenced by nurses, Direct Support Professionals, frontline supervisors, ancillary providers and Support Coordinators who have received and passed proficiency based training related to prevention and early identification.

Objective BCC1.B: Health related proficiency based training is delivered.

Action Step BCC1.B.1: Completion of mandatory proficiency based training occurs within timelines required by standards with each individual accomplishing (identified %) of compliance and performance or above.

BCC1.B.1.a. Regional and Provider nurses receive proficiency based training on writing and implementing individual Health Care Plans.

Action Step BCC1.B.2: Proficiency based training and testing will include observation and demonstration.

Action Step BCC1.B.3: Upon confirmation of compliance deficiencies, a remediation plan will be developed. (Coordinated with Continuous Quality Improvement).

Action Step BCC1.B.4: Staff found to be out of compliance must be managed through a preceptorship program until they successfully achieve proficiency.

Objective BCC1.C: Person-specific training for community staff who will be supporting individuals moving from hospitals to the community is being provided prior to discharge.

Objective BCC1.F: Quality Improvement information is used to ensure relevance of training content.

Objective BCC1.G. Quality Improvement information is reviewed by DBDD leadership and used to influence the allocation of human and material resources.

Objective CL3.H. Recommendations of accurately informed health care professionals are followed (or if not, decisions are justified, reviewed and documented).

VIII. QUALITY IMPROVEMENT

B. Mortality Review (MR)

The mortality review process provides a retrospective analysis that assures compliance with standards, reduces adverse events, leads to ongoing improvement, and generates changes of policy and procedure or protocol, development of practice standards, focused training systems and improvement strategies. In addition to cause of death, other factors such as circumstances or events related to the individual's health and safety collateral to the event need to be closely examined to maximize the opportunity to become informed about the quality of health care and the system of services.

The Community Mortality Review Committee (CMRC) identification of system issues and problem resolution is a mechanism for effecting system change with the goal of improving the provision of care, reducing morbidity and ensuring that, even though the outcome may be death, care is provided in a timely, competent and caring environment. External review is an integral aspect of mortality review to ensure objectivity. Health inequalities experienced by people with I/DD are reduced when information about mortality is systematically analyzed and findings are used to strategically improve quality of care.

OUTCOME MR2: DEATHS ARE REVIEWED AS A LEARNING OPPORTUNITY TO IMPROVE QUALITY FOR THE INDIVIDUAL, (PROGRAM AND SYSTEM)

Objective MR2.A: DBHDD has policies and procedures for the reporting, tracking, review and analysis of information related to the death of individuals regardless of their funding source at the time of their death.

Objective MR2.B: Causal analysis of deaths is strategically used to reduce the likelihood of premature and preventable[22] deaths using a standardized mortality review process that clearly defines roles, responsibilities and timelines.

Action Step MR2.B.3: An independent, objective and third party clinician reviews all deaths.
Note: Independent clinician describes the causes and factors that may have contributed to the death and any collateral findings related to the quality of care and services and makes individual and system recommendations.

C. Quality Improvement System (QIS)

OUTCOME QIS2: JOINT MONITORING/QUALITY IMPROVEMENT AT THE INDIVIDUAL LEVEL

QIS2.B. Under the supervision of the Independent Reviewer, implement Individual Quality Review Process.

IX. SYSTEM NEEDED TO SUPPORT IDENTIFIED OUTCOMES (SIO)

The successful implementation of this Plan depends on many things:

- the engagement of internal and external partners including individuals receiving services, families, advocates, service coordinators and providers;
- effective, robust and well-staffed regions;
- the successful implementation of DBHDD's overall re-engineering initiative;
- the continued goodwill and financing from the Governor and Legislature; and

[22] Without a specific even that formed part of the "pathway" that lead to death, it was probable that the person would have continued to live for at least one more year.

- ongoing funding and support from and interface with sister state and federal agencies with whom DBHDD has a long and successful relationship.

Many of the existing policies, procedures and systems will remain as they are with limited changes. Others should and will be significantly altered in an effort to improve effectiveness and stability of the system including the provider network and at the same time improve overall efficiency and accountability. It is impractical in this Priority Plan to address all of the infrastructure and systems changes that are currently taking place. Some changes do not relate specifically to services and supports to people. Some improvements that do relate directly to DD services are still being contemplated and need the thoughtful input and influence from stakeholders statewide. Consequently, this section will propose initial thinking in just a few areas with the understanding that many more opportunities for discussion and proposals for change are coming.

A. Measurable Criteria

OUTCOME SIO1: MEASURABLE CRITERIA WILL BE DEVELOPED IN IDENTIFIED AREAS OF THE PLAN.

Objective SIO1.A. Start with the supplemental report and joint filing.

Action Step SIO1.A.1. Develop measurable criteria based on recommendations outlined in the supplemental report and joint filing

SIO2: OUTCOMES IDENTIFIED IN THIS PLAN ARE SUSTAINED AS EVIDENCED BY THE ALIGNMENT OF DEPARTMENTAL STRUCTURE, ROLES AND RESPONSIBILITIES.

B. Provider Network Development

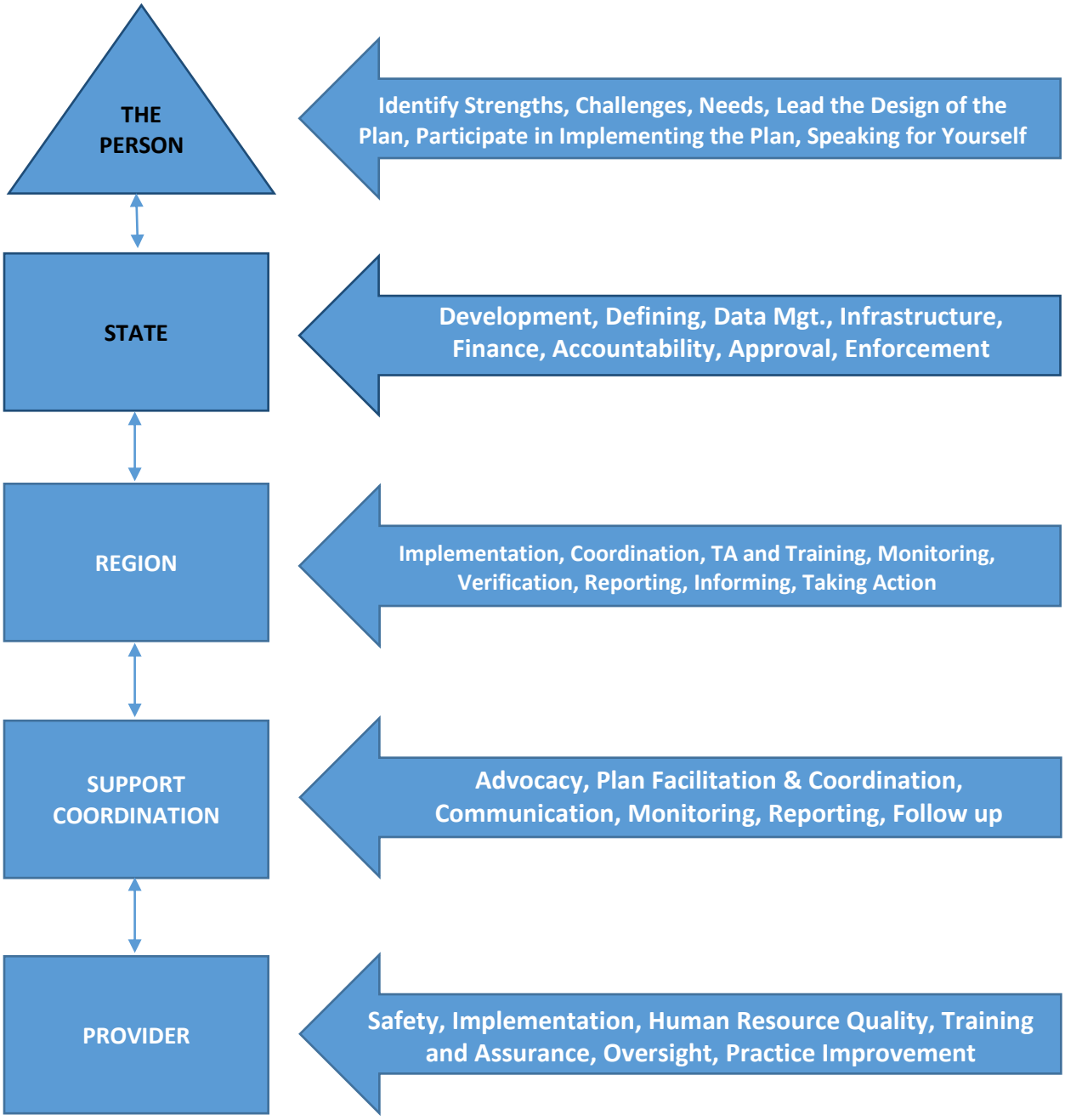
OUTCOME SIO2: A NETWORK OF QUALIFIED PROVIDERS IS AVAILABLE THROUGHOUT THE STATE.

Objective SIO2.A: Utilize results from consumer needs and service assessment to recruit the appropriate type and mix of providers.

Objective SIO2.E: Service quality and accessibility is evaluated and modified based on findings which result in improved practice.

Action Step SIO2E.2: The appropriate course of actions/remediation plans are implemented to support an adequate network (training, technical assistance, policy development, suspensions/terminations).
Action Step SIO2E.5: A consistent process provides recommendations for provider terminations and other adverse actions.

Roles and Responsibilities



C. Roles and Responsibilities of the Regions

In order to address the roles and responsibilities of one component of the system, we must consider the roles and responsibilities of the whole. Human service systems are complex, interdependent and rely on each other in order to be successful. DBHDD along with all partners must effectively and consistently carry out our respective roles in order to be successful. One measure of success for the entire system is whether or not individuals supported receive the supports and services they need so they can live safe and productive lives as defined by them.

As we consider the roles and responsibilities of the Regional and State Offices, the following depicts a high-level summary of the roles and responsibilities of some other systems partners. Stakeholders are invited to expand and improve this initial thinking.

Our initial allocation of roles and responsibilities is as follows:

The Person

- **Identifying Strengths, Challenges and Needs.** Knowing what the person has experienced, what he/she likes and is good at, knowing what the person needs to be successful… and more, are the things the Plan considers and addresses.
- ***Leading the plan*** and speaking out are all things critical to the success of identifying and providing the right things at the right time.
- ***Participating in the implementation of the plan*** so that the things that you want to do, learn, experience, enjoy really happen as you wish.
- ***Speaking for yourself*** and having the needed supports, if any, to do so.

The State:

- ***Develops*** policies, procedures, standards;
- ***Defines*** "what" is wanted in terms of individual and practice outcomes as a result of these policies or standards in guidance such as manuals, training materials, contracts, and so on.
- ***Establishes and maintains the infrastructure*** (physical and organizational structures) required to meet its obligations, responsibilities and intended individual and practice outcomes. Important infrastructure issues for this plan include, for example, structure of the regions and information technology and data management systems.
- ***Approval of policies, contracts, budgets, performance indicators*** and more are an essential responsibility of the State. In order to ensure consistency across regions, final approval and authority is located at the state level.
- ***Accountability or assuming responsibility*** for accomplishing identified tasks as identified by law, policies, procedures, standards, direction from the Governor and Legislature. Accountability and transparence is also key for maintaining the public trust.
- ***Finance,*** putting forth budgets and acquiring funding needed to fulfill the responsibilities of DBHDD key.
- ***Enforcement,*** making sure that people receive the supports and services they are entitled to receive, that commitments are met and contracts fulfilled, that others are accountable just as DBHDD is accountable is essential.

The Regions:

- ***Interpretation*** of policies, procedures and standards so individuals, families, providers, service coordinators, therapists and others know what is expected and what is possible.
- ***Implementation* of policies and procedures** occur consistently throughout the region.
- ***Coordination of necessary services.*** Regions are responsible for knowing the needs individuals supported in their regions and whether or not those services are available. If not, the Region needs to identify and report this as an issue so that the provider network can be expanded.
- ***Technical Assistance and Training*** is offered by the regions to ensure that the provider network is informed, competent, confident and performs consistent with expectations.
- ***Monitoring*** is a key function to ensure that people get what is needed as identified in their ISP, policies, procedures and standards are followed, consistent implementation of agreed upon and contracted services.
- ***Informing*** the content of contracts, budgets, Quality Improvement Plans, etc., need to take place as close to the delivery point (in this case, service delivery) as possible. The parties have firsthand information which influences the ultimate content outcome, although ultimate approval is at the state level.
- ***Verification*** of information, data, current status of service provision is essential if the regions and DBHDD are to make informed, accurate and effective decisions.
- ***Reporting*** timely and accurately so that information can be provided as a part of the 'big' picture is essential if issues are to be anticipated and resolved timely.
- ***Recommending*** specific action be taken when compliance has not occurred.
- ***Taking effective action timely*** with and on behalf of individuals to resolve problems, ensure people are a part of the community and leading meaningful lives as defined by them, people are safe and providers effectively responsive.

Support Coordination

- **Advocate.** An advocate must know the person well, listen and hear what the person wants and needs in order to communicate and push for those needs and wants to be met. Advocates must know the system inside and out so that they can 'connect' the person with what is needed. Advocates also need to know when to step back and be sure that the person's voice is heard above all others.
- **Plan Facilitation**. The development of the Individual Support Plan (ISP) should result in a 'contract' or ISP between the individual and the service system. The ISP should outline what the person wants and needs, who is going to provide those things and when. As the facilitator, getting the right people to the table, making sure assessments are used to build the plan, ensuring that the content is clear, comprehensive and practical, getting the plan out timely to those who have to implement it are all key ingredients of Plan facilitation.
- ***Service Coordination.*** The best Support Coordinators know the environment inside and out. They know the law and regulation, they know the specialty and generic resources, they know who to call to get things done, they know the community, employers, the clubs and organizations and the volunteer resources. Most important, they use this knowledge to connect individuals they support to these resources in a way that results in integrated meaningful experiences, relationships and roles.

- ***Monitoring.*** Once the ISP has been developed the Support Coordinator must monitor to see that the promised supports and services are delivered timely and as intended. This monitoring needs to be routine, in various places and at various times.
- **Reporting**. A Service Coordinator must collect and disseminate accurate and thorough information regarding issues that are or could become key to the person. Reporting on the status of the implementation of the ISP, whether or not progress is being made and the personal circumstances of the person is a critical component of ensuring that Service Coordination is the safeguard it is intended to be.
- ***Following up*** and taking action makes the difference between someone knowing there is an issue and getting the issue resolved. Knowledge without action immobilizes Support Coordination in its advocacy, safeguard role.

Providers: (Day, Residential, therapeutic, health care, behavioral health and others as needed)

- **Safety.** If individuals are to realize their hopes, dreams and aspirations they need to feel safe and be safe. If individuals are to play valued roles in their communities, be a good neighbor, have meaningful relationships and families, participate in memberships, give back to their community, they have to feel and be safe. Providers are the first line of assuring that individuals feel safe and are safe.
- ***Human Resource Quality, Training and Assurance.*** Having qualified, competent and sufficient numbers of staff is critical for every provider. Being able to recruit, train and retain competent, performance verified staff and sustain them is a significant priority for providers.
- **Service Implementation.** The ISP identifies what the person needs and wants. Providers are and should be creative about how to enable individuals to successfully acquire those needs or accomplish those goals. Providers must make sure that people get effective supports and services they need and want.
- **Oversight.** To ensure that services are provided timely, consistently and effectively, providers must ensure oversight which prevents, detects and results in rapid action being taken to remediate gaps in intended supports and services.
- **Practice Improvement.** Many of the best ideas come from experience, direct support personnel, projects tried that weren't as successful as hoped for. Providers, like all components of the system, should continually seek to find ways to improve practice which results in improved lives. Providers are uniquely placed as close to the individual as possible to identify and initiate those practice improvements.

This is a high level view of some of the roles and responsibilities ascribed to various levels of service provision. This Plan is replete with actions that have been, are or will be taken to clarify in great detail the roles and responsibilities of the Central Office, Regions, Support Coordinators and Providers.

OUTCOME SIO3: ROLES AND RESPONSIBILITIES OF THE REGIONS ARE DEFINED.

Objective SIO3.A: Assess current and future state of regional staff roles and responsibilities required as a result of the outcomes in this plan.

OUTCOMES SIO3.B. DEVELOP STRUCTURE AND PROCESS AROUND REQUIRED ROLES AND RESPONSIBILITIES.

OUTCOMES SIO3.C.: DEFINE CORE COMPETENCIES AND EXPECTATIONS OF REGIONAL STAFF.

OUTCOMES SIO3.D.: REORGANIZE ROLES AND RESPONSIBILITIES TO ALIGN WITH CORE COMPETENCIES.

OUTCOMES SIO3.E.: DEVELOP COMMUNICATION PLAN.

Regional influences, roles and responsibilities identified in this Priority Plan, so far, include:

Examples in the Plan	Regional Responsibility
Supporting Individuals Served, Ensuring Individual Needs Are Met	
SPC1.A.	Transition Plans are individualized, comprehensive.
SPC2.H	Visiting the person following transition to the community
	Monitoring the implementation of the Transition Plan
CL1.A.	Supporting the person's life in the community.
INCR2.C.	Training and TA to individuals and families.
SPC1.A.	Ensuring supports and services are provided per the Transition Plan
INCR.5.A.	Knowing what resources are available in the community.
INCR2. INCR3 INCR4	Ensuring that gaps in services are filled for individuals with special needs. (Positioning, dining/aspiration, therapy, equipment, fabrication, communication, etc.)
CL9.F.	Supporting people in crisis
CL.3	Supporting people's health care needs
CL.7.; CL.9	Supporting people with behavioral and mental health needs.
Support Coordination: Support, Training, Oversight, Monitoring and Correction	
SPC5.K.	Having personnel in the Regional Office dedicated to the support, TA and oversight of Support Coordination.
V.	Being clear about Support Coordination responsibilities for planning which Regions will monitor.
INCR2.C.	Technical Assistance and Training for SC.
SPC5.D.	Evaluating the needs of SC's based on evaluation of performance and changing population characteristics.
SPC5.N.	Implement a plan for the newly defined roles and responsibilities for SC's and RO.
SPC5.P.	Enforce policies/procedures for SC.
Provider: Support, Training, Oversight, Monitoring and Correction	
INCR2.B.	Providing Technical Assistance and Training to Teams and Providers.
INCR2.B.	Providing Technical Assistance and Training to therapists and clinicians.
CL3.C.	Health Care Coordination Oversight.
SPC2.A.11	Provider Reporting to the Regions/Regions Monitoring
QIS1.C.	Helping Providers develop Quality Improvement Plans consistent with provider

Examples in the Plan	Regional Responsibility
	strengths and challenges.
SPC1.A.12.	Monitoring Providers/mitigation of problems
QISIH.2.C.	Monitoring Provider actions to determine effectiveness of remedy.
Regions: Other Systems Improvements	
SPC5.N.1.	Structure that reflects new Roles and Responsibilities.
SPC1.A. SPC2.H.	Developing and implementing sustainable strategies for ongoing monitoring and evaluation of community placements.
SPC1.A. SPC2.H.	Developing and implementing sustainable strategies for the ongoing monitoring and evaluation of community placements to remedy issues such as lack of communication, information sharing and feedback.
QIS4.E.	Proficiency Based Training, timelines set by Region
QIS1.E.	Learning from Incident Reports
MR1	Learning from Mortality Reviews
QIS4.C.	Individual Quality Reviews with Independent Reviewer
QIS4.J.	Taking Action for Substandard Performance