GUIDELINES TRAINING
QUESTIONS FROM PROVIDERS

ORGANIZATIONAL PRACTICES

A. Program Structure:

Question: Why is it that if you have 2 different teams come out to the home they may tell you different statements as to what should be in the policy & procedures?
An agency may have different teams from the Division of DD or from different Departments coming into the facility to verify implementation of rules and regulations, policies or standards. For example: Healthcare Facility Regulation (HFR) reviews are based on their rules and regulations to license a home; and the Department of Behavioral Health and Developmental Disabilities (DBHDD) Provider Performance Unit (PPU) base their reviews on the DBHDD Community Service Standards. There are differences as one team is focusing on licensing issues while the other team is focusing on services.

Question: Why do reviewers bring their personal thoughts, i.e., "linen 6 inch off ground" that's not in policy?
Reviewers occasionally give examples to show different ways that providers can meet the standards, and these examples frequently coincide with other accrediting body requirements. Such an example is a recommendation and the provider may choose to use it or not.

Question: What are benchmark practices?
Benchmarking is learning to be better by observing the best. Benchmarking of practices helps an organization measure how well they compare with others in implementing best practices through the delivery of services.

Question: What are Best Practices?
Best practices can be defined as: programs, services or processes that research or expert opinion has shown to be effective practices. Best practices addressed during training are suggestions of ways to improve the supports provided but are not a requirement.

Question: Is there a standard appeal process across the state for under warranted S/C rating?
Monitoring report ratings are administered by the Support Coordination agency. If a provider disagrees with the rating, the provider must appeal to the Support Coordination Agency Management for consideration. If provider continues to disagree with SCA decision, refer the issue to your contracting Region.

Question: Do these guidelines mirror DCH's when they come out for audits?
Currently DCH does not have interpretative guidelines for the NOW and COMP waivers. These guidelines are for DBHDD Community Service Standards.

Question: What organization audits providers for the information covered today?
DBHDD Provider Performance Unit (same group that is conducting the training).

Question: In regards to attendance, does the individual have to sign in and out or is it ok for the Direct Care Staff to initial & sign?
There is no specific Community Standard requirement for individuals signing in and out; however, the provider should clarify with other monitoring bodies that may require this for accountability and/ billing purposes.

Question: If the organization is to write our own policy, to suit the needs of the company, then why are we penalized when the wording in our P&P is different from standards (different word, same meaning)?
There is no requirement that an agency's Policies and Procedures (P&P) use specific words from the standards. However, the agency's P&P and practice must meet the intent of the community service standards.

Question: What is the difference between an Advisory Board and Board of Directors?
The Advisory Board functions in the capacity as an advisor only and does not have the authority or power to implement an action. The Board of Directors has the power to implement an action or processes.

Day Program Question: Attendance log is required for daily transportation for day program?
Yes (See Section C. Respectful Environment No.8 B.6.)

B. Oversight of Contracted/Subcontracted Providers/Professionals:

Question: Can a provider (director) contract with another agency as contracted DDP?
There are many factors that have to be met for a DDP to function in this additional capacity of working for other agencies. The DDP would need to meet all the qualifications, current responsibilities and scheduling availability; maintain accurate number of hours per week required of the home agency for assigned case load; and cannot be a PRN (as needed) staff. The current community service standard require that if a DDP works for other agencies, there must be documented attestation that the agreed upon schedule of hours per week do not conflict with the hours of the other organization(s). There must be a qualified (no grandfathering for qualifications) DDP employed or under contract. Refer to the Community Service Standards for the new requirements of DDP (FY'14).

Question: Why and where does it say that the contractors' nurse/behavior specialists have to have an annual evaluation done, they are contractors, and this is done when we re-sign contracts each year?
The community service standards state that "regular review and evaluation of the performance of all staff is documented at least annually by Managers who are clinically, administratively and experientially qualified to conduct evaluations." (Refer to standard under Section E. Adequate and Competent Staff). Hence, all staff including the CEO/owner is required to have annual work performance evaluation.

C. Quality Improvement and Risk Management:

Question: How do we measure inclusion of cultural competence in QI?
The agency can check cultural competency by using a competency checklist, a checklist for assessing cultural competence performance as part of QI activities or conduct satisfaction surveys of cultural competence of individuals and their families.

D. Medication & Healthcare Management:

Question: If you get a physician's order to place an individual's medication in their food, can a non-licensed person/staff assist with administering the medication?
There are only 2 people that can administer medication in the individual's food with a physician's order: a licensed personnel and the individual. A proxy caregiver may be able to administer medication in the individual's food with a physician order, provided the proxy caregiver has been trained and determined competent to assist with the administration of medications by the specified licensed healthcare professional.

Question: It is not common practice for doctor's to write discontinuation prescriptions. Doctors are asking why this is needed because they do not know why it is needed. How can we be made accountable for something the doctors will not do? We have no oversight over doctors regarding what you want them to do?
A discontinuance order is required for all medications and this helps prevent medication errors. The physician can write the D/C order even on the actual physicians visit form. This type of documentation is acceptable as long as it is filed in the individual's record.

Question: The electronic prescription must have the physician's DEA #. Does that apply to the medical office visit document and/or the medication list signed by the physician with all the required components?
There is no requirement for DEA # on a physician's medical office visit document. The DEA # on an electronic prescription verifies the physician's signature.

Question: Does PRN medication, for example, dental procedures, need to be readily available? Usually order when we know the dental visit is going to occur.
If a medication is ordered for a procedure then it needs to be readily available. If a physician orders a medication after a procedure that is a PRN medication, then the order also needs to be filled to have on hand in case the individual needs it.

Question: How do you obtain an informed consent for anti-psychotic meds when the psychiatrist or psychiatric nurse practitioner refuse to provide one when the client does not have the capacity to consent and will not allow the substitute decision maker to consent?
Whenever an individual does not have the capacity to consent, a substitute decision maker is required if the individual is required to take a psychotropic medication. The treating psychiatrist/physician personally examines the individual to determine the ability or inability of the individual to consent for himself /herself. Follow the GA medical consent law protocol (O.C.G.A.§31-9-2) for obtaining a substitute decision maker.

Question: Can a proxy caregiver administer meds?
Yes, provided the proxy caregiver and agency meet the Proxy Caregiver requirements to determine which medications can be safely administered by proxy caregivers who have been trained and have the skills necessary to assist with the administration of medications by the specified licensed healthcare professional.

Question: What are the parameters for giving meds ½ hour before and after or 1 hour prior to and 1 hour following? Some providers have been trained that it should be given no earlier than 1 hour to or no later than 1 hour after.
The decision of when medications can be given is based on the physician's order. The agency medication policy and procedure should clearly state that the final decision for medication time frames is determined by the individual's physician. CMS allows the 30 minute rule before and after the medications time that is scheduled. If this 30 minute rule is practiced by the agency, then this rule needs to be included in the agency's medication P&P.

Question: For medical devices/adaptive supports, DBHDD says order is good for up to 1 year, HFRD policy says medical devices/adaptive supports orders cannot exceed 180 days. Does DBHDD policy override HFRD policy for DBHDD providers?
No, the organization should adhere to the most stringent guideline, which would be HFRD in this case.

Question: For double locks, can it be on the same door?
Yes, as long as it is two separate locks with different keys or combinations.

Question: If a prescription reads Zoloft 40 mg take 1 tablet daily and the MAR reads Zoloft 20 mg take 2 tablets daily, will that suffice?
Yes.

Question: If a provider operates a CLA, are proxy caregivers required in the CLA for clients who are not capable of self-administration of medications?
If the CLA is using paid unlicensed staff to perform "health maintenance activities" such as assistance with medications for an individual who is not capable of self-administration of medications, then the provider needs to use proxy caregivers. Please visit the HFR site for frequently asked questions about Proxy Caregivers.

Question: If a person, who receives CLS, receives their meds from their choice of pharmacy, can the provider use the same pharmacy for the biennial review, especially since the provider doesn't have a contract/agreement with the pharmacy?
The Standard requires an independent pharmacist or independent RN, not associated with the agency in any way, to perform the biennial review of medications.

Question: What if the medication is a controlled substance? How do you put medication in the refrigerator under double lock and key?
There are several examples: - One example could be using two different locks on the same box.

Question: Does Psychotropic medications have to be double locked?
There is no requirement in the standards that mandate that psychotropic medications have to be double locked. However, some psychotropic's' maybe controlled, for example the benzodiazepines. In such cases, it would require a double lock.

Question: Is a controlled substance count sheet required in a host home?
Yes.

Question: Can an AIMS test be done by a LPN?
Yes, as long as that person is trained to perform an AIMS test. Any non-clinical person can perform an AIMS assessment as long as that person is trained. Evidence of the training has to be documented and available. An RN or MD is not required to co-sign an AIMS test.

Question: Where is it in the standard that requires a doctor order for Ensure Plus? Why should Ensure be listed on the MAR?
Any OTC/Nutritional supplement requires a physician's order. It does not have to be documented on the MAR, but there should be clear documentation to verify effectiveness of any OTC/supplement. The organization's policy and procedures should outline the monitoring process for OTC/Nutritional supplements.

Question: In CAG services, we have had difficulty obtaining copies of informed consents for psychotropic medications from CRA providers and families. If we document our attempts to obtain a copy of an informed consent, is this sufficient? If not, do you have any advice on how to obtain a copy of an informed consent?
The Day Program is not responsible to maintain the informed consent unless the psychotropic medication is taken during day service hours and the day program is supervising the individual's self –administration of the psychotropic medication. It is not sufficient to document attempts of obtaining the informed consent. The provider should go through the Support Coordinator and/or Region Coordinator to obtain a copy of the informed consent from the CRA provider.

Day Program Question: Informed Consents needed for all or just who we supervise meds for? Bi-Annual Assessment – all medications or just being supervised?
The Day program should have informed consents for all medications that are administered/supervised at the day program only. In all settings in which medications are administered or self-administered, a biennial assessment has to be completed on the agencies medication practice.

Day Program Question: Parent has asked that we give a blended diet. Does this require physician's order?
Yes, all special diets require a physician's order.

E. Adequate and Competent Staff:

Question: Do you need to indicate awake staff on the schedule if it is outlined in P&P 24 hr awake staff is required?
Yes, if awake staff is required for a particular individual, then the standard states that the monthly staff schedule notes that awake staff is needed.

Question: Who offers SIS trainings?
DBHDD training staff.

Question: Why does staff have to have GA driver's license if they are not residents of GA?
A GA driver's license is not required. See NOW & COMP Part II, Chapter 900, Section 905. Note for exceptions.

Question: Why do staff members who do not transport clients required to have a 7 year MVR?
A 7 year MVR is not required for staff members who do not transport and whose job duties do not include transporting.

Question: What is the policy for staff members who do not have a 7 year MVR when under the age of 25?
The agency should still request a 7 year MVR to obtain such records as are available.

Question: Do we need copies of high school diplomas/transcripts for positions that require that level of education?
Yes.

Question: Can you please further clarify the DDP required face to face visits? Is the "specified schedule" determined by the need of the individual and specified on the ISP? For example, some individuals may need bi-monthly oversight, while others may only need quarterly visits.
1) The DDP face to face visit has be in person with the individual and documented in the individual's record; 2) The DDP schedule should reflect time spent at the agency each week; and if the agency operates several sites, then the DDP schedule needs to clearly reflect the hours spent in each specific site; 3) If there is a specified schedule noted in the Exceptional Rate, then the required hours should reflect requirements in the ER. (Refer to more details in Section E. Adequate and Competent Staff #3).

Question: Is it acceptable for CLA/host home services to have the DDP review monthly home visit documentation completed by other staff so long as the documentation addresses ISP goals, health & safety issues, etc.? If yes, can this be documented by their signature on the monthly home visit document indicating they reviewed the individual's information?
The DDP provides the clinical oversight and should review staff notes pertaining to ISP goals and health and safety issues etc. However, this process cannot be substituted for the DDP face to face visit of specified scheduled contact hours and the DDP monthly documentation to verify ISP goals training, health or safety issues and follow-up to any recommendations or needed referrals to include if applicable, the adequacy of any high intensity services.

OUTCOMES FOR PERSONS SERVED

A. Individual Rights, Responsibilities, Protections:

Question: Why would their mark on forms not be legal, especially if they have rights, is that not a violation of them?
If the individual has the capacity to understand why he/she is placing a mark on the form and this mark is witnessed, then the individual mark would serve as their signature of acceptance/rejection. However, if the individual does not have the capacity to understand/process what he/she is signing, then the mark would not be legal and a substitute decision maker would need to sign the documents. Refer to Georgia Medical Consent Law Code 31-9-2 for who can serve as a substitute decision maker.

Question: If individual's mark is not sufficient as their signature, do they have to give their permission for advocate, family member, etc., to sign with them?
See above.

Question: What is the difference between Rights subcommittee and Human Rights Committee?
These committees are not the same. The Rights subcommittee is formed within the organization and looks at the individuals' rights within the agency. The Human Rights Committee determines whether the human rights of an individual receiving DD services are protected and thus reviews issues such as allegations of suspected rights violations, behavior plans and psychotropic drug use. Refer to Human Rights Council for DD services 02-1101 for more details.

B. Behavioral Support Practices:

Clarification: We are required to document an individual's choice of which Behavior Specialist writes his/her BSP. (If I heard these statements correctly, I do not see the standard/IG that states such. Could you please direct us to the policy or IG?)
Refer to Community Service Standard under B. Behavioral Support Practices #9, which states the individual/guardian is given the choice to select the qualified person to develop the BSP.

Question: If you are required to contract with and access a behavior support service, then how do you offer choice and document choice if you have already set up and contracted with service?
It is the agency's responsibility to ensure that an individual is offered choice to access behavior support services.

Question: If an individual does not have a BSP, can staff utilize "withdrawal to a quiet area/bedroom" if the individual agrees for non-crisis actions?
If the individual utilizes or withdraws to a "quiet area/bedroom" to relax, or the individual likes to spend time without others or to be by himself /herself, then in such cases it is not considered a behavioral technique. However, if withdrawal to a "quiet area/bedroom" follows the occurrence of a specified inappropriate behavior, then it is a form of "time out" and in such cases the use of this procedure needs to be included in the PBSP. Protocols for the use of withdrawal need to be adhered to. Refer to Guidelines for Supporting Adults with Challenging Behaviors in Community settings under Glossary of Non-restrictive techniques.

Question: What do you mean by specific trends when looking at behavior programs?
Trends of targeted behavior means, if the behavior program techniques are working, then we should see a decrease in the target behavior and an increase in positive behavior.

Question: Clarify this standard: The PBSP and Safety Plan for challenging behaviors should be a collaborative effort among each provider providing services for the individual. The providers must work to develop and implement one plan that includes any modification 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.

The intent of this standard is that there is one written PBSP/Safety Plan to be implemented at all settings (Residential, Day Service, Supported Employment, etc.) with alterations for different settings, if applicable. The development of a BSP/Safety Plan should include **ALL** persons involved in providing supports to the individual in different service settings to allow for consistency in implementation. Implementation of behavioral support plans to reduce inappropriate behavior and to acquire alternative skills/behaviors is a covered and reimbursable service under the Community Residential Alternative (CRA) Services. Therefore the residential Provider, in conjunction with the individual's assigned service coordinator, should serve as the facilitator to bring about the collaboration of all persons providing services for the individual (such as community access service providers), to assist the qualified professional in developing, training and implementing the PBSP/Safety Plan. The success of this collaboration further meets another DBHDD community service standard requirement, which is developing a holistic person-centered approach to care, support and services.

Question: Clarify: Behavioral services are not covered to participants receiving Community Residential Alternative Services in the Comprehensive Supports Waiver. So how can this collaboration be handled by the CRA provider at community access facility?

CRA services include behavior support services and implementation and this is covered in the rate received for this service. Refer to COMP waiver service guidelines Part III, Chapter 2000. For collaboration to be handled by the CRA provider at community access facility, the residential provider will document the Behavior Support Consultant Service at the community access facility as observation for the development of a Behavioral Support Plan. This is the only exception under which a Behavior Support Consultant could conduct observation of an individual receiving services in a community access facility, for the development of a BSP.

C. **Respectful Service Environment:**

Statement: Page 24.k. refrigerator temp 45° should be 35°?
Refrigerator should be maintained between 36 and 41 degrees Fahrenheit.

Infection Control Practices:

Clarification: We are to maintain temp logs in refrigerators even with no medications in them. (If I heard these statements correctly, I do not see the standard/IG that states such. Could you please direct us to the policy or IG?)
The agency has to demonstrate that the refrigerator and freezer are being maintained according to the FDA guidelines, which state that the refrigerator should be at or below 41degree F. and the freezer at or below 0 degrees. (Refer to Ga. Dept. of Food Service)

Question: Is the temperature for fridge 36-41° for host homes to maintain a daily log as well?
The host agency should be able to demonstrate that the refrigerator and freezer are being maintained as stated above.

Question: Agency P&P does not allow pets in CLA, can HH contracted with agency do so?
There are many factors to be considered and the decision to contract with a HH rest with the DBHDD provider agency based on the thorough evaluation and matching process of the prospective HH. The HH evaluation study report must be reviewed by all stakeholders to ensure an appropriate match between the individual and the HH provider. One of the question asked is "does the HH have any pets", so the subject on pets should already be discussed prior to finalizing the contractual agreement.

CLS Question: If a person lives in their own home/apartment and has CLS, does a provider get cited for unmet standards in the person's own apartment for which the provider has no control? For instance: The person served doesn't meet infection control standards or keeps a log of refrigerated medications.
Yes, health and safety concerns for the individual should be the priority. A training goal for the individual could be developed and recommended to the team to be incorporated in the ISP.

Question: Are there any barriers to transportation? How does this impact choice on the weekend and especially for CAI & CAG services?
There should be no barriers to transportation. Residential service rate include taking the individuals out for recreational and leisure activities, and therefore the residential provider is compensated for transportation. For CAS transportation to and from activities and settings is included in the cost of doing business and incorporated in the administrative cost.

D. A Holistic Person-Centered Approach to Care, Support & Services:

1. **Assessments**
2. **ISP**

Question: If individual does not have exceptional rate, does DDP have to do monthly review if not indicated in ISP?
Refer to DDP regulations in the Community Standards. DDP oversight is for all the services, not just for those with an Exceptional Rate.

Question: The signature that was documented at the ISP planning meeting should not be used as signifying acceptance, since the plan may be different from what was discussed at the planning meeting. What does the provider do if the plan comes back differently?
The provider should work with the Support Coordinator to ensure that the ISP reflects what was discussed at the planning meeting. Any discrepancies should be brought to the attention of the Support Coordinator and addressed immediately for correction. Ultimately, the provider is responsible to make sure the ISP is correct.

3. **Documentation**

What is "To the Point Documentation"?
Accurate documentation that is individualized and shows the relevance of services provided, documenting what is significant, is considered "To the Point Documentation."

3. **Define inclusion and active community integration.**
Active community integration involves moving away from segregated recreation choices. Ways in which providers and individuals can help develop active community integration would include: working to have individuals included as volunteers in civic groups; working with schools/community colleges to develop academic programs; helping individuals secure employment; seeking donations of tickets to sports, cultural and community events that individuals could attend; and developing support groups and working with religious groups to develop programs to support individual's spiritual needs. Accomplishing the goal of active inclusion begins with getting to know the individual to identify his/her interests. This process may take time and can be further evaluated through the individual's involvement and response to recreation and leisure activities and knowing what community activities are taking place within the neighborhood community, e.g., community newspapers, bulletins and flyers for events at neighborhood parks.

4. **Question: Do charts have to be locked up or double-locked?**
   Single locked is sufficient for records.

5. **Information Management System**

   Question: After six years' retention of records, then what? Contact the contracting region for instructions on where to send the files.

E. <u>Management of Individual's Personal Funds:</u>

Question: Who manages individual's funds while waiting for permission of someone outside the agency? What if it takes some time for a response?
A family member or provider should manage the funds until an outside agency/entity is found to manage the funds.

Question: SSA states personal funds for individuals should be $110.00 for the individuals that get full $710. Why does DBHDD say $65.00?
The $65.00 amount is currently noted in DBHDD policy. The $110 amount mentioned is for Source Program.

Question: Is the Burial account part of inventory?
Yes, the burial information should be written on the personal inventory.