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Georgia Department
of Behavioral Health
& Developmental
Disabilities

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BE COMPASSIONATE
BE PREPARED
BE RESPECTFUL
BE PROFESSIONAL
BE CARING
BE EXCEPTIONAL
BE INSPIRED
BE ENGAGED
BE ACCOUNTABLE
BE INFORMED
BE FLEXIBLE
BE HOPEFUL
BE CONNECTED
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Statewide Clinical Oversight

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Georgia Department of Behavioral Health & Developmental Disabilities

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Statewide Clinical Oversight

- Statewide Clinical Oversight (SCO) is the process by which DBHDD confirms a timely and appropriate systemic response to indicators of heightened risk for Individuals in receipt of Home and Community-Based Services (HCBS) funded through state dollars and the Medicaid waivers- COMP/NOW.
- Statewide Clinical Oversight is available in all regions to minimize risks to individuals with I/DD in the community who face a heightened level of risk due to the complexity of their medical or behavioral needs.
- Statewide Clinical Oversight is a formal oversight function assigned to the Office of Health and Wellness.

Statewide Clinical Oversight

The purpose of Statewide Clinical Oversight is to not only identify those Individuals who are at a heightened level of risk but to provide an elevated level of monitoring and response to mitigate risks.

When individuals are considered at heightened risk this means that there is an increased change or risk of health decline or change of experiencing acute illness because of existing or newly identified physical, behavioral, environmental or even pharmacological factors.

Heightened Risk is identified by the following criteria:

- Increase of the Healthcare Level (HCL)
- Recurring Serious Illness without Resolution
- Diagnosis of Fatal Five/ Serious Six
- ER Visit / Hospitalization (Medical or Behavioral)
- Changes in Behavior; incident with Law Enforcement
- Unmet need for Medical Equipment or Healthcare Consultation
- Change in Residence
- Loss of Natural Supports

Statewide Clinical Oversight

Oversight of an individual's health is a responsibility of all entities responsible for and contributing to the support of I/DD Individuals in the community who face a heightened level of risk to environmental and the complexity of medical and behavioral needs.

Parties responsible for this support can notify the Office of Health & Wellness (OHW) for the need for statewide clinical oversight.

Who can notify OHW for Statewide Clinical Oversight?

Individuals/Family/Guardian/Caretakers

DBHDD Community Service Providers

Clinical Providers (contracted/community-based)

Intensive/Support Coordination Agencies

Regional Field Office/Central State Office

Stakeholders with a vested interest in overall DD Individual wellbeing

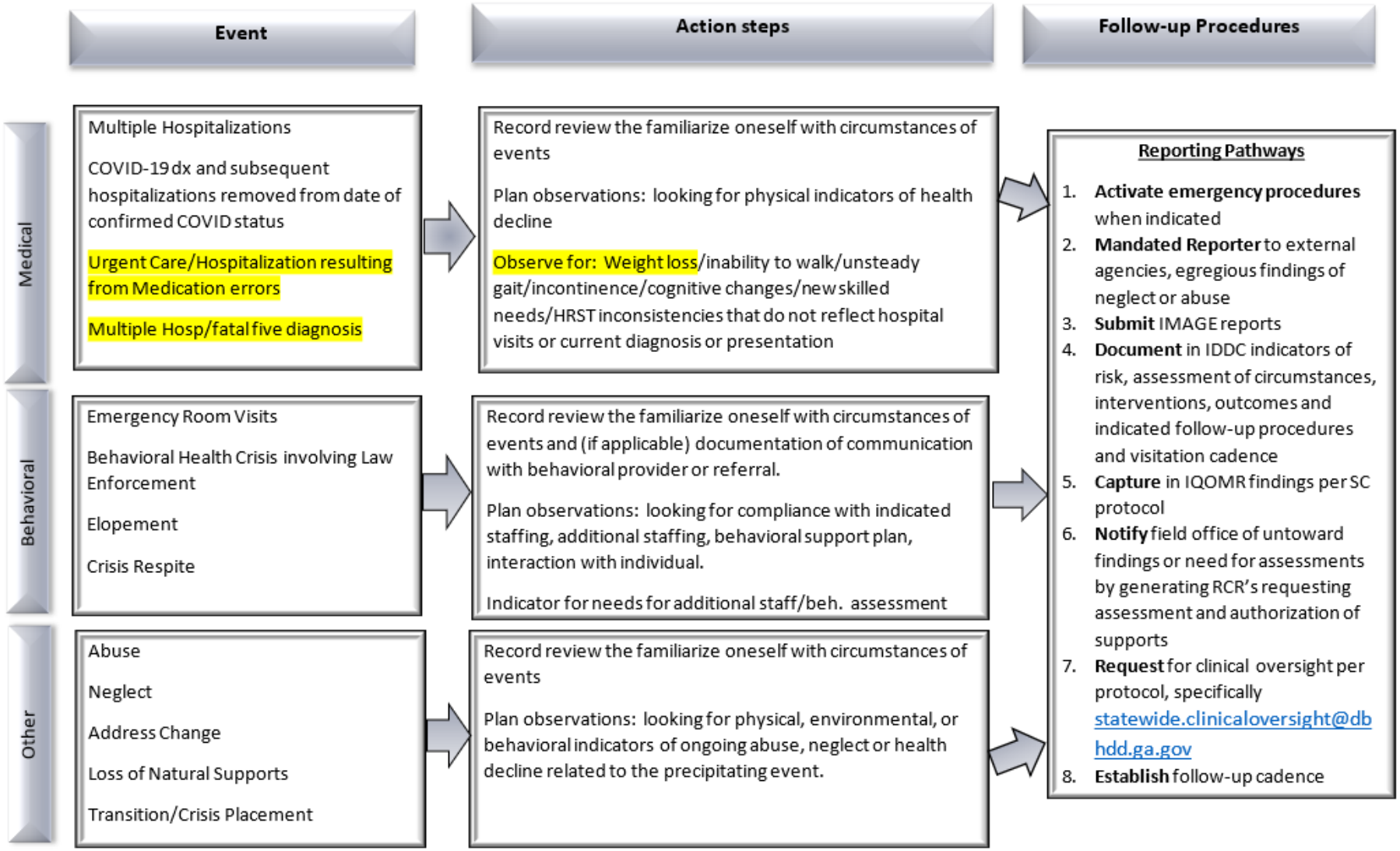
Notification of Statewide Clinical Oversight to OHW:

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

Notification to include:

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

What happens after an event or following an identified risk?


Event
Action steps
Follow-up Procedures
Medical
Multiple Hospitalizations
COVID-19 dx and subsequent hospitalizations removed from date of confirmed COVID status
Urgent Care/Hospitalization resulting from Medication errors
Multiple Hosp/fatal five diagnosis
Record review the familiarize oneself with circumstances of events
Plan observations: looking for physical indicators of health decline
Observe for: Weight loss/inability to walk/unsteady gait/incontinence/cognitive changes/new skilled needs/HRST inconsistencies that do not reflect hospital visits or current diagnosis or presentation
Behavioral
Emergency Room Visits
Behavioral Health Crisis involving Law Enforcement
Elopement
Crisis Respite
Record review the familiarize oneself with circumstances of events and (if applicable) documentation of communication with behavioral provider or referral.
Plan observations: looking for compliance with indicated staffing, additional staffing, behavioral support plan, interaction with individual.
Indicator for needs for additional staff/beh. assessment
Other
Abuse
Neglect
Address Change
Loss of Natural Supports
Transition/Crisis Placement
Record review the familiarize oneself with circumstances of events
Plan observations: looking for physical, environmental, or behavioral indicators of ongoing abuse, neglect or health decline related to the precipitating event.
Reporting Pathways
1. Activate emergency procedures when indicated
2. Mandated Reporter to external agencies, egregious findings of neglect or abuse
3. Submit IMAGE reports
4. Document in IDDC indicators of risk, assessment of circumstances, interventions, outcomes and indicated follow-up procedures and visitation cadence
5. Capture in IQOMR findings per SC protocol
6. Notify field office of untoward findings or need for assessments by generating RCR's requesting assessment and authorization of supports
7. Request for clinical oversight per protocol, specifically statewide.clinicaloversight@dbhdd.ga.gov
8. Establish follow-up cadence

Heightened Risk due to Medical Events:

- Urgent Care Visits
- Emergency Room Visits
- Admission to Hospital
- Hospitalizations
- Discharges from Hospitals

Follow up for Intensive/Support Coordination

- Confirm provider's actions to mitigate risk to the individual and stabilize/resolve. Examples: Calling the RN, PCP office, and 911.
- Confirm provider's compliance with MD recommended treatment(s), referrals (if applicable), and Discharge orders.
- Confirm that follow up appointments with PCP, referrals, or therapies have been completed.
- Confirm that the provider updated the HRST.
- Confirm that HCPs or Risk Mitigation Documents have been developed, updated as needed, and staff trained.

Statewide Clinical Oversight- Focus of OHW:

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

Individual Quality Outcome Measures Review

35	**FOCUS AREA: APPEARANCE and HEALTH**					
36	15	**The individual appears healthy. Describe any observations regarding health since the last review.**	Since the last review, are there any notable changes in appearance that would indicate a decline in health? Observations should include: Skin condition, hygiene, weight, ambulation/mobility, mood, energy/activity level, sleep pattern, cognition/memory relative to last visit, etc.	Individual's skin coloring/condition has changed or there are new bruises/injuries. Individual is noticeably smaller or heavier in body weight since the last visit. Individual has a body odor that might indicate a health condition. Individual has a new limp or unsteady gait that was not previously present. Individual appears lethargic. Individual appears to have notable memory decline since the last visit. Individual vocally complains of a health issue or pain and he/she has not received medical attention.		
37	16	**The individual appears safe. Describe any observed changes related to safety since the last review.**	Are there any indications from observation or reports from the individual that there are any new or unresolved safety concerns since the last review?	It is evident during observation that the participant is unsafe or vocally complains of feeling unsafe.		
38	17	**There have been no reported changes in health since the last review.**	When asked, do staff/family/individual report that there have been any changes in health since the last review?	Staff/family/individual reports that there have been newly diagnosed conditions, new treatments prescribed, new or unresolved injury, changes in mobility or range of motion, new or progressing skin breakdown, changes in cognition, change in body weight, etc.	If the change in health resulted in a visit to urgent care, the emergency department or a hospitalization, mention it here, but open the Clinical Referral in Question 31-32. If there is a new diagnosis of bowel impaction/ obstruction, choking, aspiration, dehydration, sepsis, or a hospitalization related to or new onset of seizure activity, submission of CIR - D Code is required (if not already submitted by provider). If there is a different recurring serious illness, submit notification to Statewide.ClinicalOversight@dbhdd.ga.gov.	
39	18	**The HRST aligns with current health and safety needs.**	*Review the current HRST.* Has the HRST been completed within the last year? Are there any changes in health and safety needs that have not been updated on the HRST? Are there any changes in medications or diagnoses that have not been updated on the HRST? Have HRST service/training considerations been considered for implementation?	HRST has not been updated in the past 365 days. HRST does not take into account the most recent health information available. New service/training considerations were indicated and provider has not been responsive regarding them.	If Coaching was offered and is not resolved within 30 days, elevate to a Clinical Referral and set to a 10 day target close date. Also, after 30 days of inaction in updating HRST, submit notification to the appropriate Outcome Resolution Coordinator based on the region.	
	19	**The ISP is available to staff on site. If there have been ISP addendums,**	Is the ISP (and any addendums/updates/version changes) available either in printed or electronic format for the staff to review at every	ISP is not available on site. ISP is available on site, but ISP addendums/updates/version changes are not. ISP is only	If there are clear training deficits around individual-specific support needs and the provider does not have a plan to resolve, notify the appropriate	

Sheet1

Individual Quality Outcome Measures Review

46	25	**Documentation is present to indicate that skilled nursing hours are being provided, as ordered.**	Are nursing hours being delivered by a LPN/RN at the frequency indicated on the Nursing Assessment?	LPN/RN was not present during a time that they were needed for skilled nursing tasks based on nursing recommendations.	If the person has no nursing, select Acceptable and indicate N/A in Comments.	
47	26	**All medical/therapeutic appointments have been scheduled and attended.**	Has the individual received an annual physical and dental exam? Has one been scheduled, if it has not yet occurred within the past year? Are indicated specialist/therapeutic appointments being scheduled and attended as recommended? Has indicated lab work/AIMS test been completed at recommended intervals?	Individual has not attended an annual physical or dental exam. Individual has not attended needed specialist/therapeutic appointments.	Coaching: If any supporters indicate lack of transportation as a reason for the individual not attending needed appointments, remind them that Non-Emergency Medical Transportation (NEMT) through Medicaid vendors can be scheduled to provide transportation to medical appointments. Information on vendors is located in Appendix H of the SC/ISC Part III Waiver Manual.	
48	27	**All follow-up appointments have been scheduled and attended.**	If a physician recommended a follow-up appointment, was the appointment scheduled and attended within the recommended timeframe?	Follow-up appointment was not scheduled in the timeframe recommended by the physician. Scheduled follow-up appointment was missed.		
49	28	**All physician/clinician recommendations are being followed.**	If recommendations were made during a previous medical visit or clinical assessment, has the individual been supported to ensure those recommendations have been followed?	Physician/clinician recommendations have not been followed.		
50	29	**All prescribed medications are being administered, as ordered, and documented accurately.**	Review all of the individuals medications and *Medication Administration Record* (MAR) to determine if prescribed medications are being administered accurately.	There is evidence of medication administration or documentation errors based on review of MAR and current medications present.	Reminder: Determine if any medication errors meet criteria to be reported as a Critical Incident (DBHDD Policy 04-106). SC is responsible for reporting if the provider did not report.	
51	30	**All required assessments/evaluations have been completed.**	If an assessment/evaluation was recommended for a person based on their current condition, has the assessment been completed? This can include OT, PT, SLT, Nutrition, and also needed DBHDD Field Office Clinical Assessments.	Ordered/needed assessments were not completed.	Consider if the individual meets criteria for an ICST referral and initiate, if indicated, to meet the assessment need. Notify Statewide.ClinicalOversight@dbhdd.ga.gov if there is an inability to meet an assessment need in the timeframe needed based on the acuity of risk.	
52	31	**Since the last review, the individual has been admitted to a hospital or has visited an emergency room or urgent care clinic.**	Since the last review, has the individual been taken to an urgent care clinic, an emergency room or been admitted to a hospital? If so, what was the reason for the hospitalization, ER visit or urgent care visits? Document the date of the visit and duration of stay.	Individual has been taken to an urgent care clinic, an emergency room or been admitted to a hospital since the last review.	Reminder: If not already submitted by provider, SC submission of CIR - D Code required for Statewide Clinical Oversight.	
53	32	**If applicable, hospital/ED/urgent care discharge plan instructions have been followed.**	If a hospital admission, hospital emergency department visit or urgent care clinic visit occurred since the last review, were the discharge plan instructions followed by those responsible for the supporting the individual with their health?	A hospital admission, hospital emergency department visit or urgent care clinic visit occurred since the last review and discharge plan instructions were not followed by those responsible for the supporting the individual with their health.		

ISC/SC Documentation of Incidents/Events in IDD-C:

- It is important to review previous documentation in Outcome and Support Notes Tab in IDD-C, HRST, and Incident Reports for the Individual prior to contacts to ensure a comprehensive follow up.
- Has there been any incidents/events since the last contact?
- Providers are responsible for notifying ISC/SC for incidents/events:
  - Emergency- notify after initiating emergency steps
  - Deteriorating Health- notify within the first 24 hours
- If previous documentation noted upcoming MD appointments, then follow up with these appointments should be noted in the current documentation.

ISC/SC Documentation of Incidents/Events in IDD-C:

- Document if the responsible party was compliant with Discharge recommendations/orders from Urgent Care Visits, ER Visits, and/or Hospitalizations.
    - Discharge Diagnosis. Admission/Discharge Dates.
    - Prescriptions of new medications are filled
    - Orders are implemented
    - Follow up appointments with PCP or referred MD have been completed
    - Follow up with therapies or home health is implemented and completed

Outcome to Medical Events:

A Clean Bill of Health

ISC/SC Following up on Incidents/Events:

Documentation should include that medical follow up appointments have been completed with findings.
Was the Individual medically cleared?
MD stated that the medical issues for the Urgent Care visit, ER visit and/or hospital admission have been resolved.
Individual has returned to their normal baseline and can return to normal activities. State if new baseline established following the incident/event.
Any referrals for further medical treatment should be followed up until issue is resolved.

ISC/SC Following up on Incidents/Events:

- Communication to the provider to ensure the HRST was updated for new diagnoses, for medication changes, and for the rating section as related to the events/incidents.
- Documentation of HCPs and staff training for HCPs. Documentation for Risk Mitigation Document (RMD) and staff training for RMD.
- Ensure that medical equipment and environmental devices have been implemented safely to prevent injuries. Ensure that equipment and assistive devices (wheelchair, hoyer lift, hospital bed, gait belt, helmet, and lap tray are in good working order. Documentation of staff training.
- Review of services with the provider to determine if additional staffing or nursing would better support the individual.


Questions?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