Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY DEVELOPMENTAL DISABILITY PROVIDERS

FOR

THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FISCAL YEAR 2025

Effective Date: ***January 1, 2025*** **(Posted:** ***December 19, 2024*****)**

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

INTRODUCTION

The FY 2025 Provider Manual for the Division of Developmental Disabilities has been designed as an addendum to your contract/agreement with DBHDD to provide you structure for supporting and serving individuals residing in the state of Georgia.

TABLE OF CONTENTS

When accessing this manual electronically, use your mouse to left click on the part or section you would like to access, and you will be quickly linked to the corresponding page. If you see a red arrow (►) please check the Summary of Changes Table for details.

SUMMARY OF CHANGES TABLE

UPDATED FOR JANUARY 1, 2025

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item #	Topic	Location	Summary of Changes
1.	Effective Date Change from October 1, 2024, to January 1, 2025 and Quarter changed from 2nd to 3rd	Page 1 et. seq	N/A
2.	Developmental Disability Services, Organizational Practices, Adequate and Competent Staff (Critical)	Part II, page 22, E. 13. a. v	Added Home and Community Based Services (HCBS) Settings Rule Training

ALL POLICIES ARE POSTED IN DBHDD POLICYSTAT LOCATED AT http://gadbhdd.policystat.com

Details are provided in the policy titled Access to DBHDD Policies for Community Providers, 04-100.

The DBHDD PolicyStat INDEX helps to identify policies applicable for Community Providers.

The New and Updated policies are listed below. For 90 days after the date of revision, users can see the track changes version of a policy by scrolling to 'New and Recently Revised Policies' on the PolicyStat Home Page.

Questions or issues related to policy and service delivery should be directed to your Provider Relations team: https://dbhddapps.dbhdd.ga.gov/DBHDDPIMS/(S(kdypqpyeeoiou1tmt44kfgiz))/Home_Ext.aspx

Questions related to the Georgia Collaborative ASO functions such as those listed below can be directed to GACollaborativePR@carelon.com

- **Provider Enrollment**
- **ASO Quality Reviews**
- **Behavioral Health Registrations, Authorizations, and Billing for State Funded Services**

Item#	Topic	Location	Summary of Changes
1.	Provider Manual for Community Developmental Disability Providers, 02-1201	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/14254341/latest
2.	Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02-703	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/16376392/latest
3.	Expedited Fair Housing Requests, 02-1205	gadbhdd.policystat.com	**NEW:** https://gadbhdd.policystat.com/policy/16895420/latest
4.	Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701-Attachment A	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/15080781/latest
5.	Guardians and Other Surrogates in Community-Based Services. 04-103	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17050105/latest

Part I

Eligibility, Service Definitions and Requirements

Provider Manual

For

Community Developmental Disability Providers

Fiscal Year 2025

Georgia Department of Behavioral Health and Developmental Disabilities

Eligibility, Service Definitions and Service Guidelines for Developmental Disability Services

Eligibility for Developmental Disability Services

To be eligible for Developmental Disabilities Home and Community-Based Waiver Program Services, individuals must meet disability and financial criteria. One of the Department of Behavioral Health and Developmental Disabilities (DBHDD) Regional Field Offices determines disability waiver eligibility for individuals residing in that region. The Department of Family and Children Services (DFCS) determines financial and Medicaid eligibility for services which are funded through Medicaid Waiver resources. Eligibility for the Medicaid Waiver programs is determined by DBHDD Regional Field Offices in accordance with waiver policies.

To be eligible for **developmental disability waiver services, an individual must meet the eligibility criteria below.** The contractor will deliver services to individuals who meet the following criteria:

1. **Most in Need:** The individual demonstrates:
   a. Substantial risk of harm to self or others; or
   b. Substantial inability to demonstrate community living skills at an age-appropriate level; or
   c. Substantial need for supports to augment or replace insufficient or unavailable natural resources.

AND

2. **Diagnosis**:
   a. **Intellectual Disability:** The individual has a diagnosis of an intellectual disability based on onset before the age of 18 years and assessment findings from standardized instruments recognized by professional organizations (American Psychological Association, American Association on Intellectual and Developmental Disabilities) of significantly sub-average general intellectual functioning and significantly impaired adaptive functioning defined as an intelligence quotient (IQ) of about 70 or below (approximately two standard deviations below the mean) and significantly impaired adaptive functioning (two or more standard deviations below the mean) in at least two of the following skill areas: self-care, communication, home living, self-direction, functional academic skills, social/interpersonal skills, use of community resources, work, leisure, health, and safety.

AND/OR

   b. **Related Condition:** The individual has a diagnosis of a condition found to be closely related to an intellectual disability, as determined by a professional licensed to do so, and is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability and meets the following criteria (Code of Federal Regulations, Title 42 Section 435.1010):
      i. Is manifested before the individual attains age 22;
      ii. Is likely to continue indefinitely;
      iii. Results in substantial limitations in adaptive functioning (two or more standard deviations below the mean) in three or more of the following areas of functioning;
         - Self-care;
         - Receptive and expressive language;
         - Learning;
         - Mobility;
         - Self-direction; and
         - Capacity for independent living; and

   The adaptive impairments must be directly related to the developmental disability and cannot be primarily attributed to mental/emotional disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention deficit/hyperactivity disorder.

Eligibility for State Funded Developmental Disability Services
Individuals who meet the above eligibility criteria for developmental disability waiver services are eligible to receive state funded developmental disability services. Individuals who do not meet the above developmental disabilities waiver criteria may receive state funded developmental disability services depending upon the availability of funding, priority of need. Please refer to the Provider Manual for DD State Funded Services located at: https://gadbhdd.policystat.com/policy/1386258/latest/.

IDD/DEVELOPMENTAL DISABILITY SERVICE DEFINITIONS (NOW/COMP WAIVER SERVICES):

1. All service descriptions funded through the Comprehensive Supports Waiver Program (COMP) and the New Options Waiver Program (NOW) are described in the Medicaid manual found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx , under COMP/NOW PART II, COMP PART III, and NOW PART III.

2. Services available through the COMP and NOW Waivers Program include:

    - Additional Staffing (COMP only)
    - Adult Skilled Nursing Services
    - Adult Nutrition Services
    - Adult Occupational Therapy Services
    - Adult Physical Therapy Services
    - Adult Speech and Language Therapy Services
    - Assistive Technology
    - Behavior Support Services Level 1 and Level 2
    - Community Access Services
    - Community Guide Services (NOW only)
    - Community Living Supports (CLS) Services
    - Community Residential Alternative (COMP only)
    - Environmental Accessibility Adaptation Services
    - Financial Support Services
    - Individual Directed Goods and Services
    - Interpreter Services
    - Natural Supports Training Services (NOW only)
    - Prevocational Services
    - Respite Services
    - Specialized Medical Equipment Services
    - Specialized Medical Supplies
    - Support Coordination and Intensive Support Coordination
    - Supported Employment Services
    - Transportation Services
    - Vehicle Adaptation Services

PART II

Standards for Developmental Disability Service Providers

Provider Manual

For

Community Developmental Disability Providers

Fiscal Year 2025

Section 1. Community Service Standards for Developmental Disability Providers

Section 2 Request for Conversion

Georgia Department of Behavioral Health and Developmental Disabilities

Part II

Section 1

Community Service Standards for Developmental Disability Providers

Vision:
Easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Mission:
Leading an accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment.

DEVELOPMENTAL DISABILITY SERVICES

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

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

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

Participant self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone.*

ORGANIZATIONAL PRACTICES

A. PROGRAM STRUCTURE

1. The organization has a description of its services that includes a description of:
   a. The population served;
   b. How the organization plans to strategically address the needs and desires of those served;
   c. The services available to potential and current individuals; and
   d. A detailed expectation and outcomes for services offered.
2. The organization has internal structures that support good business practices such as:

a. Clearly stated current policies and procedures for all aspects of the operation of the organization;
b. Policies and corresponding procedures that direct the practice of the organization;
c. Staff trained in organization policies and procedures;
d. Providing services according to benchmarked practices;
e. The level and intensity of services offered is within the organization's scope of services;
f. The identified services are offered timely as required by individual need; and
g. Administrative and clinical structures are clear and promote unambiguous relationships and responsibilities to support individual care. An accurate and updated organizational chart showing key areas of responsibility is provided to all employees. Employees are aware of established reporting relationships.

3. The organization has a formal code of conduct and other policies communicating appropriate ethical and moral behavioral standards and addressing acceptable operational principles and conflicts of interest.
   a. An ethical tone is established at the top of the organization and has been communicated throughout the organization.
   b. The code of conduct directly addresses issues such as appropriate use of resources, conflicts of interest, and use of due professional care. The code provides a process for what employees must do if they become aware of unacceptable behavior.
   c. The code of conduct is acknowledged by signature of all employees and contractors at least annually.
   d. Appropriate disciplinary action is taken in response from departures from approved policies or violations of the code of conduct.
4. The program description identifies the minimum staff to individual served ratios for each service offered. In addition, the program description needs to address the following considerations:
   a. Staff ratios reflect the needs of individuals supported, implementation of behavioral procedures, best practice guidelines and safety considerations.
   b. Staff ratios reflect considerations such as licensure waivers and special (exceptional) rates reflecting unique individual care needs, etc.
   c. Define clearly in Policy & Procedures and practice, what constitutes the staffing requirements and levels of observation procedures to meet the individual's clinical care and safety needs.
   d. Levels of observation include routine observations whereby staff is maintaining the general awareness of the individual's whereabouts and status by visually observing the individual at least every 30 minutes or as required.
   e. Continuous/special observations involve increased levels of monitoring and documentation; staff is to maintain continuous visual observation at all times and remain in close enough to intervene and prevent actions that are unsafe to the individual or others.
      i. Staff requirements for 1:1 observation: Arm's length is not necessarily 1:1 staff support, but the staff must be <u>within arm's length distance</u> while the individual is engaged in an activity. Staff is in close proximity at all times to be able to support and intervene as needed and the 1:1 staff support is exclusively focused on the individual and the staff <u>cannot provide support to another individual</u> or be engaged in any other activity at the time the 1:1 supports are mandated; and
      ii. Staffing requirements for Line-of-Sight observation: Line of sight is not 1:1 staff support but the staff has the ability to <u>always view</u> the individual and intervene and provide support as needed;
      iii. When multiple individuals are on line of sight, staffing ratios are increased to meet the care needs of each individual.
5. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.
   a. Appropriate licenses are obtained for residential services, if applicable;
   b. Licensure and other permits, when applicable, must be available at the agency or by the individual provider and open to view by the public;
   c. Accreditation/compliance with community standards requirements meet contractual requirements;

d. All DD Providers must have current general liability insurance listing DBHDD as the certificate holder in the amount of $1 million per occurrence and $3 million aggregate; and
e. The Provider must demonstrate full cooperation in allowing full and complete access by DBHDD and its agents and state and federal agencies to conduct reviews to evaluate and improve quality of service delivery, administrative performance and/or individual complaints.

6. There is a written budget which includes expenses and revenue that serves as a plan for managing resources. Utilization of fiscal resources is assessed in Quality Improvement Processes and/or by the Board of Directors.
7. The organization policy must state explicitly in writing whether or not research is conducted on individuals served by the organization.
   a. If the organization wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
      i. The agency's governing authority;
      ii. The Director of Division of Developmental Disabilities; and
      iii. The Institutional Review Board (IRB) operated by the Department of Public Health (DPH) and its policies as provided in Research, Protection of Human Subjects, and Institutional Review Board (IRB), 25-101.
   b. The research design shall include:
      i. A statement of rationale;
      ii. A plan to disclose benefits and risks of research to the participating individual;
      iii. A commitment to obtain written consent of the individuals participating; and
      iv. A plan to acquire documentation that the individual is informed that they can withdraw from the research process at any time.
   c. The organization using unusual medication and investigational experimental medications shall be considered to be doing research.
      i. Policies and procedures governing the use of unusual medications and unusual investigational and experimental medications shall be in place;
      ii. Policies, procedures, and guidelines for research promulgated by the DPH Institutional Review Board shall be followed;
      iii. The research design shall be approved and supervised by a physician;
      iv. Information on the medications used that shall be maintained include:
         a) Medication dosage forms;
         b) Dosage range;
         c) Storage requirements;
         d) Adverse reactions; and
         e) Usage and contraindications.
      v. Pharmacological training about the medication(s) shall be provided to nurses who administer the medications; and
      vi. Medications utilized shall be properly labeled.
   d. If research is conducted, there is evidence that involved individuals are:
      i. Fully aware of the risks and benefits of the research;
      ii. Have documented their willingness to participate through full informed consent; and
      iii. Can verbalize their choice to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly. Organizations that provide developmental disability services must participate in the Georgia Developmental Disabilities Provider information website. The address is https://www.georgiacollaborative.com/.

B. OVERSIGHT OF CONTRACTED PROVIDERS/PROFESSIONALS BY THE ORGANIZATION

1. The organization is responsible for the Contracted Provider (s) such as Host Home Providers and/or Contracted Professionals for Nursing and Behavioral Services and Developmental Disability Professional (DDP) are in compliance with:
   a. Contract/Agreement requirements, documented and maintained for review;
   b. Standards of practice and specified requirements in the provider manual for DBHDD, including *Community Standards for All Providers*;
   c. Licensure requirements (Provider shall hold the Community Living Arrangement License {or Personal Care Home Permit for providers approved prior to July 2011} by Healthcare Facility Regulations {HFR} for Community Residential Alternative services for all residential sites housing individuals with Intellectual and/or Developmental Disabilities (I/DD) as required by HFR);
   d. Accreditation or Community Service Standards Quality Review requirements;
   e. Quality improvement and risk reduction activities; and
   f. Contracting of Community Residential Alternative Service is Limited (Restricted) to Host Home Providers. Each Host Home require site specific enrollment.
2. There is documented evidence of active oversight of the Contracted Provider/Professional capacity and compliance to provide quality care to include monitoring of:
   a. Financial oversight and management of individual funds;
   b. Staff competency and training;
   c. Mechanisms that assure care is provided according to the plan of care for each individual served; and
   d. The requirement for a Host Home Study when contracting with a Host Home provider, to provide updating and meeting home study requirements for new members to include general health examination, screening for communicable disease, criminal records check/clearance, character references and training compliance.
3. All nursing services delivered by Contracted provider(s) with a Private Home Care (PHC) license or Community Living Arrangements (CLA) license must at a minimum meet the requirements for contracting nursing services outlined in the NOW/COMP Waiver Manuals Part II and Part III and Rules and Regulations for PHC Nursing Services found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx . **Note:** All nursing services provided under a CLA license require site-specific nursing enrollment.
4. A report shall be made quarterly to the agency's Board of Directors regarding:
   a. Services provided by Contracted/Subcontracted Provider/Professional; and
   b. Quality of performance of the Contracted/Subcontracted Provider/Professional.
5. A report shall be made to the DBHDD Regional Field Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
   a. Name and contact information of all contracted providers;
   b. The specific services provided by each contracted provider;
   c. The number and location of individual supported by each contracted provider; and
   d. Annualized amount paid to each contracted provider.

C. QUALITY IMPROVEMENT AND RISK MANAGEMENT

1. There is a well-defined quality improvement plan for assessing and improving organizational quality. The Quality Improvement (QI) plan addresses:
   a. Processes for how issues are identified;
   b. What solutions are implemented;

c. Any new or additional issues are identified and managed on an ongoing basis;
d. The internal structures minimize risks for individuals and staff;
e. The processes used for assessing and improving organizational quality are identified; and
f. The quality improvement plan is reviewed and updated at a minimum annually and this review is documented.

2. Areas of risk to persons served and to the organization are identified and monitored based on services, supports, treatment or care offered including, but not limited to:
   a. Incidents and accidents;
      i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Compliance as required by Reporting Deaths and Other Incidents in Community Services, 04-106.
      ii. There is evidence that internal incidents not required to be reported to DBHDD are recorded and monitored.
   b. Health and Safety;
   c. Complaints & Grievances;
      i. The organization's policy and process for complaints and grievances should include the external process as defined in Complaints and Grievances Regarding Community Services, 19-101.
   d. Individual Rights Violations;
      i. There is documented evidence that any restrictive interventions utilized must be reviewed by the organization's Rights Sub-Committee;
   e. Practices that limit freedom of choice or movement;
   f. Medication Management;
   g. Infection Control;
   h. Positive Behavior Support Plan (PBSP) tracking and monitoring to include restrictive interventions, to include review for efficacy of plan and needed adjustments, recommendations and modifications are made in a timely manner;
   i. Breaches of Confidentiality;
   j. Protection of Health and Human Rights of persons with developmental disabilities;
   k. Implementation of Individual Service Plans; and
   l. Community Integration.
3. Indicators of performance are in place for assessing and improving organizational quality. The organization is able to demonstrate:
   a. The indicators of performance established for each issue:
      i. The method of routine data collection and reporting;
      ii. The method of routine measurement;
      iii. The method of routine evaluation; and
      iv. Target goals/expectations for each indicator;
   b. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
   c. The inclusion of cultural diversity competency practices is evident by:
      i. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
      ii. Staff honoring these differences and preferences (such as worship or dietary preferences in supporting the individuals daily; and
      iii. The inclusion of cultural competency in Quality Improvement Processes.
   d. Distribution of Quality Improvement findings on a quarterly basis to:
      i. Individuals served or their representatives including contracting Regional Field Office(s) as indicated in the plan;
      ii. Organizational staff;
      iii. The governing body; and
      iv. Other stakeholders as determined by the governing body.

4. At least four individual records or the records of five percent (5%) of the total number of individuals served (whichever number is greater) are reviewed each quarter and the reviews are kept for a period of at least two years. Records of individuals who are "at risk" are included. Reviews include these determinations:
    a. That the record is organized; complete, accurate and timely;
    b. Whether services are based on assessment and need;
    c. That individuals have choices;
    d. Documentation of service delivery including individuals' responses to services and progress toward ISP goal(s);
    e. Documentation of health service delivery;
    f. Medication management and delivery, including the use of PRN and over the counter PRN medications; and their effectiveness;
    g. That approaches implemented for individuals with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*. When a behavioral support plan is necessary, providers of developmental disability services develop these plans in accordance with the *Best Practice Standards for Behavioral Support Service* (www.dbhdd.georgia.gov).
5. Appropriate utilization of human resources is assessed, including but not limited to:
    a. Competency;
    b. Qualifications;
    c. Numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; and
    d. Staff to individual ratios.
6. The organization has an advisory board made up of citizens, local business providers, individuals and family members. The Board:
    a. Meets at least semi-annually;
    b. Reviews items such as but not limited to:
        i. Policies;
        ii. Risk management reports; and
        iii. Assess budget and utilization of fiscal resources.
    c. Provides objective guidance to the organization.

D. MEDICATION AND HEALTHCARE MANAGEMENT (CRITICAL)

1. A current copy of the physician(s) order or current prescription dated and signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
    a. Regular, on-going medications;
    b. Controlled substances;
    c. PRN (as needed) Over-the-counter (OTC) medications;
    d. PRN medications (does not include standing orders for psychotropic medications for symptom management of behavior); or
    e. Discontinuance order.
2. Clinicians electing to prescribe psychotropic medications are to do so in accordance with their credentialed privileges and established prescribing practices. The following are also required:
    a. Informed consent for the medication is obtained and a signed copy is maintained in the clinical record. It is the responsibility of the physician/designee to complete the informed consent:
        i. Psychotropic Medication requiring informed consent include: antipsychotic, anti-manic, antidepressant, anti-anxiety and anti-obsessive medications as well as other medications employed

as treatment of psychiatric disorders. This does not include medications typically prescribed for extra-pyramidal side effects.

b. The treating physician, physician assistant and/or nurse practitioner personally examines the individual to determine whether this person has the capacity to understand to consent for herself or himself;
c. If the individual does not have the capacity to consent for herself or himself, an appropriate substitute decision maker is identified based on the Order of Priority outlined in Georgia Medical Consent Law O.C.G.A. 31-9-2;
d. The risks/benefits are explained in language the individual can understand;
e. Medication education provided by the organization's staff should be documented in the clinical record; and
f. Education regarding the risks and benefits of the medication is documented.

3. The organization must have written policies, procedures, and practices specific to the type of services provided for all aspects of medication management including, but not limited to:
   a. Prescribing:
      i. The physician's order or current prescription is defined as a prescription signed by one authorized to prescribe in Georgia; or
      ii. Electronic prescriptions (e.g. E-scripts and Surescripts), if applicable.
   b. Authenticating orders: Describes the required time frame for obtaining the actual or faxed physician's signature for telephone or verbal orders accepted by a licensed nurse (if the provider agency nurse accepts the order telephonically).
   c. Ordering, procuring medication and refills: Procuring initial prescription medication and over-the-counter medications within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current medication supply.
   d. Medication Labeling: Describes that all medications must have a label affixed by a licensed professional with the authority to do so. This includes sample medications.
   e. Storing: Includes prescribed medications, floor stock medications, refrigerated medications, and controlled substances.
   f. Security: Requires safe storage of medication as required by law including single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, and refrigeration between 36 and 41 degrees Fahrenheit and daily temperature logs. All controlled substances are double locked and there is documented accountability of controlled substances at all stages of possession.
   g. Dispensing: Describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacists or physician's signature and date when the medication was verified. Only physicians or pharmacists may re-package or dispense medications:
      i. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
      ii. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder".
   h. Supervision of individual self-administration: Includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects, each time, and supervision of individual self-administration occurs. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
   i. Administration of medications: Administration of medications may be done only by those who are <u>licensed</u> in this state to do so.

j. Recording: Includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of medications, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature and title of staff member.
k. Disposal of discontinued or out-of-date medication: Includes an environmentally friendly method of disposal by pharmacy.
l. Education to the individual and family (as approved by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.
m. All PRN or "as needed" medications will be accessible for each individual on site as per his/her prescriber(s) order(s) and as defined in the individual's ISP. Additionally, the organization must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or refrigerated when transported to different programs and home visits.
n. Timeliness of medication administration/supervision: Organizations must adopt medication administration/supervision Policy and Procedure (P&P) based on accepted standards of practice that meet the individual safety needs, the nature of the prescribed medication and its specific clinical use. P&P must address protocols for obtaining/educating organizational staff in the specific individualized medication information from the individual's primary physician, a prescribing practitioner or pharmacy for the importance of timeliness of medication administration/supervision of medications.

4. Organizational policy, procedures and documented practices stipulate that:
   a. If "health maintenance activities" are elected by an individual/guardian to be provided by Proxy Caregivers (means an unlicensed person trained to be a proxy caregiver functioning independently in a Licensed Residential Facility **OR** a Licensed Facility employs, contracts or refers proxy caregivers), the Licensed DD provider agencies, including co-employer agencies must abide by the Rules of Department of Community Health Healthcare Facility Regulation Chapter 111-80-100, Rules & Regulations for Proxy Caregivers used in licensed Healthcare facilities. The licensed DD provider agency/co-employer must:
      i. Have a written informed consent in the individual's record that designate the selected proxy caregiver to provide the actual health maintenance activities outlined in the written orders of the attending Physician, or an Advanced Practice Nurse or Physician Assistance working under a nurse protocol agreement or job description respectively;
      ii. Have documentation that demonstrate necessary knowledge and skills by proxy caregiver to perform the health maintenance activities including identified specialized procedures for such individual as written in the plan of care. **Note**: There must be a separate skills checklist for each health maintenance activity that the proxy caregiver provides. In addition, the competency-based skills checklists must reflect a testing of the knowledge and observation of the skills associated with the completion of all the discrete tasks necessary to complete the health maintenance activity in accordance with accepted standard of care;
      iii. Health maintenance activities to be implemented by the proxy caregiver are clearly defined in the written care plan for the provision of health maintenance activity to include the frequency of trainings (at a minimum must occur no less frequently than annually), additional training necessitated by changes in the written plan and competency-based evaluation requirements for the proxy caregiver. **Note:** A written plan of care form for the provision of health maintenance activities is made available by the Department of Community Health (DCH) Healthcare Facility Regulation for use. If another form is utilized, the form must contain all the required elements of this form;
      iv. The organization's policy, procedures, and documented practices clearly define the scope of what health maintenance activities can or cannot be provided by the proxy caregiver and that delivery of such activities are specified for each individual. Refer to Rules &

Regulations for Proxy Caregivers Chapter 111-80-100 for complete details of practices, including notification procedures for change in the condition of the individual which may require evaluation/treatment by a licensed healthcare professional, a back-up plan is in place in the event that the proxy caregiver is not available for any reason, and safety/security precautions to protect the individual supported. In addition, P&P must address Prohibited Assistance by Proxy Caregivers (e.g. of prohibited assistance by proxy caregivers such as mixing/compounding/converting or calculating medication doses, interpreting "PRN" (as needed) medication order when the order does not identify the individual's behavior or symptoms which would trigger the need for the PRN medication;

v. For Licensed Facilities using Proxy Caregivers to provide medication administration, if permitted, must maintain documentation that the facility has trained their proxy caregivers in accordance with the Medication Administration Training Curriculum established by DCH. A copy of this training provided by the DD residential provider agency/co-employer for the proxy caregiver in the staff file.

b. There are safeguards utilized for medications known to have substantial risk or undesirable effects, to include:
   i. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments, and follow-up appointments with the individual's physician for any further actions needed;
   ii. For individual in residential services, there is documentation of a review of polypharmacy usage in order to ensure that intra-class and inter-class polypharmacy use for psychiatric reasons are justifiable, if applicable, using the following monitoring criteria:
      - Intra-class Polypharmacy monitoring reports includes individuals who are on more than one psychotropic medication in the same single class of medications {two (2) or more antipsychotics, antidepressants, mood stabilizers}. e.g. the use of two (2) anti-depressants to treat depression.
      - Inter-class Polypharmacy monitoring reports includes individuals who are on three (3) or more different classes of medications (antipsychotics, antidepressants, and/or mood stabilizers). e.g. the use of an antipsychotic, an antidepressant and mood stabilizer to treat someone with schizoaffective disorder.

c. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
d. The organization defines requirements for timely notification to the prescribing professional regarding:
   i. Medication errors;
   ii. Medication problems;
   iii. Medication reactions;
   iv. Refusal of medication by the individual; and
   v. Failure to administer/supervise on time medications.
e. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
   i. Appropriateness of the medication;
   ii. Documented need for continued use of the medication;
   iii. Monitoring the presence of side effects (Individuals on medications likely to cause Tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS) testing);
   iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels;

v. Ordering specific monitoring and treatment protocols for diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
vi. Maintain individualized medication protocols for specific individuals receiving health maintenance activities; and
vii. Monitoring of other associated laboratory studies.

f. There is a biennial assessment of agency practice of management of medications at all sites housing medications. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
   i. A written report of findings, including corrections required;
   ii. A photocopy of the pharmacist's license or a photocopy of the license of the Registered Nurse; and
   iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.

g. The organization needs to have policy which describes the process for developing individualized healthcare plans, monitoring, reporting and, if applicable, preventative healthcare maintenance, to include but not limited to the healthcare needs referenced below:
   i. Bowel and Bladder Management
   ii. Gastrointestinal Management
   iii. Neurological Management
   iv. Skin Integrity Management
   v. Endocrine Management
   vi. Respiratory Management
   vii. Cardiovascular Management
   viii. Musculoskeletal Management
   ix. Reproductive Management
   x. Mental Health with Medication Management
   xi. Preventative and Routine Healthcare Maintenance
   xii. Other Specific Healthcare Plan

h. Healthcare plans and risk mitigation protocols are to be reviewed and revised as often as the severity of the individual's condition requires. For more information regarding healthcare plans and risk mitigation protocols see Healthcare Plans for Individuals with Intellectual/Developmental Disabilities (I/DD) in Community Residential Alternative, and Community Living Support Services with Skilled Nursing Services, 02-266 and Risk Mitigation of Health Conditions or Vulnerabilities in Intellectual and/or Developmental Disability (I/DD) Services, 02-807.

5. The "Eight Rights" for each medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
   a. Right person: check the name on the order and the individual and include the use of at least two identifiers.
   b. Right medication: check the medication label against the order.
   c. Right time: check the frequency and time to be given of the ordered medication and double check that the ordered dose is given at the correct time. Confirm when last dose was given.
   d. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription medication container and the Medication Administration Record (MAR) document to ensure all are the same.
   e. Right route: check the order and appropriateness of route ordered and confirm that the individual can take or receive the medication by the ordered route.
   f. Right position: the correct anatomical position for the medication method or route to ensure its proper effect, instillation and retention. If needed, individual should be assisted to assume the correct position.

g. Right documentation: document the administration/supervision after the ordered medication is given on the MAR; and
h. Right to Refuse Medication: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.

6. A Medication Administration Record (MAR) is in place for each calendar month that an individual takes or receives medication(s):
   a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
      i. Documentation by calendar month that is sequential according to the days of the month;
      ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
         a) Name of the medication;
         b) Dose as ordered;
         c) Route as ordered;
         d) Time of day as ordered; and
         e) Special instructions accompanying the order, if any, such as but not limited to:
            - Must be taken with meals;
            - Must be taken with fruit juice;
            - May not be taken with milk or milk products;
      iii. If the individual is to take or receive the medication more than one time during one calendar day:
         a) Each time of day must have a corresponding line that permits as many entries as there are days in the month;
      iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
      v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing discontinuation; followed by a mark through of all lines representing days and times that were discontinued.
   b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
      i. Documentation by calendar month that is sequential according to the days of the month;
      ii. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
         a) Name of medication;
         b) Dose as ordered;
         c) Route as ordered;
         d) Purpose of the medication; and
         e) Frequency that the medication may be taken;
      iii. The date and time the medication is taken or received is documented for each use;
      iv. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
   c. Each MAR shall include the legend that clarifies:
      i. The identity of the authorized staff's initials using full signature and title;
      ii. The reasons that a medication may not be given, is held or otherwise note received by the individual, such as but not limited to:

"H"	=	Hospital
"R"	=	Refused
"NPO"	=	Nothing by mouth
"HM"	=	Home Visit

"DS" = Day Service

E. ADEQUATE AND COMPETENT STAFF (CRITICAL)

1. Unless otherwise specified by DBHDD policy or within the contract/agreement with DBHDD, one or more professionals in the field must be attached to the organization as employees of the organization or as consultants on contract. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served (Refer to Professional Designation Section G).
2. When medical and/or psychiatric services involving medication are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, or psychiatrist.
3. DDP services must be rendered by a qualified individual DDP employed by or under contract with the agency. At least one agency employee or professional under contract with the agency must be a DDP (Refer to Professional Designation Section G for a list of professionals who qualify to be a DDP).
4. The DDP staff file must include the following:
    a. A signed DDP job functions that meet the DDP requirements for oversight and professional consultation;
    b. A specified schedule for each site and sufficient contract hours (not a PRN staff) to meet the individual's needs of the assigned caseload must be maintained on site;
    c. There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;
    d. A copy of diploma, license or certification to verify qualifications for performing DDP job functions is maintained; and
    e. Annual evaluation of adequacy of the DDP deliverable relative to the agency functions and needs as part of QI activities.
5. DDP documentation requirements must include the following:
    a. Agencies will identify for the DDP's ongoing review any participant receiving clinical services (nursing, therapy(s), behavioral services) and any participant with changes in functional, medical, behavioral or social status;
    b. There is documentation to verify all necessary face-to-face participant's visits, other contact or communication with or on behalf of the participants in the participant's record;
    c. Documentation will contain the purpose of the visit or contact, assessment or evaluation, training, plan for intervention, and any changes in service delivery such as change in staff recommendations;
    d. DDP documentation must meet documentations requirements of date, location of service delivery, signature (title), beginning and ending time when the service was provided.
6. Organizational policy and practice demonstrate that appropriate professional staff shall conduct the following services, supports, care and treatment, including but not limited to:
    a. Reviewing individuals clinical documentation as delineated in the I/DD Case Management System (I/DD Connects) and any other relevant documentation as appropriate;
    b. Overseeing the services, supports, care and treatment provided to individuals;
    c. Supervising the formulation of the individual service plan or individual recovery plan;
    d. Conducting diagnostic, behavioral, functional and educational assessments;
    e. Designing and writing Positive Behavior Support Plans;
    f. Implementing assessment, care and treatment activities as defined in professional practice acts; and
    g. Supervising high intensity services such as screening or evaluation, assessment, and residential positive behavior support services.
7. Providers must ensure an adequate staffing pattern to provide access to services in accordance with service guidelines and professional designations. Refer to Service Guidelines in this Provider Manual for specific staffing requirements.

8. The type and number of professional staff and all other staff attached to the organization are:
    a. Properly trained, licensed or credentialed in the professional field as required;
    b. Present in numbers to provide adequate supervision to staff;
    c. Present in numbers to provide services, supports, care and treatment to individuals as required;
    d. In 24 hour or residential care settings, at least one staff is trained in Basic Cardiac Life Support (BCLS) and first aid and is on duty at all times on each shift;
    e. DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity. Documentation includes evidence that proxy caregivers are trained in accordance with the Medication Administration Training Curriculum established by DCH.
    f. Experienced and competent to provide services, supports, care and treatment and/or supervision as required; and
    g. Providers of Behavior Support Services have documentations of proficiency trainings in behavioral support courses completed within six (6) months of enrollment as a provider of services.
9. The organization must have procedures and practices for verifying licenses, credentials, experience and competence of staff:
    a. There is documentation of implementation of these procedures for all staff attached to the organization; and
    b. Licenses and credentials are current as required by the field.
10. Federal law, state law, professional practice acts and in-field certification requirements are followed regarding:
    a. Professional or non-professional licenses and qualifications are required to provide the services offered. If it is determined that a service requiring licensure or certification by State Law is being provided by an unlicensed staff, it is the responsibility of the organization to comply with Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations, 04-101.
    b. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
11. Job descriptions are in place for all staff that include:
    a. Qualifications for the job;
    b. Duties and responsibilities;
    c. Competencies required;
    d. Expectations regarding quality and quantity of work; and
    e. Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.
12. Processes for managing staff information and records which should include but not be limited to:
    a. Criminal records checks in accordance with Criminal History Records Checks for DBHDD Network Provider Applicants, 04-104 (including process for reporting CRC status change);
    b. Driver's license checks to include Motor Vehicle Records (MVR) checks;
    c. Tuberculosis (TB) testing for all staff providing direct support is required prior to hire and when there is a known exposure.
    d. Provisions for and documentation of:
        i. Timely orientation of staff;
        ii. Periodic assessment and development of training needs;
        iii. Development of activities responding to those needs; and
        iv. Annual work performance evaluations.
    e. Provisions for sanctioning and removal of staff when:
        i. Staff are determined to have deficits in required competencies;
        ii. Staff is accused of abuse, neglect or exploitation.
    f. Administration of staff policies without discrimination.
13. All staff, direct support volunteers, and direct support consultants shall receive competency-based trainings in the following:

a. Orientation requirements are specified for all staff and are provided **prior to direct contact with individuals** and are as follows:
    i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
    ii. HIPAA and Confidentiality of individual information, both written and spoken;
    iii. Rights and Responsibilities of individuals;
    iv. Requirements for recognizing and mandatory reporting suspected abuse, neglect or exploitation of any individual:
        - To the DBHDD;
        - Within the organization;
        - To appropriate licensing agencies (Healthcare Facility Regulation) and for in home services (Adult Protective Services); and
        - To law enforcement agencies.
        (For more information regarding reporting requirements, see Reporting Deaths and Other Incidents in Community Services, 04-106. Please note attachment B includes information on incident reporting requirements to other agencies).
    v. Home and Community Based Services (HCBS) Settings Rule training.

b. Within the first sixty (60) days from date of hire, all non-designated staff having direct contact with individuals shall receive training.

Non-Designated staff includes all staff having direct contact with individuals with the exception of those holding a professional license as per Chapter 612 in the Part II of the NOW and COMP, which includes:

Registered Nurse (RN);
Licensed Practical Nurse (LPN);
Occupational Therapist (OT);
Physical Therapist (PT);
Speech Language Pathologist (SLP);
Licensed Dietitian (Nutrition); and
Assistive Technology Services Provider (AT Services)

and

Designated qualified Behavior Support Services providers Level 1 and Level 2 in accordance with the COMP Manual Part III Chapter 1800 and NOW Manual Part III Chapter 1600

Training for non-designated staff shall include, but may not be limited to:
    i. Person-centered values, principles and approaches;
    ii. A holistic approach for providing care, supports and services for the individual;
    iii. Medical, physical, behavioral and social needs and characteristics of the individuals served;
    iv. Human Rights and Responsibilities (*);
    v. Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
    vi. The utilization of:
        - Communication Skills (*);
        - Nationally benchmarked Behavioral Support and Crisis Intervention techniques for safe utilization of emergency interventions of last resort, with the exception of the use of prone manual or mechanical restraints (*); and

- The Georgia Crisis Response System (GCRS) to access crisis services.

vii. Cultural Competency Policies;
viii. Fire safety (*);
ix. Emergency and disaster plans and procedures (*);
x. Techniques of Standard Precautions to include:
- Preventative measures to minimize risk of infectious disease transmission;
- Use of Personal Protection Equipment (PPE);
- Sharps Safety (with sharp containers disposed of according to state and local regulated medical waste rules);
- Environmental Controls for cleaning and disinfecting work surfaces;
- Guides for handwashing, cleaning up spills, gloves use, and what to do with contaminated supplies;
- Respiratory Hygiene/Cough Etiquettes for cough, congestion, runny nose or increase production of respiratory secretions; and
- Approaches to individual education to include incident reporting and follow-up.

xi. First aid and safety;
xii. BCLS including both written and hands on competency training is required;
xiii. Specific individual medications and side effects (*);
xiv. Suicide Prevention Skills Training (such as AIM, QPRP);
xv. Ethics and Corporate Compliance Training;
xvi. Training to work with individuals who are dually diagnosed, as appropriate; and
xvii. Training provided on proper body mechanics for lifting/transferring/positioning as a basic requirement to assist in performing activities of daily living safely. In addition, prior to working with each individual, training on the individualized specific condition as written in each individual's care plan protocol should be conducted, if applicable. (*)

NOTE: A minimum of 16 hours of training must be completed annually from date of hire to include the trainings noted by an asterisk (*) in 13.b.

c. All Individual and Agency providers who have designated staff are required to maintain on file the verification that all licensed/certified professional staff have obtained a minimum of 25% of the required professional state licensing board Continuing Education Units (CEU) in subjects related to Intellectual and Developmental Disabilities and/or Behavioral Supports. 2. All Individual and Agency Providers classified as Behavior Support Services Provider Level II are required to meet the continuing education training requirements documented the Behavior Support Service Chapter of the NOW and COMP Manuals Part III. 3. All RNs and LPNs are required to complete curriculums in IDD Healthcare at a minimum of six (6) hours of CEUs as orientation training. All RNs/LPNs who were hired prior to January 1, 2024, are required to take Curriculums in IDD Healthcare on or prior to December 31, 2024. At the time of each license or certification renewal, at least 25% of the CEUs (since the prior license or certification renewal) for each licensed or certified staff must be for training in intellectual/developmental disabilities or behavioral supports.

14. The organization details in policy by job classification:
    a. Competency-based trainings that must be refreshed annually from date of hire;
    b. Procedures for validating staff competency within the designated orientation period as outlined in organizational policy and thereafter annually. All competency validations documentation to be maintained in the staff file;
    c. Additional training required for professional level staff; and
    d. Additional training/recertification (if applicable) required for all other staff.

15. Regular review and evaluation of the performance of all staff is documented at a minimum annually by managers who are clinically, administratively and experientially qualified to conduct evaluations on the staff's Knowledge, Skills & Abilities (KS &A) to deliver person-centered services.
16. It is evident that the organization demonstrates administration of staff policies without discrimination.

OUTCOMES FOR PERSONS SERVED

A. **INDIVIDUAL RIGHTS, RESPONSIBILITIES, PROTECTIONS (CRITICAL)**
   1. There is evidence of the individual or legal guardian's signature on notification that all individuals are informed about their rights and responsibilities:
      a. At the onset of services, supports, care and treatment;
      b. At least annually during care;
      c. Through written information that is well prepared in a language/format understandable by the individual; and
      d. How confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports, care and treatment.
   2. The organization has policies and promotes practices that:
      a. Do not discriminate;
      b. Promote receiving equitable supports from the organization;
      c. Provide services, supports, care and treatment in the least restrictive environment possible;
      d. Emphasize the use of teaching functional communication, functional adaptive skills to increase independence, and using least restrictive interventions that are likely to be effective;
      e. Incorporate Clients Rights and the Human Rights Council policy found at https://gadbhdd.policystat.com/policy/13796149/latest , as applicable to the organization; and
      f. Delineates the rights and responsibilities of persons served.
   3. In policy and practice, the organization makes it clear that under no circumstances will the following occur:
      a. Threats of harm or mistreatment (overt or implied);
      b. Corporal punishment;
      c. Fear-eliciting procedures;
      d. Abuse or neglect of any kind;
      e. Withholding basic nutrition or nutritional care; or
      f. Withholding of any basic necessity such as clothing, shelter, rest or sleep.
   4. Federal and state law and rules are evident in policy and practice including, but not limited to:
      a. For **all community based programs**, practices promulgated by DBHDD or the Rules or Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the care of individuals served. Issues addressed include but are not limited to:
         i. Care in the least restrictive environment;
         ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion; and
         iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including to maintain:
            - Civil;
            - Political;
            - Personal; and
            - Property rights.
      b. For **all DD Crisis programs service adults, children or youth**, practices promulgated by DBHDD, the Rules and Regulations for Clients Rights, Chapter 290-4-9 and Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD) are incorporated into the treatment of adults, children and youth served in the crisis programs.

5. There are no barriers in accessing the services, supports, care and treatment offered by the organization, including but not limited to:
    a. Geographic;
    b. Architectural;
    c. Communication;
        i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
        ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed. They include Nondiscrimination and Accessibility for Individuals with Disabilities and Individuals with Limited English Proficiency, 15-100, and DBHDD Field Office Access Coordinators, 15-103.
    d. Attitudinal;
    e. Procedural; and
    f. Organizational scheduling and availability.
6. The following provisions apply to services for individuals with hearing loss, or who are deaf-blind. Providers of services to individuals who either identify as deaf, deaf-blind, or hard of hearing, or whom the provider believes may be deaf, deaf-blind, or hard of hearing, must provide accommodations appropriate to allow those individuals to access services. Such accommodations include, but are not limited to:
    a. Appropriate physical plant measures such as
        i. visual fire alarms,
        ii. visual door knockers for areas where the individuals may desire privacy, and
        iii. closed-captioning or subtitles for televised programming;
    b. Staff training in American Sign Language (ASL) or in such other form of manual communication as the individual may use to communicate; such training must be sufficient to allow staff who provide direct care to the individual to communicate clearly with the individual (both to understand what the individual is saying to them and to be understood by the individual); and
    c. For individuals who communicate in American Sign Language (ASL), interpreters for the individual at ISP meetings and in other settings where needed.
7. Providers must promptly notify DBHDD's Office of Deaf Services (DeafServices@dbhdd.ga.gov, Tel: 404.232.1624) if the individual either identifies as deaf, deaf-blind, or hard of hearing, or if the provider believes the individual may be deaf, deaf-blind, or hard of hearing. The Office of Deaf Services will arrange for a Communication Assessment of the individual and prepare a Communication Assessment Report (CAR). Providers must implement accommodations recommended in the CAR within the time frames identified in the CAR.
8. There is evidence of organizational person-centered planning and service delivery that demonstrates:
    a. Sensitivity to individual differences (including disabilities) and preferences;
    b. Practices and activities that reduce stigma; and
    c. Interactions that is respectful, positive and supportive.
9. The organization must have written policies and procedures regarding the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. Such orders shall state the type and extent of the restriction. The order shall be reviewed for changes as needed and renewed at least annually. Additional orders shall follow the same procedure. The organization must meet the following requirements:
    a. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of his or her visitation rights, including any clinical restriction of such rights, when he or she is informed of his or her other rights under this section;
    b. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family

member, or a friend, and his or her right to withdraw or deny such consent at any time. However, the parent, guardian or custodian of a minor may restrict his or her visitation rights;
   c. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability;
   d. Ensure that all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual;
   e. Not restrict visitation by an individual's attorney or personal physician on the basis of the individual's physical or mental condition;
   f. Visitors/guardians are also expected to adhere to any reasonable restrictions as ordered in writing by the attending physician in the area of diet; and
   g. If visitation facilitates/results in problematic behaviors, reasonable restrictions may be ordered and incorporated into the Safety Plan.
10. Access to appropriate services, supports, care and treatment is available regardless of:
   a. Age;
   b. Race, National Origin, Ethnicity;
   c. Gender;
   d. Religion;
   e. Social Status;
   f. Physical Disability;
   g. Mental Disability;
   h. Gender Identity; and
   i. Sexual Orientation.

B. **BEHAVIORAL SUPPORT PRACTICES (CRITICAL)**

1. In policies, procedures and practices, the organization outlines and defines the adaptive, supportive, medical protection devices and the restrictive interventions that are implemented or prohibited by the organization and licensure requirements. These devices include but are not limited to:
   a. Use of adaptive supportive devices or medical protective devices (devices which restrain movement but are applied for the protection of accidental injury, required for medical treatment or for corrective/supportive needs):
      i. May be used in any service, support, care and treatment environment;
      ii. Use is defined by a physician's order (order not to exceed twelve (12) calendar months);
      iii. Written order to include rationale and instructions for the use of the device;
      iv. Authorized in the individual service plan (ISP);
      v. Are used for medical and/or protection against injury and not for treatment of challenging behaviors(s) without submission to DBHDD for Special Circumstance Review, approval, and monitoring; see Tracking Form for Request for Waiver of Requirements (Attachment C) of Requests for Waivers of Service Requirements Contained in DBHDD Provider Manuals or Policystat, 04-107 and
      vi. Renewal order of device requires documentation to justify continued use for a period not to exceed twelve (12) calendar months.
   b. Manual Hold/Restraint (also known as Personal Restraints): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body:
      i. May be used in all community settings except residential settings licensed as Personal Care Homes and Host Homes;
      ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
      iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;

iv. All use of prone manual or mechanical restraints, is prohibited in all circumstances, even when used in accordance with nationally benchmarked techniques;
v. If permitted, Manual/Personal Restraint (ten seconds or more), shall not exceed fifteen (15) minutes beyond which time the person is no longer a danger to self or to others, and use of personal restraint is documented. The length of time permitted to use manual/personal restraints for any one episode shall not exceed one (1) hour. Consecutive periods of manual restraints, which have the effect of restraining the resident in excess of one hour are prohibited;
vi. Use of manual/personal restraints must be outlined as an approved intervention in his/her crisis/safety plan; and
vii. If manual/personal restraints are implemented more than three (3) times in a six (6) month period, there must be corresponding procedures to teach the individual skills that will decrease/eliminate the use of manual/personal restraints.

c. Mechanical Restraint (also known as Physical Restraints): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts. Mechanical/Physical restraints are prohibited in community settings.
d. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical control or verbal threats to prevent the individual from leaving. Seclusion is not permitted in community settings in developmental disability services.
e. **Chemical restraint may never be used under any circumstance.**
    i. Chemical restraint is defined as a medication or drug that is:
        - Not a standard treatment for the individual's medical or psychiatric condition;
        - Used to control behavior(s); and
        - Used to restrict the individual's freedom of movement.
    ii. Examples of chemical restraint are the following;
        - The use of over-the-counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
        - The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or agitated.
f. PRN anti-psychotic medications for behavior(s) control are not permitted. See Appendix I for list of medications.
g. The use of medication for disciplinary purposes for convenience of staff, as a substitute for training or engagement, or in quantities that interfere with someone's quality of life are prohibited.

2. The approach to developing a positive behavior support plan (including a Crisis/Safety Plan) and treatment for individuals demonstrating challenging behavior(s) should be consistent with the definitions and protocols in the *Best Practice Standards for Behavioral Support Services* found at https://dbhdd.georgia.gov/. Behavior Support activities outlined in the PBSP is guided by an overall emphasis on not only decreasing target behavior(s) but also concurrently teaching and increasing skills in appropriate areas. The primary emphasis of the plan should be on pro-active skill building and prevention of challenging behavior(s).
3. The terms crisis and safety may be used interchangeably to describe a Crisis/Safety Plan. The Crisis/Safety Plan component can be included as a section of the PBSP or developed as a separate plan document. The crisis/safety plan provides staff with steps to respond to challenging behavior(s) that pose a health or safety risk to the individual and/or others, and provides general precautions and preventative measures that begins with least restrictive interventions to more restrictive only when necessary. The Crisis/Safety Plan responds to the challenging behavior(s) when it has reached a crisis level. For additional information

regarding Behavior Support Services visit NOW and COMP Waivers for Community Developmental Disability Services, 02-1202.

4. The PBSP and Crisis/Safety Plan for challenging behavior(s) should be a collaborative effort among each provider providing services for the individual to include Host Home and Community Access Services Providers. The providers must work to develop and implement one plan that includes any modification and/or interventions specific to the setting but provide a holistic strategy for all settings requiring Behavior Support Services for implementation for each service site and the modification must be addressed and approved prior to finalizing the plan. The final approved PBSP is incorporated by reference into the ISP. A copy of the individual's PBSP must be available at all service sites for implementation and placed in the case management system. The provider is responsible for training and coaching in all settings where the target behavior(s) occur.
    a. A positive behavior support plan should be developed and implemented for individuals with I/DD who receive psychotropic medications for symptom management of challenging behavior(s) that continues to pose a significant risk to the individual, others, or the environment (e.g., self-injury, physical aggression, property destruction) and is not specifically related to mental illness or epilepsy requiring treatment with psychotropic medications. The positive behavior support plan must minimally include:
        i. An operationally defined behavior(s) for which the medication is intended to affect;
        ii. Measuring target behavior(s) which shall constitute the basis on which medication adjustments will be made; and
        iii. A focus on teaching replacement behavior(s) in an effort to replace the use of medication with behavioral programming.
    b. A positive behavior support plan is not required for individuals receiving psychotropic medication to treat mental illness (e.g., schizophrenia, bi-polar disorder) or epilepsy when the record documents that the medication addresses the symptoms of the mental illness or epilepsy.
5. When positive behavior support plan is used to reduce challenging behavior(s) there must be evidence that the following issues have been addressed. The plan is:
    a. Individualized (Person-Centered Planning);
    b. Based on a functional behavioral assessment;
    c. One that has addressed potential medical causes;
    d. Developed and overseen by a qualified professional (Refer to the Outcomes for Persons Served Section G for Professional Designations Categories of Psychologist, Behavior Specialists and Board Certified Behavior Analyst);
    e. PBSP utilizes non-punitive, non-restrictive procedures & interventions;
    f. Inclusive of methods outlined to teach alternative appropriate behavior(s) that will achieve the same results as the challenging behavior(s);
    g. Inclusive of rationale for the following:
        i. Use of identified approaches;
        ii. The time of their use;
        iii. An assessment of the impact on personal choice of the individual;
        iv. The targeted behavior(s); and
        v. How the targeted behavior(s) will be recognized for success.
    h. Implemented by trained and competent staff as documented by individual who developed the PBSP and Crisis/Safety Plan and trained the staff;
    i. Has monitoring plans for review, analyzing trends, and summarizing the effectiveness of the plan and termination criteria. In addition, PBSP are routinely monitored to ensure provider compliance with prescribed data collection & interventions;
    j. Consent provided by the individual and his or her legal guardian;
    k. Discussed with the individual and family/natural supports (as permitted by the individual);

l. Developed in accordance with *Best Practice Standards for Behavioral Support Services for Providers of Developmental Disability Services* (www.dbhdd.ga.gov); and

m. All behavioral services to include Behavior Support Services, Level 2 and Level 1 adhere to the service description outlined in Part III of the NOW and COMP Manuals located at NOW and COMP Waivers for Community Developmental Disability Services, 02-1202.

6. Providers must document the following in the record of each participant receiving Behavior Support Services:
   a. Specific task/activity, training, or assistance provided;
   b. Date and the beginning and ending time when the service was provided;
   c. Location where the service was delivered;
   d. Verification of service delivery, including first and last name and title (if applicable) of the person providing services;
   e. Description of behavior(s) in observable, measurable terms with frequency, precipitating events, and data tracking methods;
   f. Progress towards goal(s) outlined in ISP; and
   g. Description of outcome specific to each target behavior(s) intervention to include but not limited to behavioral changes, acquisition of new replacement skills, ability to increase community integration and other positive life outcomes.
7. Providers must document the following in the Crisis/Safety plan:
   a. A clear, definition of the challenging behavior(s);
   b. Description of situations in which the challenging behavior(s) typically occurs;
   c. Common warning signs, triggers, and/or precursor behavior(s) that indicate a crisis is imminent;
   d. Any special considerations noted (e.g. active court order, probation officer, etc);
   e. Identification of staffing needed to carry out crisis curriculum procedures;
   f. Identification of equipment necessary, if applicable;
   g. Contact information for additional staff that may be available for assistance;
   h. Specific crisis curriculum techniques to use for each challenging behavior(s);
   i. Protocols to access community-based crisis services to include the Georgia Crisis Response System if the acute crisis presents a substantial risk of imminent harm to self and others;
   j. Protocols to access emergency room care or law enforcement (as a last resort); and
   k. Protocols for debriefing and documentation.
8. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behavior(s). These procedures are authorized, incorporated into the PBSP and Crisis/Safety Plan, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional(s) and may not be in conflict with Federal or State Laws, Rules and Regulations, Clients Right's or Department standards to include but not limited to the document the *Best Practice Standards for Behavioral Support* when developing a PBSP and Crisis/Safety Plan.
9. When Enhanced Service Delivery is approved for specialized behavioral supports, training and skilled service delivery, the following must be addressed in the PBSP and Crisis/Safety plan that includes:
   a. Person-Centered Behavior Supports Planning (PCBS);
   b. Programmatic guidelines for staff that addresses the individual's preferences and values;
   c. Collaborative teamwork by all service delivery providers to assist the behavioral professional conducting the functional behavioral assessment across settings (such as residential, day service, supported employment);
   d. Development of interventions that will be most effective in each setting or situation;
   e. Lifestyle and competency improvements based on the individual's strengths, skills, abilities, personal preferences and choices;

f. Safety checks, staff monitoring and ratio are clearly outlined and defined (such as 1:1 support, 2:1 support, line of sight, and arm's length, 1:1 inclusive line of sight);
g. A Crisis/Safety Plan to support the exceptional behavioral or medical needs;
h. There is documented evidence of a clinical assessment and validation of behavior(s) support needs. The clinical assessment is based on Health Risk Screening Tool (HRST) & SIS eligibility criteria. E.g., HRST score of 4 on Item Q for 1:1 staffing; SIS score of seven (7) or higher for behavior(s) support;
i. There is at a minimum monthly documentation by behavioral professionals to verify implementation of the enhanced supports services and the efficacy of the BSP and Crisis/Safety Plan; and
j. The documentation includes at a minimum the summarization and analysis of the behavioral data collected, the effectiveness of the additional direct 1:1 staffing supports at various settings and training of replacement behavior(s).

10. Providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and have an agency's crisis plan, that at a minimum addresses:
    a. Approved interventions to be utilized by staff;
    b. Availability of additional resources to assist in diffusing the crisis;
    c. If the acute crisis presents a substantial risk of imminent harm to self and others, that community-based crisis services to include the Georgia Crisis Response System (GCRS) serves as an alternative to emergency room care, calling 911, institutional placement, and/or law enforcement involvement (including incarceration) is implemented;
    d. Protocols to access community-based crisis services to include the GCRS must be included in agency's policy and procedures with staff trained to implement this protocol; and
    e. Notification process by Direct Support Staff that includes informing the designated on-call management staff and/or Director.
11. All organizations must have the capacity to address individual's behavioral needs. If the cause of the challenging behavior(s) cannot be determined or satisfactorily addressed by the provider, there should be evidence of DBHDD Clinical Assessment of Behavior Support Needs (CABS) and consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior(s) needs of the individual. Those authoring such plans should minimally meet professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst (Refer to Professional Designations, Section G. for professional qualifications).
12. If the need for behavior supports is identified, the individual or guardian is given a choice to select the qualified person to develop the PBSP and/or Crisis/Safety Plan.

CI. RESPECTFUL SERVICE ENVIRONMENT

1. Services, supports, care or treatment approaches support the individual in:
    a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;
    b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided;
    c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities; and
    d. Inclusion and active community integration is supported and evident in documentation.

2. Services are provided in an appropriate environment that is respectful and ensures the privacy of individuals supported or served. (For Host Homes and Community Access Services sites refer to Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers, 02-704 and Physical Environment NOW and COMP Manuals

located at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx .

3. The environment is:
   a. Clean;
   b. Age appropriate;
   c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served);
   d. Individual's rooms are personalized;
   e. Adequately lighted, ventilated, and temperature controlled;
   f. There is sufficient space, equipment and privacy to accommodate an area/room for visitation;
   g. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and
   h. The Americans with Disabilities Act of 1990 requiring facilities to be readily accessible to and usable by people with disabilities is addressed, if applicable. Refer to 2010 Standard ADA Compliance for accessible design.

4. The environment is safe:
   a. All local and state ordinances are addressed:
      i. Copies of inspection reports are available;
      ii. Licenses or certificates as applicable are current and available as required by the site or the service;
      iii. An automatic extinguishing system (sprinkler) shall be installed per city/county requirements for residential settings excluding host homes not governed by other federal, state and county rules and regulations, if applicable; and
      iv. Approved smoke alarms shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences according to national and city safety codes/standards and maintained properly as described in the user manual. Smoke alarms especially in the bedrooms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained.
   b. Installation of fire alarm system and inspection of equipment meets safety code.
   c. Fire drills are conducted for individuals and staff:
      i. Once a month at alternative times;
      ii. Twice a year during sleeping hours if residential services;
      iii. All fire drills shall be documented with staffing involved; and
      iv. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.

5. Food guidelines are in place and are being implemented for safe food consumption and storage of food in refrigerator, freezer and cupboards to maintain temperature between 36 and 41 degrees Fahrenheit, expiration dates on food items to include open items and the prevention of foodborne illnesses. When food service is utilized, required certifications related to health, safety and sanitation are available. For more information on food safety please see the FDA guidelines at: https://www.fda.gov/Food/ResourcesForYou/Consumers/ucm253954.htm. A three (3) day supply of non-perishable emergency food and water is available for all individuals supported in residences. A residence shall provide for at least one gallon of water per person a day. A residence shall arrange for and serve special diets as prescribed.
6. Policies, plans and procedures are in place that addresses Emergency Evacuation, Relocation, Preparedness and Disaster Response. Providers adhere to Disaster Preparedness, Response, and Disaster Recovery

Requirements for Community Providers, 04-102. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.

a. Plans include detailed information regarding evacuating, transporting and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
    i. Medical emergencies;
    ii. Missing persons;
        - Georgia's Mattie's Call Act provides for an alert system when an individual with I/DD, dementia, or other cognitive impairment is missing. Law requires residences to notify law enforcement within thirty (30) minutes of discovering a missing individual.
    iii. Natural and man-made disasters;
    iv. Power failures;
    v. Continuity of medical care as required;
    vi. Notifications to families or designees; and
    vii. Continuity of Operation Planning (COOP) to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. COOP must also include plans for sheltering in place (for more information go to: http://www.georgiadisaster.info/PersonsWithDisabilities/disasterpreparedness.html.

b. Emergency preparedness notice and plans are:
    i. Reviewed annually to include a signed and dated document of the renewal of the Continuity of Operation Plan (COOP) for the location(s) specified in the COOP each fiscal year.
    ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane; and
    iii. Drilled with more frequency if there is a greater potential for the emergency.

7. Residential living support service options:
    a. Are integrated and established within residential neighborhoods;
    b. Are single family dwellings;
    c. Have space for informal gatherings;
    d. Have personal space and privacy for persons supported; and
    e. **Are understood to be the "home" of the person supported or served**.
8. Video/Camera monitoring **may not be used by the provider** in the following instances:
    a. In an individual's personal residence as it is an invasion of privacy and is strictly prohibited;
    b. In residential settings/homes operated as a CLA/Host Home/PCH by a provider in areas such as bedrooms, bathrooms and changing areas;
    c. In the private areas of non-residential programs (day programs), such as bathrooms/changing areas; and
    d. In lieu of staff presence.
9. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place:
    a. Policies and procedures apply to all vehicles used, including:
        i. Those owned or leased by the organization;
        ii. Those owned or lease by subcontractors; and
        iii. Use of personal vehicles of staff.
    b. Policies and procedures include, but are not limited to:
        i. Authenticating licenses of drivers and MVR upon hire and annually;
        ii. Proof of current vehicle insurance (agency and staff to include staff vehicle riders within agency policy, if applicable);
        iii. Routine maintenance schedule;
        iv. Requirements for evidence of driver training;

v. Safe transport of persons served that includes documentation of boarding and exit time of individual with to and from location of planned trip and not leaving individuals unattended in the vehicle;
vi. Requirements for maintaining an attendance log of persons while in vehicles;
vii. Safe use of lift, seat belts, tie downs and any other safety equipment if applicable;
viii. Availability of first aid kits and seat belt cutter;
ix. Fire suppression equipment; and
x. Emergency preparedness (availability of a portable phone for emergency calls) to include process for handling and reporting an incident and accident.

10. Locks on exterior doors in **ALL** community settings (including, but not limited to Community Living Arrangements, Personal Care Homes, Host Home/Life-Sharing sites, and Day Services sites) must comply with the following provisions:
    a. **ALL** locks used on any exterior door must be capable of being unlocked from the inside by the individuals receiving services in that setting, without the need for obtaining assistance from provider staff or any other person.
    b. Neither the lock nor any mechanism or control for operating the lock may be placed in a location that is inaccessible to or concealed from any individual receiving services in the setting.
    c. No exterior door may be fitted with any lock that requires a key, key card, badge, combination, or passcode to unlock it from the inside.

CII. Infection Control Practices are Evident in Service Settings

1. The organization, at a minimum, has a basic Infection Control Plan which is reviewed annually for effectiveness and revision, if needed. The Infection Control Plan addresses:
    a. Standard Precautions;
    b. Hand Washing Guidelines;
    c. Proper Storage of Personal Hygiene items; and
    d. Specific common illnesses/infectious diseases likely to be emergent in the particular service settings. (For more information go to https://www.cdc.gov/).
2. The organization has policies, procedures and practices for controlling and preventing infections in the service setting. There is evidence of:
    a. Guidelines for environmental cleaning and sanitizing;
    b. Guidelines for safe food handling and storage;
    c. Guidelines for the proper disposal of biohazardous materials and sharps;
    d. Guidelines for laundry that include the collection, sorting, transporting, washing and storage in a manner that prevents the spread of infections and contamination of the environment; and
    e. Guidelines for food preparation.
3. Procedures for the prevention of infestation by insects, bed bugs, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
4. No vicious/dangerous animals shall be kept. Any pets living in the service setting must be healthy and not pose a health risk to the individual supported. All pets must meet the local, state, and federal requirements to include the following:
    a. All animals that require rabies vaccinations annually must have current documentation of the rabies inoculation;
    b. Exotic animals must be obtained from federally approved sources; and
    c. Parrots and Psittacine family birds must be USDA inspected and banded.

D. A HOLISTIC PERSON-CENTERED APPROACH TO CARE, SUPPORT AND SERVICES

I. Assessments:

1. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's

hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services. Assessments should include, but are not limited to, the following:

a. The individual's:
    i. Hopes and dreams, or personal life goals;
    ii. Perception of the issue(s) of concern;
    iii. Strengths;
    iv. Needs;
    v. Abilities; and
    vi. Preferences.
b. Medical history;
c. A current health status report or examination in cases where:
    i. Medications or other ongoing health interventions are required;
    ii. Chronic or confounding health factors are present;
    iii. Medication prescribed as part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
    iv. Allergies or adverse reactions to medications have occurred; or
    v. Withdrawal from a substance is an issue.
d. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
e. Social history;
f. Family history;
g. School records (for school age individuals);
h. Collateral history from family or persons significant to the individual, if available:
    i. NOTE: When collateral history is taken, information about the individual **may not be shared** with the person giving the collateral history unless the individual has given specific written consent; and
i. Review of legal concerns including:
    i. Advance directives;
    ii. Legal competence;
    iii. Legal involvement of the courts; and
    iv. Legal status as adjudicated by a court.

2. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
    a. Assessment of trauma or abuse;
    b. Suicide risk assessment;
    c. Functional assessment;
    d. Cognitive assessment;
    e. Behavioral assessments;
    f. Spiritual assessment;
    g. Assessment of independent living skills;
    h. Cultural assessment;
    i. Recreational assessment;
    j. Educational assessment;
    k. Vocational assessment;
    l. Nutritional assessment; and
    m. Nursing assessment (Note: Required for nursing services to identify healthcare risks).
3. Policies, procedures and practice describe processes or referral of the individual based on ongoing assessment of individual need:
    a. Internally to different programs or staff; or

b. Externally to services, supports, care and treatment not available within the organization, including but not limited to:
   i. Health care for:
      a) Routine assessment such as annual physical examinations;
      b) Chronic medical issues;
      c) Ongoing psychiatric issues;
      d) Acute and emergent needs:
         - Medical;
         - Psychiatric;
   ii. Diagnostic testing such as psychological testing or labs; and
   iii. Dental services.

II. Individual Service Plan (ISP)

1. An individualized service plan is developed by the individual (along with any representatives), a Support Coordinator, a State Services Coordinator or a Planning List Administrator with input from the service providers.
2. Provider signature on the ISP signature page indicates provider agreement to service delivery as outlined in the ISP.
3. The individual's signature on the ISP indicates the acceptance of the ISP and is required unless the individual has been adjudicated an adult who is incapacitated in which case the ISP must be signed by the legal guardian or other substitute decision maker appointed by the court to act on the individual's behalf.
4. Detailed information about the ISP development process, meeting, and meeting participant roles is defined in The Service Planning Process and Individual Service Plan Development, 02-438.
5. The ISP must list the services to be provided in the service summary.
6. No service will be reimbursed unless listed on the ISP approved by the DBHDD Regional Field Office clinical staff.
7. Each goal/objective is supported by the services provided. Statement of goal(s) or objectives of the individual are:
   a. **S**pecific to the desired outcomes;
   b. **M**easurable for progress;
   c. **A**chievable skills;
   d. **R**elevant to service provision; and
   e. **T**ime-limited with specified target dates.
8. The frequency or intensity that the specific service, support, care and treatment will be given or provided is stated within the ISP and Individual 360.
9. There is clear authorization of the plan:
   a. Refer to definitions of service included in this Provider Manual to determine who must authorize the plan:
      i. Part I, Section 2: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines.*
10. A physician reviews the plan when it includes medical care and treatment or for individuals with a high level of medical need typically indicated by a HRST Healthcare Level 3 or above;
11. Documents to be incorporated by reference into an Individual Service Plan include, but are not limited to:
    a. Medical updates as indicated by physician orders or notes (diagnosis are indicated to ensure treatment of medical conditions such as obesity and diabetes);
    b. Version Change as required when a portion of the plan requires reassessment or changes;
    c. A behavior support plan and/or a Crisis/Safety plan for individuals demonstrating challenging behavior(s); and
    d. A PBSP and Crisis/Safety plan for individuals who received psychotropic meds for symptom management.

12. Wellness of individuals is facilitated through incorporation of wellness goals within the individual plan as assessed and recommended or requested by the individual.
13. There is evidence that the person's data from documentation has been reviewed, analyzed for trends, and summarized to determine the progress toward goal(s) **at least quarterly**.
14. Individualized plans or portions of the plan must be reassessed as indicated by the following:
    a. Changing needs, circumstances and responses of the individual, including but not limited to:
        i. Any life change;
        ii. Change in provider;
        iii. Change of address;
        iv. Change in service type or frequency; and
        v. Change in medical, behavioral, cognitive or physical status.
    b. As requested by the individual;
    c. As required by re-authorization;
    d. At least annually; and
    e. When goal(s) are no longer relevant to the individual.
15. ISP Annual Review: Each ISP must be reviewed and/or edited annually or more often as needed to reflect all life changes, progress or lack of progress to identify changes in outcome, review changes in medical/psychological or social services and to identify new problems or goal(s).

III. Documentation

1. The individual record is a legal document, information in the record should be:
    a. Organized;
    b. Complete;
    c. Current;
    d. Meaningful;
    e. Succinct; and
    f. Essential to:
        i. Provide adequate and accurate services, supports, care and treatment;
        ii. Tell an accurate story of services, supports, care and treatment rendered and the individual's response;
        iii. Protect the individual; their rights; and
        iv. Comply with legal regulation.
    g. Dated, timed, and authenticated with the authors identified by name, credential and by title:
        i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";
        ii. Documentation is to be done each shift or service contact by staff providing the service;
        iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record; and
        iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
    h. Written in black or blue ink;
    i. Red ink may be used to denote allergies or special precautions;
    j. Corrected as legally prescribed by:
        i. Drawing a single line through the error;
        ii. Labeling the change with the word "error";
        iii. Inserting the corrected information; and
        iv. Initialing and dating the correction.
2. At a minimum, the individual's information shall include:

a. The name of the individual, precautions, allergies (or no known allergies – NKA) and "volume #x of #y" on the front of the record;
    i. Note that the individual's name, allergies and precautions must be flagged on the medication administration record.
b. Individual's identification and emergency contact information;
c. Financial information;
d. Rights, consent and legal information including but not limited to:
    i. Consent for service (written agreement);
    ii. Release of information documentation;
    iii. Any psychiatric or other advanced directive;
    iv. Legal documentation establishing guardianship;
    v. Evidence that individual rights are reviewed at least one time a year; and
    vi. Evidence that individual responsibilities are reviewed at least one time a year.
e. All medical care received, including hospitalizations, ER visits, procedures, lab reports, office visits, etc.;
f. Screening information and assessments, including but not limited to:
    i. Functional, psychological and diagnostic assessments.
g. Individual service plan, including:
    i. Identified goal(s) (in measurable terms);
    ii. Interventions or activities occurring to achieve the goal(s);
    iii. The individual's response to the interventions or activities (progress notes, tracking sheets, learning logs or data);
    iv. A projected plan to modify or decrease the intensity of services, supports, care and treatment as goal(s) are achieved; and
    v. Discharge planning is begun at the time of admission that includes specific objectives to be met prior to decreasing the intensity of service or discharge.
h. Discharge summary information provided to the individual and new service provider, if applicable, at the time of discharge includes:
    i. Strengths, needs, preferences and abilities of the individual;
    ii. Services, supports, care and treatment provided;
    iii. Achievements;
    iv. Necessary plans for referral; and
    v. A dictated or hand-written summary of the course of services, supports, care and treatment incorporating the discharge summary information provided to the individual and new service provider, if applicable, must be placed in the record within 30 days of discharge.
i. The organization must have policy, procedures and practices for Discharge/Transfer/immediate transfer due to medical or behavioral needs of individuals in all cases. Agency employees, subcontractors and their employees and volunteers who abandon an individual are subject to administrative review by the contracting Regional Field Office(s) representing DBHDD to evaluate increasing new admission capacity further or continuing the relationship with the provider agency.
j. All relocation/discharge of individuals within or outside the agency must have prior approval from the contracting Regional Field Office representing DBHDD. A copy of the approval must be maintained in the individual record.
k. Progress notes describing progress toward goal(s), including:
    i. Implementation of interventions specified in the plan;
    ii. The individual's response to the intervention or activity based on data; and
    iii. Date, location and the beginning and ending time when the service was provided.
    iv. For continuity of care, at a minimum the current ISP review span progress notes must be maintained on site.
l. Event notes documenting:
    i. Issues, situations or events occurring in the life of the individual;

ii. The individual's response to the issues, situations or events;
iii. Relationships and interactions with family and friends, if applicable;
iv. Missed appointments including:
- Findings of follow-up; and
- Strategies to avoid future missed appointments.

v. Records or reports from previous or other current providers; and
vi. Correspondence.

3. A provider must ensure that DBHDD, DCH, Healthcare Facility Regulation (as applicable) and Support Coordination are provided updated, accurate information which includes but is not limited to the following:
    a. Correct address of the agency/business location;
    b. Correct street address of the service location, if different from above;
    c. Current phone number(s);
    d. Name of contact person(s) Comprehensive Supports Waiver Program;
    e. Data on subcontractors providing direct member care; and
    f. Enrolled providers are required to furnish written notice to the DBHDD Provider Enrollment Unit, DCH, the Support Coordination agency, and individual supported within ten (10) calendar days change in provider data. Changes requiring written notice include, but are not limited to the following:
        i. Address of the provider agency administrative business office;
        ii. Address of the service location;
        iii. Payee changes;
        iv. Change in permit/license issued by Healthcare Facility Regulation Section; and
        v. If the contact person for the administrative or service location changes, the provider must notify the DBHDD applicable region within 30 calendar days of the change.
4. The provider must maintain on file a copy of all approved authorizations for additional service units or approvals and have such documents available for review by DBHDD and/or DCH. The original letter may be maintained at the provider office location, but a copy of the approval documents and all supporting documentation relevant to service delivery must be maintained in the individual record at the service delivery site(s). The provider must notify the Regional Services Administrator or designee when there is any change to services authorized. During reviews or monitoring by state agencies, a copy of authorization letters as well as all documentation of need is provided to the review team. All special authorizations are approved for a specified time and expire on the date indicated on the approval letter.
5. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
    a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment; and
    b. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.
6. Community integration and inclusion into the larger natural community is supported and evident. Terms "Integration and Inclusion" mean:
    a. Use of community resources that are available to other citizens;
    b. Providing the opportunity to actively participate in community activities and types of employment as citizens without disabilities;
    c. The organization has community partnerships for capacity building and advocacy of activities to achieve this goal of integration;
    d. The organization must provide supports and inclusion activities that show respect for the individual's dignity, personal preference and cultural differences;
    e. There is documentation of individualized preferences, person-centered integration, informed choice, autonomy and inclusion in the community;
    f. Building of community relationships (natural/paid/unpaid);

g. Supporting individual's choice as measured by the amount of control an individual has over his/her life; and
h. Supervised Apartment Living Arrangements such as scattered and cluster arrangements must meet all standards for integrated settings and comply with all state and local zoning regulations (such as setting attributes & choice).

7. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.

IV. Information Management System That Protect Individual Information and is Secure, Organized and Confidential

1. The organization has clear policies, procedures and practices that support secure, organized and confidential management of information, to include electronic individual records, if applicable.
2. All individuals determine how their right to confidentiality will be addressed including but not limited to who they wish to be informed about their services, supports and treatment. Maintenance and transfer of both written and spoken information is addressed:
   a. Personal individual information;
   b. Billing information; and
   c. All service related information.
3. The organization has a Confidentiality and HIPAA Privacy policy that clearly addresses state and federal confidentiality laws and regulations, including but not limited to federal regulations on "Confidentiality of Alcohol and Drug Abuse Patient Records" at 42 C.F.R. Part 2 (as applicable) and state laws at O.C.G.A. §§ 37-3-166 (MH), 37-4-125 (DD) and 37-7-166 (AD) as applicable. The organization has a Notice of Privacy Practices that gives the individual adequate notice of the organization's policies and practices regarding use and disclosure of their Protected Health Information (PHI). The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization addresses:
   a. HIPAA Privacy and Security Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
   b. Appointment of the Privacy Officer;
   c. Training to be provided to all staff;
   d. Posting of the Notice of Privacy Practices in a prominent place;
   e. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record;
   f. Provision of the rights of individuals regarding their PHI as defined in federal and state laws and in HIPAA, including but not limited to:
      i. Right to access to one's own record.
      ii. Right to request an amendment.
      iii. Right to request communications by alternative means.
      iv. Right to request restriction of access by others.
   g. Identification of its Business Associates, and obtaining Business Associate agreements with Business Associates, in compliance with HIPAA requirements;
   h. Identification of violations of confidentiality or HIPAA and follow up to include compliance with all requirements of HIPAA at 45 C.F.R. sections 164.400 through 164.414:
      i. Reporting of violations to the Privacy Officer;
      ii. Risk assessment of the violation as required by HIPAA provisions;
      iii. Determination of whether the violation constitutes a "breach" as defined by HIPAA; and
      iv. Notifications of breaches to the individual(s) affected, to the Secretary of Health and Human Services, and if necessary to the media, in compliance with HIPAA requirements.
   i. Corrective Actions for sanctions of employee(s) as necessary, mitigation of harm to any individual and preventing risks to PHI.

4. A record of all disclosures of Protected Health Information (PHI) is kept in the medical record, so that the organization can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
    a. Date of disclosure;
    b. Name of entity or person who received the PHI;
    c. A brief description of the PHI disclosed;
    d. A copy of any written request for disclosure; and
    e. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
5. Authorization for release of information is obtained when PHI of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of PHI are followed. Information contained in each release of information must include:
    a. Specific information to be released or obtained;
    b. The purpose for the authorization for release of information;
    c. To whom the information may be released or given;
    d. The time period that the release authorization remains in effect (reasonable based on the topic of information, may not exceed a year); and
    e. A statement that authorization may be revoked at any time by the individual, to the extent that the organization has not already acted upon the authorization.
6. Exceptions to use of an authorization for release of information are clear in policy:
    a. Disclosure may be made if required or permitted by law;
    b. Disclosure is authorized as a valid exception to the law;
    c. A valid court order or subpoena are required for mental health or developmental disability records;
    d. A valid court order and subpoena are required for alcohol or drug abuse records;
    e. When required to share individual information with the DBHDD or any provider of treatment or services for the individual under contract or LOA with the DBHDD; or
    f. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release PHI to the treating physician or psychologist.
7. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
    a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later);
    b. Protocols for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement; and
    c. Compliance with HIPAA Security Rule provisions to the degree mandated by or appropriate under the Security Rule to protect the security, integrity and availability of records.
8. The organization has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not be limited to:
    a. A complete certified copy of the record to DBHDD or the provider who will assume service provision, that includes individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of the individual's continuity of care and treatment;
    b. Unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts; and
    c. The time frames by which transfer of documents and personal belongings will be completed.
9. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individual's records for six (6) years.

E. MANAGEMENT-SUPERVISION-SAFEGUARDING OF POSSESSIONS, VALUABLES, PERSONAL FUNDS, AND DAY TO DAY LIVING EXPENSES IN DEVELOPMENTAL DISABILITY RESIDENTIAL SERVICES

1. Providers adhere to Supervision and Protection of Personal Funds and Belongings in Intellectual and Developmental Disability Residential Services, 02-702.

F. FAITH OR DENOMINATIONALLY BASED ORGANIZATIONS WHO RECEIVE FEDERAL OR STATE MONIES ADDRESS ISSUES SPECIFIC TO BEING A FAITH OR DENOMINATIONALLY BASED ORGANIZATION IN THEIR POLICIES AND PRACTICE

1. Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
   a. Its religious character;
   b. The individual's freedom not to engage in religious activities;
   c. Their right to receive services from an alternative provider:
      i. The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
2. If the organization provides employment that is associated with religious criteria, the individual must be informed.
3. In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
   a. Inherently religious activities;
   b. Religious instruction; or
   c. Proselytizing.
4. Organizations may use space in their facilities to provide services, supports, care and treatment without removing religious art, icons, scriptures or other symbols.
5. In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 *Charitable Choice Provisions and Regulations: Final Rules* shall apply.

G. PROFESSIONAL DESIGNATIONS-When the requirement for a degree in a course of study is referenced, the degree must be from an accredited college or university.

1. **Developmental Disability Professional (DDP):**

All DDP services rendered by a provider agency must be provided by an individual qualified to be a DDP. The DDP may be employed by or be under professional contract with the provider agency.

At least one agency employee or professional under contract with the agency must:

a. Be a Developmental Disability Professional (DDP), and
b. Have responsibility for overseeing the delivery of waiver and/state services to participants with the focus on overall quality of service delivery by the provider agency.

The same individual may serve as the agency Director and DDP, provided the staff member meets the professional qualifications of each position. The duties of each role must be delivered and documented separately. Documentation related to particular activities will be delineated by the use of either professional designation following the staff member's signature.

2. **The Developmental Disability Professional (DDP) Job Functions:**

Each Developmental Disability Professional (DDP) has a specified schedule with sufficient hours to meet the oversight role required by the level of need for individual(s) supported which includes but is not limited to:

a. Overseeing the services and supports provided to participant for general guidance to the provider agency in areas of compliance and quality improvement;
b. Assuring that the supports provided are within the scope of the agency's service enrollment and experience to assure effective delivery;
c. Assuring that the services address the participant's needs and adhere to the application of person-centered values, choice and participant's rights;
d. Providing, arranging or overseeing curricula used in staff training and directed to service delivery in the context of the individual's goal(s) and objectives;
e. Recommend other needed services/supports or changes to the delivery model using a continuous quality improvement approach;
f. Providing consultation to the provider agency in ISP implementation strategies that are specific, measurable, achievable, relevant, realistic and time limited in order to meet the needs and personal goal(s) of the participant;
g. Assess areas of risks either individually or overall risks to persons supported through agency practice, policy or lack of policy or procedures/protocols. Providing risk mitigation strategies to the provider agency;
h. Reviewing that functional assessments are in place to support formulation of the participant's plan for delivery of all waiver services that include:
    i. The Health Risk Screening Tool;
    ii. The Supports Intensity Scale;
    iii. Functional Behavioral Evaluation;
    iv. Others (E.g., Nursing, OT, PT etc.) as needed or required.
i. Oversee high intensity services if applicable that address health and safety risks for the participant's that includes:
    i. The implementation and effectiveness of Behavior Support Plans;
    ii. The implementation and effectiveness of the Participant's Crisis Plan; and
    iii. Identifying ongoing supports as needed (medical and /or behavioral) in collaboration with agency staff, staff of other agencies providing supports to the participants mutually served or other members of the healthcare team.

3. **Developmental Disability Professional Requirements:**

The provision of DDP oversight and service provision must be documented in the Participant's record when DDP services are needed for an individual participant.

The DDP staff file must include the following documents:

a. A signed DDP job description or contract that meet the DDP requirements for oversight and professional consultation;
b. A specified schedule for each site and sufficient contract hours (not a **PRN** staff) to meet the agency's need for general oversight and quality improvement activities as well as consultation and/or evaluation of individual participants as needed;
c. There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;
d. A copy of diploma, license or certification to verify qualifications for performing DDP job functions is maintained in the staff file; and
e. Annual evaluation of adequacy of the DDP deliverables relative to the agency functions and needs as part of QI activities.

Note: A DDP is not scheduled to work only on a PRN (pro re nata) basis.

Documentation Requirements for DDP:

Agencies will identify for the DDP's ongoing review any participant receiving clinical services (nursing, therapy(s), behavioral services) and any participant with changes in functional, medical, behavioral or social status.

There is documentation to verify all necessary face-to-face participant's visits, other contact or communication with or on behalf of the participants in the participant's record. Documentation will contain the purpose of the visit or contact, for assessment or evaluation, training, plan for intervention, and any changes in service delivery.

DDP documentation must meet documentations requirements of date, location of service delivery, signature (title), beginning and ending time when the service was provided.

Required Training for Developmental Disability Professionals:

In addition to the initial orientation requirements for new employees listed in the NOW and COMP Policy Manual Part II located at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx other required trainings for DDPs' in their first year of employment include:

a. Individual Service Planning (Person-Centered);

b. Support Intensity Scale overview;

c. Health Risk Screening Tool on-line training overview; and

d. The provider agency must also show participation and document the participation of each DDP employed or under contract, a **minimum of eight (8) hours per year** of DBHDD sponsored or other training in the area of developmental disabilities in the DDP employee's file or require and maintain the documentation of participation in such training on an annual basis from any DDP independent contractors.

Developmental Disability Professional Competency:

The provider will be responsible for monitoring and ensuring the DDP meets his/her above assigned responsibilities utilizing the below performance indicators as follows:

a. Consulted with, supervised, trained and/or provided guidance to direct support staff regarding implementation of service to comply with person-centered values and techniques. Documentation of consultation may be maintained in the form of training agenda, staff meetings, etc. This documentation shall include the signature, title/credentials, timed (beginning and end time of delivery of training or in-service support) and date. Copy maintained by the provider agency;

b. Assist and provide feedback to the provider in reviewing the quality of the services delivered;

c. Provide technical assistance to the provider agency in corrective action requirements and participate in response regardless of the origin of the Corrective Action Plan requirement; and

d. Participate in the agency's Quality Improvement Plan and Risk Management Reviews based on qualifications and training background; provide medical and behavioral recommendations and guidance as needed.

4. **The following Professionals qualify to be a Developmental Disability Professional:**

a. **Advanced Practice Nurse:** A registered professional nurse licensed in the State of Georgia, who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND has one year experience in treating persons with intellectual/developmental disabilities (I/DD).

b. **Behavior Specialist/Consultant:** A behavior specialist or consultant who has completed a Master's degree in psychology, school psychology, counseling, social work, education, or a related field OR licensure/certification as a Licensed Professional Counselor, Psychologist, Licensed Clinical Social Worker, or Psychiatrist AND a minimum of 12 coursework hours or training certification hours in behavior functional assessment or analysis, data collection and analysis, plan development, behavior interventions, training, and implementation, AND has one year of experience in a treatment and/or community setting working with individuals with I/DD.

c. **Board Certified Behavior Analysis (BCBA):** A **BCBA** who has completed a Master's degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analysis Certification Board Exam, AND maintains a prescribed number of continuing education units annually AND has one year of experience in providing services to individuals with I/DD.

d. **Board Certified Assistant Behavior Analyst (BCaBA)**: A person who has completed an acceptable bachelor's degree from an accredited university, acceptable 180 hours of undergraduate and/or graduate coursework in behavior analysis, and have a period of 1000 hours defined supervised practical experience in the field with 5% of those hours being supervised by a BCBA, AND current Assistant Behavior Analysis Board Certification in good standing with the Behavior Analysis Certification Board, AND maintains a prescribed number of continuing education units annually, AND has one year of experience in providing services to individuals with I/DD. BCaBAs provide behavior services under the supervision of a Board Certified Behavior Analyst (BCBA) and may supervise the work of Registered Behavior Technicians (RBTs).

e. **Educator:** An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND has one year of experience in teaching individuals with I/DD.

f. **Human Services Professional:** A human services professional with at least a bachelor's degree in human services field including but not limited to: sociology, special education, rehabilitation counseling, and psychology AND has one year of experience in providing human services to individuals with I/DD.

g. **Master's or Doctoral Degree Holders:** A person with a Master's or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as

evidenced by college coursework AND has one year of experience in providing services to individuals with I/DD.

h. **Physical or Occupational Therapist:** A physical or occupational therapist licensed in the State of Georgia AND has one year of experience in treating individuals with I/DD.

i. **Physical or Occupational Therapy Assistant:** A physical or occupational therapy assistant certified by the American Physical Therapy Association American Occupational Therapy Association or another comparable body AND has one year of experience in treating individuals with I/DD.

j. **Physician:** A physician licensed in the State of Georgia to practice medicine or osteopathy AND has one year of experience in treating individuals with I/DD.

k. **Physician's Assistant:** A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of a physician, AND has one year experience in treating individuals with I/DD.

l. **Psychologist:** A holder of a Doctoral degree in Psychology from an accredited university or college, AND who is licensed as a Psychologist in the State of Georgia AND has one year of experience in providing services to individuals with I/DD.

m. **Registered Nurse (Associate Degree or Diploma):** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, AND has one year experience in treating individuals with I/DD.

n. **Registered Nurse (Bachelor's Degree):** A registered nurse who is authorized by license to practice nursing as a registered professional nurse AND who holds a Bachelor's degree in nursing with one year experience in treating individuals with I/DD.

o. **Speech Pathologist or Audiologist:** A speech pathologist or audiologist licensed in the State of Georgia AND has one year of experience in treating individuals with I/DD.

p. **Therapeutic Recreation Specialist:** A therapeutic recreation specialist who graduated from an accredited program AND has one year experience in providing therapeutic recreational services to individuals with I/DD.

q. **Social Worker:** A social worker who holds at minimum a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body AND has one year experience in providing services to individuals with I/DD.

H. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. All requests for waivers of these standards must be done in accordance with Requests for Waivers of Service Requirements Contained in DBHDD Provider Manuals or PolicyStat, 04-107.

I. For DD Providers Utilizing Proxy Caregivers and Health Maintenance Activities

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities, Chapter 111-8-100 (Go to

https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-laws-regulations). The policies and procedures specified below are applicable to all providers:

Health Maintenance Activities Definition: Health maintenance activities, which are limited to those activities that, but for a disability, a person could reasonably be expected to do for himself or herself. Such activities are typically taught by a registered professional nurse, but may be taught by an attending physician, advanced practice registered nurse, physician assistant, or directly to a person and are part of ongoing care. Health maintenance activities are those activities that do not include complex care such as administration of intravenous medications, central line maintenance (i.e., daily management of a central line, which is intravenous tubing inserted for continuous access to a central vein for administering fluids and medicine and for obtaining diagnostic information), and complex wound care; do not require complex observations or critical decisions; can be safely performed and have reasonably precise, unchanging directions; and have outcomes or results that are reasonably predictable. Any activity that requires nursing judgment is not a health maintenance activity. Health maintenance activities are not considered the practice of nursing. Health maintenance activities are specified for an individual participant in written orders of the attending physician, advanced practice registered nurse, or physician assistant.

1. **Written Plan of Care Requirements:** Health maintenance activities are as defined in the written plan of care that implements the written orders of the attending physician, advanced practice registered nurse, or physician assistant and specifies the frequency of training and evaluation requirements for the proxy caregiver, including additional training when changes in the written plan of care necessitate added duties for which such proxy caregiver had not previously been trained. The written plan of care is developed by a licensed healthcare professional in accordance with the written orders by an attending physician, advanced practice registered nurse, or physician assistant. This written plan of care for health maintenance activities must be maintained in the individual's record and available for the proxy caregiver.

2. **Written Informed Consent:** A participant or individual legally authorized to act on behalf of the individual must complete a written informed consent designating a proxy caregiver (proxy caregivers functioning independently in licensed residential facilities or licensed facilities delivering services through proxy caregivers) and delegating responsibility to such proxy caregiver to receive training and to provide health maintenance activities to the individual pursuant to the written orders of an attending physician, an advanced practice registered nurse or physician assistant working under a nurse protocol agreement or job description.

3. **Requirements for Individuals Providing Health Maintenance Activities:** Individuals who provide health maintenance activities in accordance with the above conditions must meet the following:

    a. Be selected by the individual or a person legally authorized to act on behalf of the individual to serve as the individual's proxy caregiver;

    b. Receive training by licensed healthcare professionals who are licensed and authorized under Georgia Law to perform certain healthcare practices, that teaches the proxy caregiver the necessary knowledge and skills to perform the health maintenance activities documented in the individual's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the individual; and

    c. Ensure that the proxy caregiver is familiar with emergency evacuation procedures.

4. **Non-Covered Health Maintenance Activities:** Health maintenance activities that meet any of the following are non-covered:

    a. Complex care such as administration of intravenous medications, central line maintenance and complex wound care.

    b. Provided by an individual without written informed consent designating that individual as a proxy caregiver and delegating responsibility to such proxy caregiver to receive training.

    c. Provided without the written orders of an attending physician, advanced practice registered nurse, or physician assistant working under a nurse protocol agreement or job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.
    Provided without written plan of care as defined above. Provided by individuals who do not meet the requirements specified above.

Appendix I:

Antipsychotic Medications	
Generic	**Trade**
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Serentil
Mesoridazine	Lidone
Molindone	Moban
Olanzapine	Zyprexa
Palinperidone	Invega*
Perphenazine	Trilafon
Pimozide (for Tourette's)	Orap
Quetiapine	Seroquel
Risperidone	Risperdal*
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine
Trifluopromazine	Vesprin
Ziprasidone	Geodon
Mood Stabilizer Medications	
Generic	**Trade**
Lithium Carbonate	Eskalith or Lithonate
Divalproex Sodium	Depakote
Tiagabine	Bagatril
Levetiracetam	Keppra
Lamotrigine	Lamitcal
Gabapentin	Neurontin
Carbamazepine	Tegretol
Oxcarbazepine	Trileptal
Topiramate	Topomax
Zonisamide	Zonegran
Verapamil	Calan
Clonidine	Catapres
Propranolol	Inderal
Mexiletine	Mexitil
Guanfacine	Tenex

***Also has a sustained release injectable for**

Part II

Section 2

Request for Conversion
(Appendix: A)

To obtain Request for Conversion Form, please go to:

https://s18637.pcdn.co/wp-content/uploads/sites/15/2017/08/Request-for-Conversion.pdf

PART III

Block Grant Funding Requirements

Title XX Social Services Block Grant for I/DD Services

Provider Manual

For

Community Developmental Disability Providers

Fiscal Year 2025

Georgia Department of Behavioral Health and Developmental Disabilities

D·B·H·D·D

PART III

Block Grant Funding Requirements

TITLE XX SOCIAL SERVICES BLOCK GRANT

Congress passed Public Law 93-647, or Title XX of the Social Security Act (SSA), in 1974 to make federal funds available for states to provide social services which address the needs of each individual state. Social Services Block Grant (SSBG) funds are used to provide a variety of services to Georgia's citizens, including vulnerable children and adults who need protection, persons with I/DD, and the elderly.

The Department of Human Resources prepares an annual report to inform the Secretary of the U.S. Department of Health and Human Services and the people of Georgia of the intended use of the funds the State is to receive under provision of the Act. This annual report is called the Report on the Intended Use of Title XX Social Services Block Grant Funds. The following description of services to persons with I/DD (I) and the statements on limitations/assurances on the use of the grants (II) are taken from the Report on Intended Use.

I. SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Services for persons with developmental disabilities are services or activities to maximize the potential of persons with disabilities, help alleviate the effects of disabilities, and to enable persons served to live in the least restrictive environment possible. Component services or activities may include personal and family counseling, respite care, family support, recreation, transportation aid to assist with independent functioning in the community and training in mobility, communication skills, the use of special aides and appliances and self-sufficiency skills.

II. LIMITATION/ASSURANCES ON USE OF GRANTS

The Georgia Department of Human Resources gives assurance that Title XX Social Services Block Grant funds will **NOT** be used:

1. For the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility; or
2. To provide cash payments for costs of subsistence or to provide room and board (other than cost of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service); or
3. For payment of the wages of any individual as a social service (other than payment of wages of welfare recipients employed in the provision of day care services); or
4. For the provision of medical care; or
5. For social services provided in and by employees of any hospital, skilled nursing facility, or prison, or to any individual living in such institution. The only exceptions to this limitation are services to an alcoholic or drug dependent individual or rehabilitation services; or
6. For the provision of any educational service which the state makes generally available to its residents without cost and without regard to their income; or
7. To provide childcare services unless such services meet applicable standards of State and local law; or
8. For the provision of cash payments as a service.

III. APPLICATION FOR SERVICE

Each individual or family unit shall have the right to apply for Social Services Block Grant Services without delays in the application process. Application for services may be made by the applicant or by a relative, friend, neighbor or legal guardian acting responsibly on behalf of the person needing the service. The application should be made to Field Office's designated point of entry.

IV. ELIGIBILITY

All recipients of Social Services Block Grant (SSBG) funded services must be physically located in the State of Georgia.

- **Non School Aged Adults** – SSBG funded services may be provided to non-school aged adults with a documented programmatic need and a current diagnosis of I/DD.

- **School Aged Individuals** – School aged individuals may be provided non-education-related services with a documented programmatic need and a current diagnosis of I/DD.

- **Pre-School Aged Individuals** –SSBG funded services may be provided to pre-school aged individuals with a documented programmatic need and a current diagnosis of I/DD.

V. BEGINNING THE SERVICES

If the service is temporarily unavailable, the individual should be placed on a Planning List.

V. PLANNING LIST

Planning Lists will be maintained in accordance with Planning Lists for Developmental Disability Services for Individuals Living in the Community, 02-101.

VI. SERVICES TO PERSONS RESIDING IN INSTITUTIONS

In most instances, services to persons residing in institutions are the responsibility of staff of the facility. Accordingly, SSBG funds may not be used for the provision of social services that are the inherent responsibility of the institution. Those facilities which are Intermediate Care Facilities or Skilled Nursing Facilities, and which receive funding under Title XVIII (Medicare) and/or Title XIX (Medicaid) are required either to provide social services or arrange for them with qualified outside resources. In these facilities and in any other where an investigation indicates that social services are an inherent responsibility of the institution, Social Service Block Grant Services to eligible persons are limited to assisting an individual and/or family to seek admission to the institution, and/or supporting or augmenting the discharge plan of the facility for the individual. If social services are not an inherent responsibility of the institution, SSBG services may be delivered to eligible persons.

VII. DOCUMENTATION OF SERVICE PROVISION

1. Contractors are responsible for the documentation of service delivery in compliance with the terms of the provider contract.

NOTE: Reporting of Services delivered must be reported in compliance with the Terms of the provider contract.

VIII. NOTIFICATION TO THE INDIVIDUAL OF SERVICE TERMINATION

A. Notification to the individual must follow a decision by the agency to terminate services. Form 5536, included below, and shall be used. **(Note: Even though space is available on this Form, the Form should not be used to notify an individual of eligibility for service. Form 5536 should only be used to notify a client of termination of service).** In cases of termination of service, services must continue through the ten (10) day notice period and the notification process must be (1) adequate and (2) timely.

1. **Adequate notice** is defined as a written communication (Form 5536) that includes a statement of the specific action the agency intends to take, the reason for the intended action, explanation of the individual's right to request a fair hearing and the circumstances under which services are continued if a hearing is requested.

2. **Timely notice** is defined as the notice being mailed or hand delivered to the individual at least ten (10) calendar days before the date the action is to become effective. No action shall be taken to terminate services during the ten (10) day notice period. If the individual does not request a hearing before the expiration of the tenth (10th) day, the services shall be terminated after the tenth day has passed.

B. Waiver of Timely Notice - The following are situations in which timely notice (10 calendar days) is not required but adequate (written) notice shall be given not later than the effective date of action:

1. The agency received a clearly written statement signed by individual that he/she no longer wishes to receive services.

2. The whereabouts of the consumer are unknown and mail to him/her has been returned by the Post Office indicating no forwarding address. Returned mail should be filed in the service record.

3. The individual moves to another State and the move is documented by the agency.

4. The individual was informed in writing, at the time the services began, that the service would automatically terminate at the end of a specified period.

5. A change in either Federal/State law or policy requires automatic service adjustments for categories of service recipients.

IX. INDIVIDUAL GRIEVANCES

Providers shall make a grievance and appeal process available to aggrieved individuals in compliance with Federal regulations governing the SSBG, and policy and procedure promulgated by the Division and the State of Georgia.

Georgia Department of Human Resources
NOTIFICATION FORM FOR TITLE XX SOCIAL SERVICES

Agency Name: _____
DATE: _____
CASE ID: _____

Your application for social services has been given careful consideration. The following determination has been made

I. A. INITIAL DETERMINATION: You have been determined eligible/ ineligible for the following Title xxx Social Services:

Reason (if ineligible)

B. REDETERMINATION: You have been determined eligible/ineligible for the following Title xx Social Services effective

The following Title xx Social Services have been/will be terminated:

Reason if (ineligible)

II. You are still eligible for these Title xx Social Services:

However, if the following services will be:

A. Reduced effective:
Reason: _____

B. Terminated effective:
Reason:
_____

III. LIMITED ELIGIBILITY

You have been determined eligible for the following Title xx services_____
You have been determined ineligible for the following Title xx services_____

If for any reason you disagree with this decision you may request a hearing. You may request a hearing orally or in contacting this agency within 10 days of the date given at the top of this form. This agency will be glad to furnish the form (s); help you in filing your appeal and in any way possible to prepare for the hearing.

The hearing will be held in your county by a hearing officer. You may be represented at the hearing by legal counsel or other spokesperson. If you would like an attorney, contact this agency which can provide information about legal services that may be available in your community at no cost to you.

Form 5536 (Rev. 05-00)

_____
Signature of Agency Representative
Georgia Department of Human Resources
Title XX Administration

PART IV

General Policies and Procedures

Provider Manual

For

Community Developmental Disability Providers

Fiscal Year 2025

DBHDD PolicyStat enables community providers of mental health, developmental disabilities and/or addictive diseases services to have access to all DBHDD policies that are relevant for community services. DBHDD PolicyStat can be accessed online anytime at http://gadbhdd.policystat.com. By virtue of their contract or agreement with DBHDD, providers are required to comply with DBHDD policies relevant to their contracted services and according to the applicability as defined in the policy itself.

Additional information about how to utilize DBHDD PolicyStat is included in Access to DBHDD Policies for Community Providers, 04-100.