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**Georgia Department of Behavioral Health & Developmental Disabilities**

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# **PROVIDER MANUAL**

**FOR**

## **COMMUNITY DEVELOPMENTAL DISABILITY PROVIDERS**

**FOR**

### **THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES**

**FISCAL YEAR 2022**

**Effective Date: *October 1, 2021* (Posted: *September 1, 2021*)**

“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 (September – October), 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 2022 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.

# DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

## FY 2022 COMMUNITY DEVELOPMENTAL DISABILITIES PROVIDER MANUAL

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## SUMMARY OF CHANGES TABLE

**UPDATED FOR OCTOBER 1, 2021**

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
No Changes for FY2022, 2 <sup>nd</sup> Quarter			

**ALL POLICIES ARE POSTED IN DBHDD POLICYPSTAT LOCATED AT <http://gabhdd.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 clicking on [New and Recently Revised Policies](#) at the bottom of PolicyStat Home Page.

Questions or issues related to service delivery as outlined in the DBHDD Provider Manuals should be directed to your Provider Relations team: <https://dbhddapps.dbhdd.ga.gov/PIMS/Default.aspx>

Questions related to DBHDD policies located at <https://gabhdd.policystat.com> should be directed to [policyquestions@dbhdd.ga.gov](mailto:policyquestions@dbhdd.ga.gov).

Questions related to the Georgia Collaborative ASO functions such as those listed below can be directed to: [GACollaborativePR@beaconhealthoptions.com](mailto:GACollaborativePR@beaconhealthoptions.com)

- Provider Enrollment
- ASO Quality Reviews

Item#	Topic	Location	Summary of Changes
1.	COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 7/1/2021	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/10047002/latest/">https://gabhdd.policystat.com/policy/10047002/latest/</a>
2.	Planning Lists for Developmental Disability Services for Individuals Living in the Community, 02-101	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/3943407/latest/">https://gabhdd.policystat.com/policy/3943407/latest/</a>
3.	Healthcare Plans for Individuals with Intellectual/Developmental Disabilities (I/DD) in Community Residential Alternative, and Community Living Support	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/10174887/latest/">https://gabhdd.policystat.com/policy/10174887/latest/</a>

	Services with Skilled Nursing Services, 02-266		
4.	Family Support Services, Direct/Brokered Goods, and Services List and Protocols, 02-409	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/7319214/latest/">https://gabhdd.policystat.com/policy/7319214/latest/</a>
5.	Outcome Evaluation: “Recognize, Refer, and Act” Model, 02-435	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/9973217/latest/">https://gabhdd.policystat.com/policy/9973217/latest/</a>
6.	The Service Planning Process and Individual Service Plan Development, 02-438	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/9973361/latest/">https://gabhdd.policystat.com/policy/9973361/latest/</a>
7.	Support Coordination and the Incident Process, 02-440	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/9973518/latest/">https://gabhdd.policystat.com/policy/9973518/latest/</a>
8.	Selection of Support Coordination/Intensive Support Coordination Provider, 02-441	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/9977688/latest/">https://gabhdd.policystat.com/policy/9977688/latest/</a>
9.	Region of Responsibility Determination for Developmental Disability Providers, 02-602	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/2519640/latest/">https://gabhdd.policystat.com/policy/2519640/latest/</a>
10.	Risk Mitigation of Health Conditions or Vulnerabilities in Intellectual and/or Developmental Disability (I/DD) Services, 02-807	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/10171999/latest/">https://gabhdd.policystat.com/policy/10171999/latest/</a>
11.	Disaster Preparedness, Response, and Disaster Recovery Requirements for Community Providers, 04-102	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/10247079/latest/">https://gabhdd.policystat.com/policy/10247079/latest/</a>
12.	Maintenance of Records for Closed Providers, 04-117	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gabhdd.policystat.com/policy/9893124/latest/">https://gabhdd.policystat.com/policy/9893124/latest/</a>

13.	Actions Necessary upon Closure, Suspension of Services, or Termination of a DBHDD Community Services Provider, 04-119	Part IV General Policies and Procedures	<b>REVISED:</b> <a href="https://gadbhdd.policystat.com/policy/9893690/latest/">https://gadbhdd.policystat.com/policy/9893690/latest/</a>
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## **Part I**

# ***Eligibility, Service Definitions and Service Guidelines for Developmental Disability Services***

## **Provider Manual**

### **For**

## **Community Developmental Disability Providers**

### **Fiscal Year 2022**



**D·B·H·D·D**

**Georgia Department of Behavioral Health  
and Developmental Disabilities  
October 2021**

## ***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/>, under COMP/NOW PART II and 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
  - 
  - Behavior Support Services Level 1 and Level 2
  - Community Access Services
  - Community Guide Services
  - 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
  - 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**

- Section 1:** Community Service Standards for Developmental Disability Providers
- Section 2:** Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)
- Section 3:** Operational & Clinical Standards for Autism Spectrum Disorder Crisis Support Homes
- Section 4:** Request for Conversion



**Georgia Department of Behavioral Health  
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## 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 P&P 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 within arm's length distance 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 cannot provide support to another individual 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 always view the individual and intervene and provide support as needed; 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 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/>. **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 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 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 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 ISPs; 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](http://www.dbhdd.georgia.gov)); and
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 Sure scripts), 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 licensed 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 via 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) antidepressants to treat depression.
      - Inter-class Polypharmacy monitoring reports includes individuals who are on three (3) or more different classes of medications (antipsychotics, antidepressants, 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 are to be reviewed and revised as often as the severity of the individual's condition requires (i.e., change in medication, treatment, parameters, or condition) or at a minimum of annually (in conjunction with the ISP review). The review must be accompanied by an updated RN signature and date. Healthcare Plans do not expire. They are applicable to the individual until there is a condition change that results in an update or termination of the plan. For more information regarding healthcare plans 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](#).
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 demonstrates 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 onestaff 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. Behavior Support Consultant and provider 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; and
    - c. Annual TB testing (for all staff providing direct support).
    - d. Provisions for and documentation of:
      - i. Timely orientation of staff;
      - ii. Periodic assessment and development of training needs;
        - Development of activities responding to those needs; and
      - iii. 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.
  - b. Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive training in the following which shall include, but 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. Ethnic, and Cultural Diversity 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;
      - Skills 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 their side effects (\*);
- xiv. Suicide Prevention Skills Training (such as AIM, QPRP);
- xv. Ethics and Corporate Compliance training is evident.
- xvi. Training to work with individuals who have co-occurring 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. (\*)
- xviii. 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.

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 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 [www.dbhdd.ga.gov](http://www.dbhdd.ga.gov), 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);
  - c. for individuals who communicate in American Sign Language (ASL), interpreters capable of interpreting 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](mailto: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 B) 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](http://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 Rights 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 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; and
  - 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.

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 Georgia Crisis Response System 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/>. 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;
  - g. An area/room for visitation; and
  - h. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported.
  - i. 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.
3. 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; including;
    - ii. Twice a year during sleeping hours if residential services;
    - iii. All fire drills shall be documented with staffing involved;



- iv. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
4. 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.
  5. 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.
  6. 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.**
  7. 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.
- 8. 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.
- 9. 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 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 Individual Service Plan 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. Specific to the desired outcomes;
  - b. Measurable for progress;
  - c. Achievable skills;
  - d. Relevant to service provision; and
  - e. Time-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 Health Risk Screening Tool 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.

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 VI-19.
    - e. Data on subcontractors providing direct member care.
    - 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.
      - 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; and
  - 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); and
  - g. Supporting individual's choice as measured by the amount of control an individual has over his/her life.
  - 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) (Refer to [Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities, 02-601](#) for details).
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; and
  - 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.
    - 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 Protected Health Information;
  - c. A brief description of the Protected Health Information 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 Protected Health Information 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 Protected Health Information 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 Protected Health Information 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. Refer to the Professional Designations Section G in the DBHDD Provider Manual for Community DD Providers Part II Section 1 of the Community Service Standards for a list of Professionals who qualify to be a DDP.

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 (DDP) 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/> 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 (DDP) Competency:**

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

#### **Performance indicators of the responsibilities listed are 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;
- 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 o has one year experience in treating persons with intellectual/developmental disabilities.
- 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 [www.dch.georgia.gov/hfr-laws-regulations](http://www.dch.georgia.gov/hfr-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.
  - 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:**

<b>Antipsychotic Medications</b>	
<b>Generic</b>	<b>Trade</b>
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Serentil
Mesoridazine	Lidone
Molindone	Moban
Olanzapine	Zyprexa
Paliperidone	Invega*
Perphenazine	Trilafon
Pimozide (for Tourette's)	Orap
Quetiapine	Seroquel
Risperidone	Risperdal*
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine
Trifluopromazine	Vesprin
Ziprasidone	Geodon
<b>Mood Stabilizer Medications</b>	
<b>Generic</b>	<b>Trade</b>
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 form

## **PART II**

### **Section 2**

# ***Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)***

## **Provider Manual**

**For**

**Community Developmental Disability Providers**

**Fiscal Year 2022**



**Georgia Department of Behavioral Health  
and Developmental Disabilities  
October 2021**

**D·B·H·D·D**

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## **PROGRAM DESCRIPTION**

The Georgia Crisis Response System (GCRS) provides community-based crisis services that support individuals with I/DD in their communities as an alternative to institutional placement, emergency room care, and/or law enforcement involvement, including incarceration. By design, these services, hereinafter referred to as “intensive in-home” and “intensive out-of-home,” are a measure of last resort and provided on a time-limited basis to ameliorate the presenting crisis. As an intended outcome of these services, the interventions should enhance the family and/or caregiver’s ability to meet the needs of the individual and minimize the need for the individual to leave his/her home in order to resolve the presenting crisis.

The individual’s assessment, completed by Mobile Crisis, is an essential part of this service delivery system in that it determines the appropriate response for the presenting crisis. Entry into this system takes place through the Georgia Crisis and Access Line, available toll-free 24/7. Intake staff determine if an individual meets the criteria for Mobile Crisis dispatch.

### **A. GENERAL REQUIREMENTS**

1. All intensive in-home and intensive out-of-home providers must comply with the Community Service Standards for Developmental Disabilities Providers found in the *DBHDD Provider Manual for Community Developmental Disabilities Providers* as applicable for crisis services, as well as the Operational and Clinical Standards for GCRS.
  - a. Prior to operation, a compliance review of the GCRS, to include intensive in-home and intensive out-of-home, should be conducted.
  - b. When the provider is found in compliance with the aforementioned standards, a one-year certificate is provided to operate these services. The certificate is non-transferrable and for each specific site. Note: At any time, DBHDD may request a special compliance review to assess the provider’s compliance with these standards. In addition, individuals receiving intensive out-of-home services shall receive additional clinical oversight to ensure that their medical and behavioral needs are met.
2. The following requirements are applicable to organizations that provide crisis support services to individuals, family members, caregivers, and/or DD waiver provider agencies that access the Georgia Crisis Response System. This system should be utilized for an acute crisis that may present with a substantial risk of imminent harm to self or others or behavior with seriously negative consequences. As a result, the situation may require interventions/actions beyond those outlined in the individual’s Behavior Support Plan/Safety Plan, if applicable. To support individuals in the most integrated, inclusive settings, it is preferred that intensive in-home is rendered, if clinically indicated, prior to referring an individual to intensive out-of-home. Intensive out-of-home is not to be used as respite or to address housing instability absent a behavioral crisis as assessed by Mobile Crisis.
  - a. Intensive in-home and intensive out-of-home staff will coordinate with the individual’s current provider(s), when applicable, for assessment and to recommend any changes in services. Mobile Crisis assesses individuals ages 4 and older who meet eligibility criteria for dispatch. Intensive in-home serves individuals ages 4 and older, while intensive out-of-home is available only to adults ages 19 and older and children ages 10 through 18. Decisions regarding interventions are based on an assessment to ensure that the least restrictive interventions likely to be successful are utilized and to justify the need for any restrictive interventions and/or or placements, i.e. referrals to intensive out-of-home

supports, Crisis Stabilization Units, or other recommended care that meets the needs of the individual.

- b. Plans intended to modify behavior over time (not including agency's crisis plans) will not be developed unless appropriate behavioral assessments are completed, the individual and caregiver are willing to accept this support, and the staff who develop the plans are able to provide follow-up support, replacement activities and training.
- c. Discharge planning should begin at intake and continue throughout utilization of intensive crisis supports. The discharge planning process should include collaboration with all applicable parties, family members/provider(s), Support Coordination, and Regional Field Office staff, including the Planning List Administration and Intake and Evaluation (I&E) teams. The social work staff in the Crisis Response System must coordinate this process with the oversight of a Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC). The discharge process from intensive out-of-home is governed by an established transition process with clearly defined responsibilities of all involved stakeholders.
- d. If an individual is referred to the intensive out-of-home support, the Mobile Crisis Provider is responsible for arranging transportation for the individual to the intensive out-of-home site. Upon discharge from this service, the crisis provider is responsible for arranging transportation or transporting the individual to their place of residence or new provider, if applicable.
  - i. In addition to current reporting requirements, DD crisis providers must send an email to the DD Crisis Manager/Director of DD Field Operations, and both the Regional Services Administrators of the individual's region of origin and the region of the intensive out-of-home site within 24 hours of admission or discharge. In addition, information for the current or potential provider to be included such as the providers/agency's name, contact information and address. Documented evidence of notification will be maintained by the intensive out-of-home provider. This provider is also required to input the individual's information in the I/DD Crisis Beds Inventory Status Board on BHL Web within 24 hours of admission. The same requirements apply at discharge.

## **B. Intake Requirements**

1. Refer to [Provider Manual for Community Behavioral Health Providers, 01-112](#) for definition of Mobile Crisis.

## **C. Intensive In-Home and Out-of-Home Staffing Requirements**

1. The crisis provider will have sufficient staff at all times to provide intensive in-home and out-of-home services simultaneously.
  - a. Staffing composition must include, at minimum, an LCSW/LPC, behavior specialist, RN, and sufficient direct support staff. The crisis provider may supplement this staff with additional direct support staff, MSW, RN, LPN, and Safety Officers. A psychiatrist should remain available for consultation.
  - b. The use of proxy care in intensive out-of-home services is strictly prohibited.
  - c. The crisis provider is required to notify the DD Crisis Manager staff vacancies that impact service delivery and may be required to submit an interim staffing plan.

2. All licensed or certified team members are required to comply with [Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations, 04-101](#) maintaining valid/current license or certification.
3. The LCSW/LPC provides clinical oversight of service provision and ensures that all documentation is completed in compliance with these standards and related policies.
4. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed (i.e. [Nondiscrimination and Accessibility for Individuals with Disabilities and Individuals with Limited English Proficiency, 15-100](#), and [DBHDD Field Office Access Coordinators, 15-103](#)). In addition, crisis providers must consult with the Office of Deaf Services, in accordance with policy, for additional evaluation and support, if needed.

**D. Case Management by Crisis Provider:**

1. Once the presenting crisis has been stabilized, individuals receiving intensive in-home or intensive out-of-home support shall also receive case management provided by the provider. Case management continues until the individual is safely transitioned. Individuals receiving intensive out-of-home services are automatically eligible for Intensive Support Coordination during their admission and for at least 30 days post-transition.
2. Case management is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, collaborate with the individual, Intensive Support Coordination, provider/family, behavioral health providers, behavior support providers, and other community-based providers for the development of a discharge plan.

**E. Intensive Crisis Support Services Requirements:**

1. The Crisis Provider must maintain and develop protocols that describe processes for the provision of intensive crisis supports. At a minimum, the description must include the following processes:
  - a. Accessing Intensive Crisis Supports;
  - b. Types of Intensive Crisis Supports it plans to provide;
  - c. Procedures for utilizing Intensive Crisis Supports both in and out of the individual's home.:  
and
  - d. Follow-up recommendations for on-going individual care that includes Family and/or Provider supports, linkages and training.
2. When behavioral interventions are necessary, Crisis Response staff follow applicable *Best Practice Standards for Behavioral Support Services* and the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disabilities Providers as applicable to crisis supports services. The Guidelines for Supporting Adults with Challenging Behavior in Community Settings* provides additional information to consider when developing intervention strategies. (The standards and guidelines are found at [Provider Information: Provider Toolkit](#)).
3. With the oversight of a licensed clinician, the Mobile Crisis Team determines and documents the existing level of crisis that requires the initiation of intensive crisis supports. Referrals to intensive crisis supports are initiated through Mobile Crisis. Please note, the individual must have evidence of a DD diagnosis in order to access these services.
  - a. The criteria to receive intensive in-home include:
    - i. The Mobile Crisis Team is not able to mitigate the crisis in a reasonable amount of time OR

- ii. The crisis was resolved but environmental variables and/or the individual's lack of adaptive behavioral responses make another crisis imminent AND
    - iii. The caregiver or DD service provider is not capable of providing necessary intervention and protection for the individual or others living with the individual AND
    - iv. The intensive in home crisis supports will enable the individual to avoid institutional placement (such as a placement in a behavioral health hospital, nursing home, jail or correctional facility).
  - b. The criteria to receive intensive out-of-home include:
    - i. All of the intensive in-home supports criteria AND
    - ii. The safety of others living in the home with the individual or others living in the community cannot be maintained through the use of Intensive In-Home Supports with written justification based on clinical observation and/or assessment OR
    - iii. Extensive physical environmental modifications are needed because of the crisis and the individual cannot safely reside in the home with Intensive In-Home Supports while modifications are completed.
    - iv. May not be used as respite or to address housing instability absent a behavioral crisis as assessed by the Mobile Crisis Team. In addition, this service will not be used to address allegations of abuse, neglect, or exploitation in which funding from Child/Adult Protective Services or other state agencies is available.
- 4. When the individual meets the following criteria, he/she must be discharged from the service with an accompanying written discharge plan indicating at a minimum that:
  - a. The crisis has been resolved and a plan has been developed that identifies early interventions to prevent future crisis or allows current caregivers, family or staff to maintain safety should future crises arise AND
  - b. Family and/or all providers providing direct supports have been trained and can implement all components of the plan AND
  - c. The individual has met the discharge criteria and the plan of discharge was developed in collaboration with and reviewed with family, Support Coordination, Regional Field Office staff and/or DD service provider(s) OR
  - d. The individual exhibits medical conditions requiring more intensive medical care that cannot be provided through intensive crisis supports.
- 5. Prior to admission, the crisis provider will review the rules and procedures of this service as part of the consent for treatment. If the individual's family, caregivers, friends, or other visitors do not comply with the rules such that it causes, or has the potential to cause, a significant disruption to the milieu and/or safety risk to the individuals and staff, the crisis provider reserves the right to restrict and/or prohibit visits. In the event this occurs, the crisis provider should provide education about the rules and establish a plan to resume visits, provided it is safe and therapeutically beneficial for the individual.
- 6. In addition, individuals who spend more than 48 consecutive hours, planned or unplanned, in the care of natural or paid caregivers without the assessed need by the out-of-home provider to return to this service for further stabilization or additional opportunities for transition preparedness, will be discharged from this service. Exceptions will apply to those individuals who must have routine trial visits in preparation for transition.
- 7. If the individual will be admitted from an inpatient or acute care setting (i.e., ER), the individual must be free from the administration of chemical restraint (i.e., PRN psychotropic, anxiolytic,

sedative medication) and the application of physical restraint (i.e., 2-point and 4-point restraints) for at least 24 consecutive hours prior to admission. Intensive out-of-home is not an environment or service that should be used for psychiatric stabilization.

**F. Intensive In-Home Support Requirements:**

1. Intensive In-Home Support services include, but are not limited to the following:
  - a. Implementation of behavioral intervention strategies, under the direction of the crisis provider behavior specialist/clinician and, when applicable, in collaboration with behavior service providers already working with the individual, to include any effective interventions outlined in the individual's current behavioral support and/or safety plan. Other in-home supports include the provision of one-to-one support to address the crisis; modeling of interventions with family and/or provider staff; identification of needed supports for individuals dually diagnosed, assistance with simple environmental adaptations as necessary to maintain safety; and, when necessary, accompanying the individual to appointments related to the crisis supports.
  - b. The provision of a staffing pattern up to 24 hours per day, seven (7) days per week, with the intensity of the staff supports decreasing over seven (7) calendar days. When an individual is in the care of paid caregivers, intensive in-home should only be provided when the residential/CLS provider confirms the staffing ratio required by the individual's ISP. In-home services are not to be used for staffing coverage.
  - c. Maintenance of stakeholder's involvement in the response to the crisis, in order to restore the individual to pre-crisis supports and/or provider services.
  - d. Training provided by qualified professionals, including behavioral specialists to support crisis stabilization and the return of the individual to pre-crisis services and supports, to include:
    - i. Demonstration of interventions to the family/caregiver and/or existing DD service provider (if applicable);
    - ii. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable); and
    - iii. Decrease dependence on restrictive services such as hospital emergency rooms and jails and to focus on effective crisis plans that are more proactive than reactive and to prevent or manage crisis with as little a change in their day-to-day community life.
2. Documentation of Intensive In-Home Support services is to:
  - a. Occur on a daily basis;
  - b. Include a description of the behavioral interventions utilized; and
  - c. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.
3. As a time-limited response, intensive in-home services should not exceed seven (7) calendar days. Extensions beyond seven (7) calendar days are the exception and are not typical. However, clinical follow-up by the behavior specialist or clinician is allowed for up to fourteen (14) days when the need is justified and documented appropriately.
  - a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the provider.
  - b. Extensions beyond 7 calendar days are to be approved by the DD Crisis Manager or designee. Note: As soon as the crisis provider's staff indicates the need, the DD Crisis Manager or



designee engages and reviews all necessary information for an individual whose circumstances determine the need for this exception.

4. Intensive In-Home providers must develop and maintain operational protocols for the service. At a minimum, protocols must include detailed descriptions of processes that address:
  - a. Stabilization interventions that emphasize positive approaches and protect the health and safety of the individuals, and include the utilization of professional consultation; training available to individuals, family members, and providers; utilization of existing positive behavior support plan and safety plans; ongoing assessment of health and safety needs by qualified professionals; and the role of direct support professionals when working in an individual's home;
  - b. Referral and/or transport to intensive out-of-home crisis supports. Note: Justification for why out-of-home crisis supports is recommended needs to be included in the referral;
  - c. Referral to hospital emergency department to include justification for the referral.
5. **Training Requirements:** Training records are to be maintained, which document that all Crisis Response System staff (in-home and out of home) have participated in training (that includes applicable DBHDD Community Services Standards required trainings) and there is documentation to demonstrate their competence in all crisis protocols and relevant applicable trainings that includes but is not limited to:
  - a. Single Point of Entry (SPOE):
    - i. Mobile crisis dispatch criteria
    - ii. Telephonic crisis intervention
  - b. Mobile team members and intensive support staff are trained in protocols for:
    - i. Assessing the crisis (specific I/DD training in treating and diagnosing problems)
    - ii. Onsite service operations determination for any risks
    - iii. Referral decision criteria
    - iv. Required crisis intervention curriculum
      - Crisis Prevention Institute (CPI) [www.crisisprevention.com](http://www.crisisprevention.com)
      - Handle with Care Behavior Management System, Inc. [www.handlewithcare.com](http://www.handlewithcare.com)
      - Mindset <http://interventionsupportservice.com/>
      - Safe Crisis Management [www.jkmtraining.com](http://www.jkmtraining.com)
      - Safety- Care (QBS, Inc.) [www.qbscompanies.com](http://www.qbscompanies.com)
    - v. Cardiopulmonary Resuscitation (CPR)
    - vi. First Aid
    - vii. Documentation standards and expectations
    - viii. Person Centered Planning
    - ix. Training in working with I/DD population with dual/co-occurring diagnosis, and
    - x. Training in Trauma Informed Care for individuals with I/DD.

#### **G. INTENSIVE OUT-OF-HOME SUPPORT REQUIREMENTS FOR CRISIS SUPPORT HOMES**

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided in the DD Crisis Support Homes, which may provide crisis supports to no more than four individuals simultaneously. Individuals under the age of 18 years cannot be served in an Adult DD Crisis Support Home. There is currently no required licensure for the DD Adult Crisis Support Homes. However, each DD Crisis Support Home (both Adult and Child & Adolescent) must receive an initial DBHDD

compliance review, which is valid for six months, and approximately, after six months of serving individuals, a full compliance review will be conducted. Provider will adhere to [Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02-703](#).

Referrals to this service are initiated by Mobile Crisis and reviewed/approved by the DD Crisis Manager or designee.

#### *G-1. DD CRISIS SUPPORT HOME PROTOCOL FOR OPERATIONS*

1. Intensive out-of-home providers must develop and maintain protocols for the DD Crisis Support Homes that include but are not be limited to:
  - a. Criteria for determining when and if a referral to an out-of-home crisis support is necessary;
  - b. Staffing plan to include the minimum staffing of a registered nurse, a licensed professional nurse, day, evening and night staff, a behavior specialist, and a psychologist;
  - c. Transportation plan to and from home(s);
  - d. The availability of a licensed clinical social worker to assist crisis support home staff with case management and discharge planning services, to ensure that appropriate referrals and/or coordination of services are part of the transition back to the home environment.
  - e. Accessing emergency health services;
  - f. Medication Management;
  - g. Utilization of an individual's health care plan and protocols;
  - h. Utilization/development/revision of an individual's behavior support plan and/or safety plan, when applicable;
  - i. Identification of needed BH/DD supports for individuals with dual diagnosis; and
  - j. Coordination with an individual's family, support coordinators, residential providers, behavioral support professionals, Regional Field Office, and health care providers, as applicable. The focus of the collaboration is to enable the individual to return home or to the previous placement as appropriate.
2. In addition, the protocols must meet the following:
  - a. For anyone not currently receiving I/DD services, provider must contact the Regional Field Office within 24 hours of admission to initiate eligibility determination.
  - b. Intensive out-of-home support should be used a time-limited, goal directed service and never viewed as a residential option.
  - c. Discharge is determined by the individual's behavioral stability and availability of community-based supports identified to appropriately address the individual's assessed needs. Although admission is not intended to be greater than 30 days, the Division acknowledges that stability is an individual construct and, as a result, some individuals may require longer – or shorter – lengths of stay.
  - d. DD Crisis Manager reviews the status of all transitions at least biweekly and monitors progress as reflected in the crisis transitions process. The DD Crisis Manager addresses transition barriers with the Intensive Support Coordinator and crisis provider.
3. The development of a discharge plan is to be person-centered, beginning at intake and noting:
  - a. An evaluation of additional supports and services by Intensive Support Coordinator
  - b. Intensive support team has trained the staff in post-crisis services placement and/or family members regarding any interventions utilized in the out-of-home crisis placement that will be needed upon transition back home.
4. Upon discharge from this service, the individual may:

- a. Return to his/her family home or provider placement;
  - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) version change based upon the long-term interests of the individual and in accordance with DBHDD policies.
5. Support services and discharge planning case management are to be documented daily by appropriate staff.
  6. Records of pre-service and annual training of Crisis Support Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.
  7. Intensive out-of-home services are voluntary. As such, an individual and/or his/her legal guardian has the right to request discharge at any time. In this event, the crisis provider should adhere to the following escalation protocol:

<b>Presents with <u>no</u> plan or access to supports<sup>1</sup></b>	<b>Presents <u>with</u> a plan and access to supports<sup>2</sup></b>
<ol style="list-style-type: none"> <li>1. Clinical/supervisory staff will meet with the individual to explore reasons for wanting to leave the crisis home.</li> <li>2. Clinical/supervisory staff will ask the individual what supports are needed in order to feel safe/supported in the crisis home and will implement supports, within reason.</li> <li>3. Clinical/supervisory staff will review replacement behaviors and/or coping skills with the individual and use de-escalation strategies to address the situation.</li> <li>4. Clinical/supervisory staff will discuss options and related consequences if the individual (a) decides to remain in the crisis home and (b) decides to voluntarily discharge from this service.</li> <li>5. Clinical/supervisory staff will document the individual's response to all interventions.</li> </ol>	<ol style="list-style-type: none"> <li>1. Clinical/supervisory staff will meet with the individual to explore options as identified by the individual.</li> <li>2. Clinical/supervisory staff will support the individual in informed decision-making, contemplating consequences of (a) remaining in the crisis home and (b) discharging from the crisis home.</li> <li>3. If individual maintains his/her decision to discharge, clinical/supervisory staff will engage the individual in thoughtful planning and will confirm individual's residence post-discharge.               <ul style="list-style-type: none"> <li>a. Crisis provider should offer intensive in-home for a period post-discharge if the environment allows for such intervention.</li> </ul> </li> <li>4. Clinical/supervisory staff will document the individual's response to all interventions.</li> </ol>
<b>Required communication from the crisis provider:</b>	
<ol style="list-style-type: none"> <li>1. Clinical/supervisory staff will <b>call and email</b> the I/DD Crisis Manager and Intensive Support Coordinator (a) within 2 hours if de-escalation strategies are proving to be ineffective or (b) within 4 hours if de-escalation strategies are proving to be effective, with the latter serving as notification of the individual's actions. Clinical/supervisory staff will provide hourly updates to the I/DD Crisis Manager via email or phone call, based on their judgment, until the situation is resolved.               <ul style="list-style-type: none"> <li>a. If an individual requests discharge to a homeless shelter, the I/DD Crisis Manager should be notified within an hour of this request.</li> </ul> </li> <li>2. In turn, the I/DD Crisis Manager will notify RSA (region of origin), Regional Field Operations Director, Office of Transitions, and Intensive Support Coordinator via email (or phone call, depending on the situation) for further consultation and planning.</li> </ol>	

<sup>1</sup> Expresses a *desire* to leave the crisis home, displays behaviors that indicate a desire to discharge (i.e., elopement attempts) but has no actionable plan

<sup>2</sup> Expresses a *plan* to discharge, with access to resources, money, and/or supports

*G-2. DD CRISIS HOME PHYSICAL ENVIRONMENT REQUIREMENTS:*

1. A residence must be constructed, arranged, and maintained so as to provide adequately for the health, safety, access, and well-being of the individual and meet ADA requirements for accessibility and safety.
2. A Crisis Support Home must provide for common living space, dining and private sleeping areas;
  - a. The living and sleeping areas for an individual must be within the same building;
  - b. Supportive devices must be installed as necessary to enable the individual to achieve a greater degree of mobility and safety from falling;
  - c. The general floor plan of the home provides for optimal line of sight observations throughout the home. Blind spots shall be addressed through use of unbreakable convex viewing mirrors that allow visual access by staff;
  - d. All DD Crisis Support Homes must provide an area that affords privacy for the individual and visitors. There must be common spaces, such as living and dining rooms, for use by the individual without restriction;
  - e. Common areas of the residence must be large enough to accommodate the individual without crowding. The areas must be comfortably furnished;
  - f. Upon request, the residence must provide a means of locked storage for the valuables or personal belongings of the individual;
  - g. The residence must provide laundering facilities on the premises for individual's personal laundry;
  - h. All stairways and ramps must have sturdy handrails, securely fastened not less than 30 inches nor more than 34 inches above the center of the tread. Exterior stairways, decks, and porches must have handrails on the open sides unless the surface of the deck or porch is so close to ground level that it does not pose a significant risk of injury to the individual to fall from the deck or porch. If railings include balusters, the spacing should not allow for an individual to put their head through them.
  - i. Floor coverings must be intact, safely secured, and free of any hazard that may cause tripping;
  - j. All areas including hallways and stairs must be lighted sufficiently. Lights shall have flush mounted lighting fixtures that are tamper proof with Lexan or other strong translucent materials. Light switches and electrical outlets shall be secured with non-tamper type screws.
  - k. The following exterior conditions must be maintained;
    - i. Entrances and exits, sidewalks, and escape routes must be maintained free of any obstructions that would impede leaving the residence quickly in the case of fire or other emergency. All such entrances and exits, sidewalks, and escape routes must be kept free of any hazards such as ice, snow, or debris,
    - ii. The yard area, if applicable, must be kept free of all hazards, nuisances, refuse, and litter, and
    - iii. The residence must have its house number displayed, to be easily visible from the street.
    - iv. The home must provide for an outside area where individuals may have access to fresh air and exercise. The area must provide privacy from public view and be constructed/designed to minimize elopement from the area.

3. The following minimum standards for bedrooms must be met:
  - a. Bedrooms must have sufficient space to accommodate, without crowding, the individual, the individual's belongings, and the minimum furniture of a bed and dresser;
  - b. The individual's bedroom must have at least one window (screened and in good repair for ventilation) and a closet. In addition, all windows shall be protected with a safety film preferably textured for privacy (so curtains/drapes will not be required) to protect against glass breakage, hold glass pieces in place in an impact situation or prevent dangerous flying glass pieces. For newer house construction or replacement of windows, the use of Tempered glass/Lexan/Plexiglass is required.
  - c. Bedrooms for individuals must be separated from halls, corridors, and other rooms by floor to ceiling walls. Hallways must not be used for sleeping;
  - d. The floor plan must be such that no person other than the occupant of that bedroom must pass through a bedroom in order to reach another room;
  - e. The bedroom occupied by the individual must have doors that can be closed. For bedrooms that have locks on doors, both the occupant and staff must be provided with keys to ensure easy entry. Double-cylinder locks (locks requiring a key on both sides) may not be used on the bedroom of an individual. Doors shall not be locked from within and shall be capable of swinging outward or be mounted so that the door can be removed from outside if the door is barricaded from the inside;
  - f. A room must not be used as a bedroom where more than one-half of the room height is below ground level. Bedrooms which are partially below ground level should have adequate natural light and ventilation and be provided with two useful means of egress;
  - g. When an individual is discharged, the room and its contents must be adequately cleaned;
  - h. Each bedroom must contain a standard, non-portable bed measuring at least 36 inches wide and 72 inches long with comfortable springs and a clean mattress. The mattress must be not less than five (5) inches thick or four (4) inches of a synthetic construction. The use of beds with springs, cranks, rails or wheels including hospital beds, rollaway beds, cots, bunk beds, stacked, hide a beds and day beds is prohibited; and
4. Beds and other furniture capable of being used to barricade a door shall be secured to the floor or wall. The following minimum standards apply to bathroom facilities:
  - a. At least one functional toilet, lavatory, and bathing or showering facility must be provided for every four individuals residing in a Crisis Support Home;
  - b. At least one fully handicap accessible bathroom must be available;
  - c. Flush mounted safety grab bars must be installed in all showers and area near the toilet;
  - d. Non-skid surfacing or strips must be installed in all showers, tubs and bathing areas;
  - e. Bathrooms and toilet facilities must have a window that can be opened or must have forced ventilation;
  - f. Toilets, bathtubs, and showers must provide for individual privacy;
  - g. Shower head fixture in bathrooms shall be recessed or have a smooth curve from which items cannot be hung and/or bear weight;
  - h. There shall be no overhead metal rods, fixtures, privacy stalls supports or protrusions capable of carrying more than a thirty (30) pound load;
  - i. Mirrors shall not be common glass. A polycarbonate mirror, fully secured and flat mounted to the wall is required. Polished metal mirrors shall not be permitted;
  - j. The toilet shall be a flushometer-type, not residential with water tank and cover; and
  - k. Access to a bathroom shall not be through another individual's bedroom.

*G-3. CRISIS SUPPORT HOME FURNISHINGS AND FIXTURES:*

1. Furnishings in the living room, bedroom, and dining room, including furnishings provided by the individual, must be maintained in good condition, intact, and functional.
2. Furnishings and housekeeping standards must be such that a residence presents a clean and orderly appearance. The Crisis Support Home must provide the following bedroom furnishings based on safety:
  - a. An adequate closet or wardrobe;
  - b. Lighting fixtures sufficient for reading and other activities;
  - c. A bureau, bed, dresser, or the equivalent and preferably weighted throughout the home site; and
  - d. The furnishings shall be of durable materials not capable of breakage into pieces that could be used as weapons and must not present a hanging risk.
3. The Crisis Support Home must provide to each individual clean towels, washcloths at least twice weekly, and more often if soiled.
4. The Crisis Support Home must provide bedding for each individual including two sheets, a pillow, a pillowcase, and a minimum of one blanket and bedspread. The Crisis Support Home must maintain a linen supply for not less than twice the bed capacity and must adapt the supply to meet any special needs of an individual.

*G-4. CRISIS SUPPORT HOME PHYSICAL PLANT, HEALTH, AND SAFETY STANDARDS*

1. Each Crisis Support Home must provide a safe and healthy environment for its individuals, and where subject to fire and safety standards promulgated by Office of the Safety Fire Commissioner, such Crisis Support Home must comply with those standards.
2. Each Crisis Support Home must comply and remain in compliance with all state and local ordinances for fire safety in residences of that size and function. In the absence of or in addition to any such local ordinances, the following requirements must be met:
  - a. Wall-mounted electric outlets and lamps or light fixtures must be maintained in a safe and operational condition;
  - b. Cooking appliances must be suitably installed in accordance with approved safety practices;
  - c. Space heaters must not be used;
  - d. Fire screens and protective devices must be used with fireplaces, stoves, heaters, and air-conditioning units;
  - e. If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence must be protected with carbon monoxide detectors;
  - f. Each residence must have at least one charged, 5 lb. multipurpose ABC fire extinguisher on each occupied floor and in the basement that must be readily accessible. These extinguishers must be checked annually by a fire safety technician and monthly by the staff of the Crisis Support Home to ensure they are charged and in operable condition;
  - g. Exterior doors must be equipped with locks that do not require keys to open the door from the inside;
  - h. An automatic extinguishing system (sprinkler) shall be installed per city/county requirement for residential settings not governed by other federal, state and county rules and regulations, if applicable; and

- i. An approved smoke alarm with battery backup shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences per safety code. The smoke alarms when activated/tested must initiate an alarm that is audible in the sleeping rooms. All smoke alarms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained. Note: For individuals with special needs such as hearing impairment or deep sleepers who have difficulty in waking to a typical smoke alarm, an alternate safety plan must be addressed in policy and implemented in their sleeping room such as using a Smart Strobe Light smoke alarm or an alarm designed to give reliable early warning of the present of smoke when both audible and visual alarms are required. Strobe type smoke alarms are not recommended for individuals who have epilepsy/seizure disorder.
3. Water and sewage systems must meet applicable federal, state, and local standards and regulations.
4. Floors, walls, and ceilings must be kept clean and in good repair.
5. Kitchen and bathroom areas must be cleaned with disinfectant and maintained to ensure cleanliness and sanitation.
6. The storage and disposal of biomedical wastes and hazardous wastes must comply with applicable federal and state rules and standards.
7. The storage and disposal of garbage, trash, and waste must be accomplished in a manner that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents. Waste must be removed from the kitchen as necessary and from the premises at least weekly.
8. No animals/pets may be kept at the residence with the exception of a service animal;
9. Poisons, caustics, and other dangerous materials must be stored in clearly labeled and appropriate containers, safeguarded in an area away from medication storage areas and from food preparation and storage areas and secured as required by the capacity of the individuals.
10. The Crisis Support Home must be equipped and maintained so as to provide a sufficient amount of hot water for the use of the individuals. Heated water provided for use by individuals must not exceed 120 degrees Fahrenheit at the hot water fixture, unless a cooler temperature is required by the needs of the individual. **A water temperature monitor or a scald valve must be installed where necessary to ensure the safety of the individuals.**
11. There must be clearly accessible route(s) for emergencies throughout the residence.
12. The temperature throughout the residence must be maintained by a central heating system or its equivalent at ranges that are consistent with individual's health needs. No individual must be in any area of the residence that falls below 65 degrees or that exceeds 82 degrees Fahrenheit.
13. There must be a supply of first-aid materials available with a minimum of the following: bandages, antiseptic, gauze, tape, thermometer, and gloves.
14. No weapons shall be kept in the Crisis Support Home.
15. The Crisis Support Home staff shall have access to provide 24/7 non-emergency transportation as needed.

#### *G-5. CRISIS SUPPORT HOME RECORD MANAGEMENT*

1. All records must be kept in accordance with requirements of the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disability Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*.

*G-6. CRISIS SUPPORT HOME DOCUMENTATION OF SERVICES*

1. Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:
  - a. Dates (beginning and ending) of service
  - b. Completed intake/evaluation documents (Medical and/or Behavioral Assessment)
  - c. Determined model of support
  - d. Discharge plan
2. Additionally, documentation of Intensive Out-Of-Home Support services is to:
3. Occur on a daily basis;
4. Include a description of the behavioral interventions utilized;
5. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.

*G-7. CRISIS SUPPORT HOME INDIVIDUAL FILES AND INFORMATION*

1. All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Section t, Section I, Community Standards for All Providers.

*G-8. INDIVIDUAL RIGHTS IN A CRISIS SUPPORT HOME*

1. All services delivered should be in accordance with Client's Rights Chapter 290- 4-9 and [Human Rights Council for Developmental Disability Services, 02-1101](#).

*G-9. ABUSE IN A CRISIS SUPPORT HOME*

1. It is expressly prohibited to mistreat; abuse; neglect; exploit; seclude; and apply physical restraint as punishment, for staff convenience, or to restrict movement to all youth in this service.
2. All staff must receive training on critical incident reporting as outlined in [Reporting Deaths and Other Incidents in Community Services, 04-106](#).
3. Provider will comply with the definitions of seclusion and physical restraint contained in this manual.
4. Refer to Part II, Section 1, in this manual for additional details.

*G-10. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A CRISIS SUPPORT HOME*

1. Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to [Reporting Deaths and Other Incidents in Community Services, 04-106](#) found in the Georgia Department of Behavioral Health and Developmental Disabilities PolicyStat Webpage (<http://gadbhdd.policystat.com>).

*G-11. CRISIS SUPPORT HOME SERVICES*

1. Each Crisis Support Home must provide room, meals, and crisis services that are commensurate with the needs of the individuals to include special diets. Services must be provided by appropriately qualified staff members.
2. Personal hygiene assistance must be given to those individuals who are unable to keep themselves neat and clean.



3. The Crisis Support Home administrator or his or her designee must teach each individual the techniques of “Standard Precautions,” as appropriate to the individual’s ability, or must support each individual in the performance of the techniques of “Standard Precautions,” including washing his or her hands thoroughly after toileting, sneezing, or any other activity during which the individual’s hands may become contaminated.
4. The routine of the residence must be such that an individual may spend the majority of his or her non-sleeping hours out of the bedroom if he or she so chooses. Activities/positive coaching or modeling training must be provided to increase positive replacements behaviors according to each individual’s plan of care as determined by the MCT.
5. The Crisis Support Home administrator or his or her designee must be available to any person within the Crisis Support Home, including each individual served.

*G-12. NUTRITION SERVICES IN A CRISIS SUPPORT HOME*

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning (breakfast), at midday(lunch), and the evening(supper), with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least two nutritious snacks must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a Crisis Support Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A Crisis Support Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.
5. A Crisis Support Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned. Items for individualized special diet included, if applicable.
6. A Crisis Support Home must arrange for and serve special diets as prescribed.
7. The Crisis Support Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

*G-13. MEDICATION MANAGEMENT IN A CRISIS SUPPORT HOME*

1. All medication must be kept and administered in accordance with requirements of the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disability Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*. **Note:** A Crisis Support Home shall not utilize staff in the Proxy Caregiver Role.

G-14. *DISASTER PREPAREDNESS AND RESPONSE PLAN FOR CRISIS SUPPORT HOME:*

1. In the case of a natural disaster (i.e. tornado, flood, hurricane etc.) the crisis provider must develop a plan in compliance with [Disaster Preparedness, Response, and Disaster Recovery Requirements for Community Providers, 04-102](#). Crisis providers must notify the DD Crisis Manager and Director of Field Operations of any need to evacuate a home.

**H. Intensive Out-of-Home Support Requirements for Children and Adolescents (C&A):**

1. Children and Adolescent between ages 10-18 years needing intensive out of home case management must be served in a Child & Adolescent (C&A) out-of-home site. The intent of this service is to provide nursing and behavioral support on a time-limited basis. The C&A out-of-home site must receive an initial DBHDD compliance review, which is valid for six months, and approximately, after six months of serving individuals, a full compliance review will be conducted. Providers will adhere to [Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02-703](#).
2. The C&A Home provider must comply with the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disability Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*. C&A Home supports will be available twenty-four hours a day, seven days a week, and 365 days a year. It is critical that children and adolescents remain in their family home environment and thus extraordinary circumstances must exist in order to place children and adolescent in this level of support.
3. Referrals to this service are initiated by Mobile Crisis and reviewed and approved by the Autism and I/DD Crisis Services Manager or designee.

*H-1. C&A HOME PROTOCOL FOR OPERATION*

1. C&A providers must develop and maintain protocols that include but are not be limited to:
  - a. Criteria for determining when and if a referral to a C&A Home is necessary
  - b. Staffing plan to include the minimum staffing of an RN, Behavior Specialist, C&A coordinator, C&A staff, and a Psychiatrist.
  - c. Transportation plan to and from home(s)
2. In addition, the protocols must meet the following:
  - a. Intensive out-of-home support should be used a time-limited, goal directed service and never viewed as a residential option.
  - b. Discharge is determined by the individual's behavioral stability and availability of community-based supports identified to appropriately address the individual's assessed needs. Although admission is not intended to be greater than 30 days, the Division acknowledges that stability is an individual construct and, as a result, some individuals may require longer – or shorter – lengths of stay.
  - c. The DD Crisis Manager reviews the status of all transitions at least biweekly and monitors progress as reflected in the crisis transitions process. The DD Crisis Manager addresses transition barriers with the Intensive Support Coordinator and crisis provider.
3. The development of a discharge plan is to be person-centered, beginning at intake and noting:
  - a. An evaluation of additional supports and services by the Intensive Support Coordinator

- b. Referral for intake and evaluation by the Regional Field Office I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
  - c. Intensive Out-of-Home support staff have trained the staff in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement; coordination with the family and/or DD service provider on a plan for return to school/educational activities.
4. Upon discharge from the C&A Crisis Home, the individual may:
    - a. Return to his/her family home or provider placement;
    - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) version change based upon the long-term interests of the individual and in accordance with DBHDD policies.
  5. Support services and discharge planning case management are to be documented daily by appropriate staff.
  6. Records of pre-service and annual training of C&A Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.
  7. The applicable Regional Field Office is to be immediately notified of the child/youth's admission into the C&A home.
  8. The C&A provider is to collaborate with to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Regional Field Office I & E Teams) in order to establish a comprehensive discharge plan. A discharge plan may include "step downs" to a host home model and then back to family or provider with scheduled maintenance respite in place. The C&A home provider will be required to follow DBHDD and agency policies and procedures. The Home Provider will be required to follow a plan of support determined by the assessment team. Additional support will be provided if authorized.

## *H-2. C&A HOME RECORD MANAGEMENT*

1. All records must be kept in accordance with requirements of the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disability Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*.

## *H-3. C&A HOME DOCUMENTATION OF SERVICES*

1. Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:
  - a. Dates (beginning and ending) of service
  - b. Completed intake/evaluation documents (Psychiatrist, Medical and/or Behavioral Assessment)
  - c. Determined model of support
  - d. Discharge plan
2. Additionally, documentation of Intensive Out-Of-Home Support services is to:
  - a. Occur on a daily basis;
  - b. Include a description of the behavioral interventions utilized;
  - c. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.

#### *H-4. C&A HOME INDIVIDUAL FILES AND INFORMATION*

1. All individual files and information must be kept in accordance with requirements of the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*.

#### *H-5. INDIVIDUAL RIGHTS IN A C&A HOME*

1. All services delivered should be in accordance with Client's Rights Chapter 290- 4-9.

#### *H-6. ABUSE IN A C&A HOME*

1. It is expressly prohibited to mistreat; abuse; neglect; exploit; seclude; or apply physical restraint as punishment, for staff convenience, or to restrict movement to all youth in this service.
2. All staff must receive training on critical incident reporting as outlined in [Reporting Deaths and Other Incidents in Community Services, 04-106](#).
3. Provider will comply with the definitions of seclusion and physical restraint contained in this manual.

#### *H-7. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A C&A HOME*

1. Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to [Reporting Deaths and Other Incidents in Community Services, 04-106](#) found in the Georgia Department of Behavioral Health and Developmental Disabilities PolicyStat Webpage (<https://gadbhdd.policystat.com/>).

#### *H-8. NUTRITION SERVICES IN A C&A HOME*

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning (breakfast), at midday (lunch), and the evening (supper), with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least two nutritious snacks must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a C&A Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A C&A Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.
5. A C&A Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.
6. A C&A Home must arrange for and serve special diets as prescribed.
7. The C&A Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

#### H-9. MEDICATION MANAGEMENT IN A C&A HOME

1. All medication must be kept and administered in accordance with requirements of the Medication and Healthcare Management Section in the Community Service Standards for Developmental Disability Providers found in the *Georgia Department of Behavioral Health and Developmental Disabilities Provider Manual for Community Developmental Disability Providers as applicable to crisis supports services*.

#### I. Quality Assurance and Standard Compliance Requirements

1. The DD Crisis Providers of the Crisis System shall develop and maintain performance indicators and outcome data as part of their quality management system that will assist DBHDD and Georgia Crisis Access Line (GCAL) to monitor and generate monthly reports of the Georgia Crisis Response System (GCRS-DD) to make quality improvement decisions based on data collected.
2. The DD Crisis Providers' quality assurance data system shall at a minimum include the following performance indicators and outcomes:
  - a. **Intensive in-home:**
    - i. Names of individuals supported for in home supports
    - ii. Admit and discharge dates;
    - iii. Total # of hours of direct support provided by staff name and supporting documentation; and
    - iv. Plans developed for follow-up post discharge;
  - b. **Intensive out-of-home:**
    - i. Occupancy rate for each site;
    - ii. Individuals at each site on last day of month (admit date, LOS, discharge date, planned disposition, discharge activities documentation for the month and any barriers to discharge); and
    - iii. Individuals discharged for this month (admit date/discharge date, LOS, discharge disposition, date discharged, planned follow-up activities to support individual/family/provider post discharge and discharge plan uploaded to CIS).
3. The DD Crisis Provider must participate in data collection and generate monthly quality assurance reports for the crisis services provided for submission to DBHDD. In addition to the monthly data reports, the DD Crisis Providers may be requested to provide additional data/ad hoc reports as needed.
4. DD Crisis Providers must develop an internal risk management system that addresses the QI standards areas found in the Community Service Standards for DD Providers under Section C. Quality Improvement and Risk Management (areas 2 a-j).

#### J. STAFFING REQUIREMENTS

1. Qualifications and Standards of intensive crisis supports professional staff:
2. Qualifications of Professional Social Worker (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
  - a. Clinical social work licensure (LCSW/LPC) issued by the State of Georgia that is current and unrestricted AND
  - b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
  - c. Knowledge of federal, state, and local programs that have been developed for people with developmental disabilities including eligibility criteria and how to access these services AND

- d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities (ADA) Act and their legal mandates as they relate to special education programs and the rights of people with disabilities.
3. Professional Social Worker Standards:
    - a. Social workers must adhere to the values and ethics of the social work profession, utilizing the National Association of Social Workers (NASW) Code of Ethics as a guide to ethical decision making.
    - b. Social workers must adhere to clinical practice guidelines outlined in the NASW Standards for Clinical Social Work in Social Work Practice.
    - c. In accordance with the NASW Standard for Continuing Professional Education and the Georgia State Composite Board's licensure requirements for Continuing Education Units, clinical social workers should obtain any applicable certifications for crisis intervention curricula approved by DBHDD.
  4. Qualifications of Registered Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    - a. Must be a Registered Nurse with an unrestricted license to practice nursing in the state of Georgia AND
    - b. Have experience in caring for individuals with I/DD who are in crisis.
  5. Professional Registered Nurse Standards:
    - a. The Registered Nurse is committed to promoting health through assessment, nursing diagnosing, planning, intervention, evaluation and treatment of human responses when faced with a crisis. The Registered Nurse employs a purposeful use of self as its art and a wide range of nursing, psychosocial and neurobiological theories and research evidence as its science.
    - b. The Registered Nurse will adapt the American Nurses Association Code of Nursing standards and use these standards as comprehensive holistic assessment prior to engaging in any plan to resolve a crisis. The Registered Nurse will be directly involved in all aspect of crisis intervention by utilizing the nursing process.
  6. Qualifications of Licensed Practical Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    - a. Must be a Practical Nurse with an unrestricted license to practice nursing in the state of Georgia under the supervision of a Registered Nurse; AND
    - b. Have experience in caring for individuals with I/DD who are in crisis.
  7. Professional of Licensed Practical Nurse Standards:
    - a. The Licensed Practical Nurse must accept the responsibilities as an accountable member of the health care team; AND
    - b. Shall function within the limits of educational preparation and experience as related to assigned duties; AND
    - c. Function with other members of the health care team in promoting and maintaining health, preventing diseases and disabilities in order to obtain optimal health, utilizing the nursing process under the supervision of the Registered Nurse.
  8. Qualifications of Behavioral Specialist (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
    - a. Possess a minimum of a Master's degree in psychology, behavior analysis, education, social work or a related field; AND
    - b. Possess specialized training and education in behavioral analysis and positive behavioral supports for people with developmental disabilities by provision of evidence of a minimum of

thirty-five (35) hours of training and education in behavior analysis and behavioral supports for individuals with I/DD, which may include college transcripts and/or copies of training certificates or evidence of national certification as a Board Certified Behavior Analyst through documentation of a certificate from the Behavior Analyst Certification Board; AND

- c. Have at least two years' experience in behavioral supports evaluation and services for people with developmental disabilities and/or dually diagnosed.
9. Behavior Specialist Standards: Behavior Specialists are to adhere to the *Best Practice Standards for Behavioral Support Services*.
10. Qualifications of Physician (M.D; D.O; etc.):
  - a. Graduate of medical or osteopathic college; AND
  - b. Licensed by the Georgia Composite Board of Medical Examiners
11. Qualifications of Psychiatrist (M.D; etc.):
  - a. Graduate of medical or osteopathic college and a resident in psychiatry approved by the American Board of Psychiatry and Neurology; AND
  - b. Licensed by the Georgia Composite Board of Medical Examiners

## **K. Definitions**

1. **Crisis Services**: Occur through intensive on-site or off-site supports. This system is designed to be the measure of last resort for an individual with I/DD undergoing an acute crisis presenting substantial risk of imminent harm to self or others and serve as an alternative to emergency room care, law enforcement involvement, and/or institutional placement. Crisis services are time-limited and present-focused in order to address the immediate acute crisis and develop appropriate links to alternate services.
2. **Crisis Support Home**: A home that serves up to four (4) individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which have not responded to Intensive-In-Home Support services.
3. **Developmental Disability**: An individual is determined to have developmental disability by a professional licensed to make this determination. The developmental disability is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments. The developmental disability manifests before the individual attains age 22 years and is likely to continue indefinitely.
4. **Case Management by Crisis Services**: Is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the acute crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.
5. **Mobile Crisis**: Refer to [Provider Manual for Community Behavioral Health Providers, 01-112](#) for definition of Mobile Crisis.
6. **Safety Officer**: An individual who provides support related to safety issues during the provision of GCRS-DD service. This individual is to have safety related training and dressed in a safety related uniform. A GCRS-DD safety officer must not carry any form of a weapon (such as a gun, any form of a "Billy club", baton", hand cuffs, Taser gun).
7. **Child & Adolescent (C&A)**: A C&A Home is to serve no more than four children ages 10 thru 18 years of age, who are diagnosed with a developmental disability and are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. Placement in a C&A home is to only occur as a last resort and after a clinical determination for this level of placement has occurred.

## **Part II**

### **Section 3**

# **Operational and Clinical Standards for Autism Spectrum Disorder Crisis Support Homes**

## **DBHDD Provider Manual**

**For**

**Community Developmental Disability Providers**

**Fiscal Year 2022**



**Georgia Department of Behavioral Health  
and Developmental Disabilities  
October 2021**

**D·B·H·D·D**



## SERVICE DESCRIPTION AND UTILIZATION CRITERIA

The Autism Spectrum Disorder Crisis Support Home (ASD CSH) is a service that provides stabilization support for up to three (3) children/youth who are experiencing a serious emotional/behavioral change or distress that leads to a disruption of essential functions, and/or which may compromise the child/youth's ability to remain in their home or community. The intent of this service is to stabilize the child/youth through the use of crisis intervention techniques and behavioral supports on a time-limited basis. A behavioral support plan related to the crisis episode must be created/updated and utilized while the child/youth resides in the ASD CSH.

The intended outcomes for this service are: 1) The crisis-related behavior is stabilized to the extent that the child/youth can safely return to his or her home/community; 2) The child/youth's caregiver has received training on behavioral interventions for use in the home/community and the support needed to use these interventions successfully; and 3) The child/youth and caregiver/family have received referrals and assistance with linkage to any services and supports needed to maintain the child/youth's progress and to increase the likelihood that the child/youth will be able to successfully remain in his or her own home/community.

### A. TARGET POPULATION

1. A child or adolescent (hereinafter referred to as a "youth") between the ages of 10 through 17; **and**
2. For whom there is documented evidence of an ASD diagnosis made by a professional qualified to render diagnoses under Georgia law, or
3. Individualized Education Program (IEP) indicates eligibility of classification of ASD services.

### B. ADMISSION CRITERIA

The youth must meet the following criteria in each of the primary categories (1-4) that follow:

#### 1. HARM

Mobile Crisis has intervened but continues to have concern for safety and/or stabilization. However, the youth does not demonstrate the risk acuity to meet admission criteria for Crisis Stabilization Unit (CSU) level of care; and one or more of the following:

- a. Presents with a behavioral risk of harm to self or others (without clear intent to cause harm); **and/or**
- b. There has been at least one episode of a seriously problematic behavioral issue that, if continued and/or intensified, may compromise the youth's ability to remain in their home/community.

## 2. COPING/CRISIS MANAGEMENT

Youth needs temporary relief from their current environment/environmental stressors; **and** one or more of the following:

- a. Youth demonstrates insufficient resources or skills necessary to cope with current stress or crises; **and/or**
- b. Youth demonstrates lack of judgment and/or impulse control or cognitive/perceptual abilities to manage current stress or crises.

## 3. DISTRESS/DISRUPTION

Youth presents with an emotional/behavioral change or distress that is causing a major disruption to essential baseline youth and caregiver/family functioning such that the youth is at risk of longer-term out-of-home placement at a higher level of care.

## 4. CLINICAL/LEVEL OF NEED

Youth needs short-term, voluntary (not 1013), out-of-home care that includes crisis intervention, and for whom another level of care is not appropriate.

### C. CONTINUING STAY CRITERIA

1. Youth continues to meet admission criteria as defined above; **and**
2. A behavioral support plan related to the crisis episode has been created/updated and implemented, but the crisis-related behavior has not stabilized to the extent that the youth can safely return to his or her home/community; **and**
3. A higher level of care is not indicated.

### D. DISCHARGE CRITERIA

1. Youth no longer meets admission criteria, is stabilized, and an adequate discharge/continuing support/care plan has been established; **or**
2. The youth's legal guardian requests discharge; **or**
3. The youth's behavior has not stabilized and a higher level of care is indicated; **or**
4. The youth meets any of the Clinical Exclusion criteria post-admission and a higher level of care is indicated.

## E. CLINICAL EXCLUSIONS

1. Youth has acute symptoms of a psychotic disorder; and/or suicidal thoughts/behavior with realistic means by which to carry out the behavior;
2. Youth has had episodes of wandering, bolting<sup>3</sup>, or other elopement behavior in the past 45 days that have placed the youth at imminent risk to self or others, or such behavior occurs post-admission to the CSH;
3. Youth has a known history of sexually inappropriate behavior that may place other residents at risk, or such behavior occurs post-admission to the CSH;
4. Youth has significant verified or suspected underlying medical issues that may require a higher level of care for the purpose of increased medical supervision/intervention, or such issues become known post-admission to the CSH;
5. Youth requires **total care** (i.e. total physical assistance) to complete all Activities of Daily Living (ADLs); **and**
6. Youth's behavior must be the issue causing the crisis, not an issue emanating from the caregiver or environment.
7. In addition to the above, if the youth is admitted from an inpatient or acute care setting, (s)he must be free from the administration of chemical restraint (e.g., PRN psychotropic, anxiolytic, sedative medication) and the application of physical restraint (e.g. 2- and 4-point restraints) for at least 24 consecutive hours immediately prior to admission. It should not impede the ASD CSH from initiating the referral/admission process, with the understanding that admission cannot occur until this requirement is met.

## F. SERVICE EXCLUSIONS

1. The following services may not be provided simultaneously with the ASD CSH service:
  - a. PRTF;
  - b. CSU;
  - c. Inpatient hospitalization;
  - d. Any other behavioral health (BH) residential or I/DD residential services.
2. Youth in formalized care settings (i.e. oversight provided by paid professional caregivers) may be admitted at the discretion of the DD Crisis Manager, or designee, upon evaluation from the Mobile Crisis Team.

## G. REQUIRED COMPONENTS

1. Referrals to this service will only be accepted from Mobile Crisis and, in special circumstances, as a request of the Division of Developmental Disabilities. DD Crisis Manager,

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<sup>3</sup> In this context, "bolting" differs from "wandering" as an elopement behavior, in that wandering is a slower or more meandering movement away from a place of safety, whereas bolting is a sudden and fast-paced movement (e.g. running/sprinting/darting), usually toward something of interest or away from something considered by the individual to be aversive (perhaps in nervousness, fear, or irritation/agitation). "Bolting behavior" is discussed often in the ASD literature and may be more common in youth with ASD versus other diagnoses. In the literature, bolting is discussed as a particular concern due to the higher likelihood of resultant accidents (e.g. bolting into traffic), stemming from the lower opportunity for a caregiver or others to observe and respond in a timely manner.

- or designee, will review all referrals and notify the ASD CSH provider to proceed with admission accordingly. The ASD CSH provider will admit all youth approved for this service.
2. The provider is required to place new admissions on the I/DD Crisis Beds Inventory Status Board (BHL Web) within 24 hours of admission.
  3. If youth has an I/DD waiver, the provider must work with the youth's Support Coordinator to ensure that an appropriate service and support array is available to the youth upon discharge.
  4. Provider must develop and maintain policies and procedures for the ASD CSH.
  5. Three (3) regularly scheduled/shift staff must be present in each ASD CSH at all times.
  6. Telemedicine is allowed for a variety of supportive ASD CSH functions, specifically observation, consultation, plan development and caregiver training. All professionals must adhere to relevant regulatory requirements for service provision as set forth by their professional standards and Georgia law.
  7. Provider must engage collaboratively with any community providers, including outpatient ASD service provider(s), currently serving the youth. The ASD CSH provider will obtain the guardian's authorization to communicate with these providers.
  8. In collaboration with the guardian/caregiver – and Case Expeditor, as needed – the ASD CSH provider will make a diligent effort to refer the youth to community services, including outpatient ASD service provider(s), to address ongoing support needs. The ASD CSH provider must document their efforts in the youth's record.
  9. ASD CSH provider must contact the youth's school system within 48 hours of admission to plan for implementation of the youth's IEP and to arrange for needed/required educational services while the youth is in the ASD CSH.
  10. Prior to admission, the ASD CSH provider must obtain a Consent to Treatment signed by the youth's legal guardian, which must include, but not be limited to the following elements:
    - a. Signed acknowledgement by the legal guardian that admission to, continued stay in, and discharge from in the ASD CSH are subject to medical necessity criteria that must be adhered to;
    - b. Signed acknowledgement by the legal guardian and caregiver if different that their involvement in the youth's treatment planning and interventions is required;
    - c. Signed acknowledgement by the legal guardian that they are expected to either directly provide or arrange for transportation of the youth from the ASD CSH upon discharge. The ASD CSH provider may assist the guardian with these arrangements, with the understanding that this provider is not responsible for providing transportation at discharge.

## **H. STAFFING REQUIREMENTS**

1. The ASD CSH must use a team approach for staffing and service delivery. Minimum staffing for the team shall include:
  - a. A FTE Program Manager (minimum of a bachelor's level in a human services field), whose time may be split between the two homes. The Program Manager is responsible for functions involving daily operations of the homes, such as ensuring

adequate staffing coverage on each shift, ensuring that each home has the furnishings, equipment and supplies needed to operate, etc.;

- b. A registered nurse (RN) to supervise the administration of medication, complete health assessments, and provide oversight to LPNs, among other duties as consistent with O.C.G.A. 43-26-1 et seq., Georgia Nurse Practice Act;
  - c. One (1) LPN per shift for the administration of medication and participation in the delivery of healthcare services and other specialized tasks under the supervision of an RN and in accordance with O.C.G.A. 43-26-1 et seq., Georgia Nurse Practice Act;
  - d. One Registered Behavior Technician (RBT) per shift, resulting in 24 hour coverage;
  - e. One or more Board Certified Behavior Analysts (BCBAs) to equal 1 FTE, whose time may be split between the two ASD CSHs;
  - f. A FTE case manager (minimum of a bachelor's level in a human services field), whose time may be split between the two ASD CSHs. The case manager is responsible for functions involving the successful discharge and transition of each youth back to their home/community or to a more appropriate level of care, such as contacting/collaborating with existing providers of supports and services in the community, arranging for supports and services that may not have previously existed but that are necessary for successful discharge/transition, ensuring the parent/caregiver/family has the support needed for a successful transition, etc.;
  - g. A consulting psychiatrist must be available for medical consultation, medication consultation/orders, and assessments as needed. These services may be provided via telemedicine;
  - h. A referral arrangement with a licensed psychologist, as needed; and
  - i. There must be a minimum of two (2) direct care staff on site at all times, but no less than a 1:1 staff to consumer ratio shall be maintained at all times.
2. The service fails to meet model-integrity in the absence of any key position. It is understood that there may be periodic vacancies of key clinical/programmatic positions, specifically BCBA, case manager, program manager, nurse, RBT, and consulting psychiatrist/psychologist. In this event, the ASD CSH provider must submit written notification to the DD Crisis Manager, Autism Project Coordinator, and Director/Office of Transitions of any such turnover within 24 hours of the awareness of a staff vacancy. The provider must submit a written plan for the provision of immediate coverage (as accepted below) and recruitment with timeline.

3. The provider must arrange for continuation of the critical functions related to a key position via one of the following means:
  - a. Documentation that there is a temporary contract in place for the position with an external professional who fully meets the qualifications for that position; **or**
  - b. Documentation that there is another fully qualified professional who is typically employed elsewhere in the agency, but who is providing the position functions temporarily; **or**
  - c. Specific to the BCBA position, if the provider cannot comply with either item a or b above, a combination of one or more licensed psychologists, or a combination of one or more licensed psychologists and a BCaBA may be used to provide short-term coverage for the BCBA position's functions. This option may only be used as a last resort, and for this to be allowed, the agency must provide the following to the DD Crisis Manager, Autism Project Coordinator, and Director/Office of Transitions: documentation that recruitment is underway and other options were first exhausted. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising.
  - d. In the event that a position cannot be filled within 90 days OR in the event that there is no ability to provide the coverage articulated in items a-c, there shall be written notification to the State DBHDD Office (Division of DD Director, Assistant DD Director, Director/Office of Transitions, DD Crisis Manager, and Autism Project Coordinator) and the associated Regional Field Office of the intent to cease billing for the service and begin transitioning currently admitted children/youth to other services that will be able to meet their needs.
4. All licensed or certified team members are required to comply with [Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations, 04-101](#) and the Professional Licensing and Certification Requirements of Practice Act, as well as maintenance of valid or current license or certification.
5. A Case Expeditor, supervised by the Autism Project Coordinator, will:
  - a. monitor service provision through routine announced and unannounced site visits, and
  - b. serve as an engaged member of each youth's identified transition team (generally comprised of the ASD CSH team, the youth, family/caregiver, established care providers, representatives from the school system, Support Coordinator when applicable, and any others, including Regional Field Office representatives, whose participation is deemed necessary) as evidenced by:
    - i. Participation in all formal discharge planning meetings,
    - ii. Assistance with service linkage, when clinically indicated and/or requested by the case manager,

- iii. Post-transition follow-up at a frequency determined by the transition team but not to exceed 60 days, and
  - iv. Participation in routine case consultation with ASD CSH clinical staff.
6. The activities of the Case Expeditor supplement – and do not supercede – the responsibilities of the ASD CSH’s clinical team, most notably the case manager and BCBA, as outlined in job descriptions and these standards.

**I. CLINICAL OPERATIONS**

1. A BCBA must begin a behavioral assessment of each youth within 36 hours of admission to help inform the development of an individualized crisis plan and to initiate the process of developing a behavioral support plan.
2. A nurse must evaluate each youth within 12 hours of admission. The nurse shall also perform medication management functions and conduct other assessments/evaluations as needed within their scope of practice. An LPN must work under the supervision of a RN. Note: All treatment for youth in the ASD CSH provided by an LPN who receive oversight supervision from RNs must adhere to the requirements as outlined in [Registered Nursing Oversight in I/DD Community Settings, 02-808](#).
3. As part of the needs assessment, provider must work to identify needed BH and/or I/DD supports for youth with co-occurring diagnoses.
4. Crisis Management/Intervention:
  - a. Immediately upon admission, and until an individualized crisis plan has been developed, the provider must implement its internal policies and procedures/protocols for the management of crisis situations and for ensuring the health and safety of its staff and the youth served.
  - b. Within two (2) days of admission, an individualized crisis plan must be developed (or updated if one already exists) and implemented for each youth served.
  - c. Within five to seven (5-7) days of admission, the results of a preliminary behavioral assessment must be available to inform the development of an individualized behavioral support plan which is primarily focused on the crisis-related behavior.
  - d. Within seven to nine (7-9) days of admission, the preliminary draft of an individualized behavioral support plan must be developed or updated (with BCBA oversight) and finalized/implemented within ten to twelve (10-12) days of admission.
5. Upon admission, the provider must begin implementation of a new or revised individualized discharge plan. The case manager must assist each youth and

caregiver/family with identifying and accessing needed services/supports post-discharge and must update/coordinate with any existing supporting providers.

6. Provider must work with the youth's caregiver/family/support system (as applicable) to begin to evaluate and address needed training in behavioral and/or crisis de-escalation techniques/supports. Provider will work with the youth's community outpatient provider(s) to facilitate any needed continuation of this training post-discharge.
7. A daily activity schedule (per shift) must be posted in the ASD CSH and available to external reviewers. A significant portion of the daily schedule must consist of structured activities. These activities should be related to skills training and education (to enhance positive/functional behavior and reduce challenging behavior) and be consistent with each youth's needs as identified in his or her behavioral support/crisis plan.

## **J. DOCUMENTATION REQUIREMENTS**

1. Provider will meet all requirements of the Administrative Services Organization (ASO) and as articulated in this manual Part II, Section 1, D, III.
2. Provider will adhere to any documentation requirements set forth in their contract related to quality management, utilization management, etc.
3. Youth receiving ASD CSH services shall be reported as a per diem encounter based upon occupancy at 11:59 PM. Youth entering and leaving the ASD CSH on the same day (prior to 11:59 PM) will not have a per diem encounter reported.
4. The notes for the program must have documentation to support the per diem, including admission/discharge time, shift notes, and specific consumer interactions.
5. Additionally, the provider must document the following in each youth's record:
  - a. Specific activity, training, or assistance provided daily, to include description of behavioral interventions;
  - b. Date and the start and end times when services were provided;
  - c. Verification of service delivery, including first and last names and titles (if applicable) of the staff providing the service/training;
  - d. Progress toward goals outlined in the behavioral support plan and/or care plan; and
  - e. Description of outcomes specific to each target behavior and related interventions and goals training, including, but not limited to, behavioral changes, acquisition of



replacement skills, ability to increase community integration, and other positive outcomes.

#### **K. REPORTING AND BILLING REQUIREMENTS**

1. Admission requires approval from the DD Crisis Manager or designee. Utilization management will occur through the Division of Developmental Disabilities.
2. The provider will post all applicable information as required to the I/DD Crisis Beds Inventory Status board on BHL Web.
3. The provider must report information on all youth served.
4. The provider shall submit per diem encounters for all youth served.
5. Span claiming in the ASO system may occur for this service, meaning that the start and end date are not the same on a given service claim line. The span dates may cross months (start date and end date on a given service line may begin in one month and end in the next).

#### **L. MEDICAID REQUIREMENTS**

None. This is not a Medicaid billable service.

#### **M. CERTIFICATION REQUIREMENTS**

1. There is currently no licensure required for the operation of an ASD CSH. However, prior to operation, each ASD CSH must receive an initial DBHDD compliance review by the Office of Provider Certification & Services Integrity, Division of Accountability & Compliance. If the provider is found in compliance, OPCI issues a six (6) month provisional certificate. At six (6) months, the provider receives a full certification visit conducted by OPCI, at which time the provider may be issued a one (1) year certificate. At one (1) year, a certification visit is conducted; the provider may be issued a certificate for up to five (5) years if determined to be in substantial compliance. [Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02-703](#).
2. The certificate is non-transferrable and is for the specific site. Note: At any time, DBHDD may request a special compliance review to assess the provider's compliance with the applicable DBHDD community service standards and ASD standards referenced in this document.

#### **N. ORGANIZATIONAL PRACTICES**

1. The provider must have policies and procedures (P&P) that address, at minimum, the following:

- a. Description of services for how ASD crisis services are provided, types of assessments, use of evaluation tools, management of crisis situations, development of behavioral/safety/crisis plans utilizing evidence-based practices;
- b. Quality improvement processes for assessing and improving quality of supports;
- c. Risk management plan that identifies and monitors risk issues on an ongoing basis;
- d. Admission and discharge process;
- e. Staff P&P that outlines staffing qualification requirements, protocols for hiring practices, and competency and background checks. Note: Providers must adhere to [Criminal History Records Checks for DBHDD Network Provider Applicants, 04-104](#);
- f. Utilization/development/revision of a youth's behavioral support plan and/or safety plan to include how behavioral needs are monitored daily to include data collection and efficacy of behavioral interventions and replacement behavioral training;
- g. Monitoring and evaluation of services that demonstrate respect for the youth's rights, choices, and person-centered planning. The use of aversive techniques, such as denial of meals and sleep, is strictly prohibited and should be reflected in the provider's P&P; and
- h. Transportation plan to appointments and community activities. Vehicle(s) must be operated only by provider staff who have received the required defensive driving training and possess a valid Georgia driver's license.
- i. ASD CSH provider must maintain policies and procedures for all vehicles used in this service, as required by DBHDD Provider Manual for Community Developmental Disability Providers, to include:
  - 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 youth served that includes documentation of boarding and exit time of youth with to and from location of planning trip and not leaving youth unattended in the vehicle;
  - vi. Requirements for maintain an attendance log of persons while in vehicle;
  - vii. Safe use of lift, seat belts, tie downs, and any other safety equipment if applicable;
  - viii. Availability of first aid kits and seatbelt cutter;

- ix. Fire suppression equipment; and
- x. Emergency preparedness (availability of portable phone for emergency calls) to include process for handling and reporting an incident and accident.

2. Person-centered planning for treatment and therapies that includes:

- a. Identification of known and possible behavior patterns that are exhibited during a crisis, as well as environmental stressors that will escalate to an acute crisis. The focus of plans should emphasize crisis prevention through the manipulation of antecedent strategies, proactive skill building, and prevention of acute crisis.
- b. Behavioral/crisis support plans are developed and based on a functional assessment to understand the causes maintaining the challenging behaviors, to include past trauma, so replacement behaviors can be identified in an effort to teach alternative behaviors that will achieve the same results as the challenging behaviors.
- c. Focus on the youth's strengths and attributes, with an assessment of past trauma and abuse, to guide the process for determining early interventions for how the youth would prefer to be approached if/when in crisis.
- d. An environment structured to meet the youth's needs for space, privacy, and safety to minimize incidents.
- e. Collaboration of integrated holistic care to establish an effective behavior/safety/crisis plan for continuity of care that services to compliment and provide for integrated supports across service settings once the youth is transitioned to the community.
- f. Plans for follow-up supports and maintenance of stakeholder's (treatment agencies, family, school system) involvement in the youth's response to safety/crisis plan in order to provide continuity of care when discharged.

3. This service is time-limited and should not exceed thirty (30) days. Extensions beyond thirty (30) days are the exception and not typical. Requests for extensions in increments of seven (7) days will be submitted by ASD CSH provider to the Autism Project Coordinator or designee. The BCBA and/or Program Manager will submit the Service Extension Form to the Autism Project Coordinator or designee no later than 72 hours prior to the projected discharge date. Extensions are only approved when discharge criteria have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented daily.

- a. Note: As soon as the provider and staff indicate the need for extension and initiate the written extension request, the Autism Project Coordinator or designee reviews all necessary information on the youth whose circumstances determine the need for the extension and will schedule routine meetings with the provider to monitor the youth's progress and address barriers to transition. The Autism Project Coordinator or designee will approve or deny the extension within 24 hours of receipt with written notice (inclusive of clinical justification) to the ASD CSH provider and DD Crisis Manager.
4. All applicable practices regarding Limited English Proficiency and Sensory Impairment must be following in accordance with [Nondiscrimination and Accessibility for Individuals with Disabilities and Individuals with Limited English Proficiency, 15-100](#). In addition, the provider should consult with the Office of Deaf Services (ODS) for additional supports if needed and to refer youth with hearing loss to ODS.

## **O. EDUCATIONAL REQUIREMENTS**

1. For a holistic approach to treatment and continuity of services while as the ASD CSH, the educational needs of youth must be addressed in the P&P that includes:
  - a. IEP developed by the school system should be an integral part of the behavioral treatment and programming at the ASD CSH when the youth is anticipated to be absent from school for a minimum of ten (10) consecutive school days.
  - b. Collaboration with the school staff to implement educational supports that are outlined in the youth's current IEP, to include service goals training, within 48 hours of admission.
  - c. Partnership with a school system located in the area for change of placement for educational supports, to include:
    - i. How the ASD CSH and school system plans to provide for the continuity of educational training as outlined in the youth's current IEP. (All trainings/supports provided must meet documentation requirements and be maintained in the youth's file).
    - ii. All activities and trainings must be individualized and reflect the youth's participation and choice. The IEP may need revisions to meet the evolving needs of the youth.

## P. STAFF TRAINING REQUIREMENTS

1. Provider must maintain staff training records as documentation that all staff have participated in training, to include applicable Community Service Standards prior to direct contact with youth and trainings within first sixty (60) days of hire. Training records should include documentation as demonstration of their competence in all crisis protocols and relevant, applicable ASD trainings that include, but are not limited to:
  - a. Assessing the behavioral crisis (specific ASD training in treating and diagnosis problems);
  - b. Onsite service operations determination for any risk;
  - c. Completion of a nationally recognized crisis intervention curriculum approved by DBHDD and taught by a certified trainer in such program as Crisis Prevention Institute (CPI);
  - d. Cardiopulmonary Resuscitation (CPR) that includes both written and hands on competency training;
  - e. Instructions on how to monitor the breathing, verbal responsiveness, and motor control of a youth who is subject of an emergency safety intervention;
  - f. Training in working with youth with ASD to recognize their strengths and opportunities in thinking and learning;
  - g. Person-centered planning;
  - h. Trauma informed care;
  - i. Techniques of Standard precautions, to include:
    - i. Preventative measures to minimize risk of infectious disease transmission;
    - ii. Use of Personal Protection Equipment (PPE);
    - iii. Sharps safety (with sharp containers disposed of according to state and local regulated medical waste rules);
    - iv. Environmental controls for cleaning and disinfecting work surfaces;
    - v. Skills guides for handwashing, cleaning up spills, gloves use, and what to do with contaminated supplies;
    - vi. Respiratory hygiene/cough etiquette for cough, congestion, runny nose, or increased production of respiratory secretions; and
    - vii. Approaches to individual education, to include incident reporting and follow-up.

- j. Documentation and retraining, if applicable, when implementation of emergency safety interventions results in a youth injury; and
- k. Annual training of staff, including names of persons trained, trainer, the training source, content, dates, length of training, and copies of certificates must be maintained in staff files and readily accessible.

## **Q. RECORD MANAGEMENT**

All records must be kept in accordance with the requirements of the Community Service Standards found in the DBHDD Provider Manual for Community Developmental Disability Providers.

## **R. FILES AND INFORMATION**

Providers abide by all applicable state and federal laws regarding record retention and confidentiality.

## **S. RIGHTS**

All services delivered should be in accordance with Client's Rights Chapter 290-4-9 and [Human Rights Council for Developmental Disability Services, 02-1101](#). Providers should refer to this manual for additional information and instructions as to rights protections.

## **T. ABUSE**

It is expressly prohibited to mistreat; abuse; neglect; exploit; seclude; and apply physical restraint as punishment, for staff convenience, or to restrict movement to all youth in this service.

1. Prior to service delivery, all staff must receive training on critical incident reporting as outlined in [Reporting Deaths and Other Incidents in Community Services, 04-106](#).
2. ASD CSH provider will comply with the definitions of seclusion and physical restraint contained in the DBHDD Provider Manual for Community Developmental Disability Providers.
3. The phone numbers for DFCS and the Long-Term Care Ombudsman Program must be readily available and accessible to all in the home.

## **U. REPORTING AND INVESTIGATIONS OF DEATHS AND CRITICAL INCIDENTS**

Deaths and/or critical incidents involving youth served in an ASD CSH must be reported to DBHDD in accordance with [Reporting Deaths and Other Incidents in Community Services, 04-106](#) and [Investigating Deaths and Other Incidents in Community Services, 04-118](#).

## V. MEDICATION MANAGEMENT

All medication must be kept and administered in accordance with the requirements of the DBHDD Provider Manual for Community Developmental Disability Providers. The use of proxy care in this service is expressly prohibited. Note: LPNs must be under the supervision of a licensed RN.

## W. DISASTER PREPAREDNESS AND RESPONSE PLAN

In accordance with [Disaster Preparedness, Response, and Disaster Recovery Requirements for Community Providers, 04-102](#), the provider must develop a Continuity of Operations Plan (COOP) that addresses disaster preparedness, response, and recovery. At the time of disaster plan implementation, the providers should contact the State Office, in particular the Autism Project Coordinator and DD Crisis Manager, , as well as the related Regional Field Office. The provider should refer to this manual for additional instructions.

## X. PHYSICAL ENVIRONMENT REQUIREMENTS

The residence must be constructed, arranged, and maintained to provide adequately for the health, safety, accessibility, sensory needs, and well-being of the youth. The residence must meet ADA requirements for accessibility.

1. Must provide for common living space, dining, and private sleeping areas:
  - a. The living and sleeping areas must be within the same building;
  - b. Alarm systems should be applied to all windows and doors;
  - c. Supportive devices must be installed as necessary to enable the youth to achieve a greater degree of mobility and safety from falling;
  - d. The general floor plan of the home provides for optimal line of sight observations throughout the home. Blind spots shall be addressed through the use of unbreakable convex viewing mirrors that allow visual access by staff;
  - e. Must provide an area that affords privacy for the youth and visitors;
  - f. Common spaces, such as living and dining rooms, must be available for use by the youth and without restriction;
  - g. Common areas must be large enough to accommodate youth without crowding and should be comfortably furnished with sturdy furniture;
  - h. Must provide a means of locked storage for the valuables or personal belongings of the youth;
  - i. Must provide access to a working washer and dryer and staff must assist youth with laundry;

- j. All stairways and ramps must have sturdy handrails, securely fastened not less than 30° nor more than 34° above the center of the tread. Exterior stairways, decks, and porches must have handrails on the open sides unless the surface of the deck or porch is so close to the ground that it does not pose a significant risk of injury to the youth to fall from the deck or porch. If railings include balusters, the space should not allow for a youth to put his or her head through them.
  - k. Floor coverings must be intact, safely secured, and free of any hazard that may cause tripping; and
  - l. All areas, including hallways and stairs, must be lighted sufficiently. Lighting fixtures shall be recessed and tamper proof with Lexan or other strong translucent materials. Light switches and electrical outlets shall be secured with non-tamper type screws. In consideration of the sensory needs of youth in this service, lighting should be fitted with dimmers.
2. The following exterior conditions must be maintained:
- a. Entrances and exits, sidewalks, and escape routes must be maintained free of any obstructions that would impede leaving the residence quickly in the case of fire or other emergency and must be kept free of any hazards, such as ice, snow, or debris;
  - b. The yard, if applicable, must be free of all hazards (including poisonous plants), nuisances, refuse, and litter;
  - c. The residence must have its house number displayed, which should be easily visible from the street;
  - d. The residence must provide for an outside area where youth may have access to fresh air and exercise and should allow for privacy. It should be designed/constructed to minimize elopement from the area, preferably using a fence.
3. The following minimum standards for bedrooms must be met:
- a. Bedrooms must have sufficient space to accommodate the youth, the youth's belongings, and, minimally, a bed and dresser without crowding. The single bedroom shall have at least 75 square feet of usable floor space that does not include a built-in closet;
  - b. The youth's bedroom must have at least one window (screened and in good repair for ventilation) and a closet;
  - c. All windows shall be protected with a safety film, preferably textured for privacy (such that curtains/drapes are not required), to protect against glass breakage, hold glass pieces in place in an impact situation, or prevent dangerous flying glass pieces. For newer construction or replacement of windows, the use of tempered glass, Lexan, or Plexiglas is required;



- d. Bedrooms for youth must be separated from halls, corridors, and other rooms by floor to ceiling walls. Hallways cannot be used for sleeping;
  - e. The floor plan must be such that no person other than the occupant of that bedroom must pass through a bedroom to reach another room;
  - f. The bedroom must have doors that can be closed. For bedrooms that have locks on doors, both the occupant and staff must be provided with keys to ensure easy entry. Double-cylinder locks (locks requiring a key on both sides) may not be used on the bedroom of a youth. Doors shall not be locked from within and shall be capable of swinging outward or be mounted so that the door can be removed from outside if the door is barricaded from the inside;
  - g. A room must not be used as a bedroom where more than one-half of the room's height is below ground level. Bedrooms which are partially below ground level should have adequate natural light and ventilation and be provided with two useful means of egress;
  - h. When the youth is discharged, the bedroom and its contents must be adequately cleaned;
  - i. Each bedroom must contain a standard, non-portable bed measuring at least 36" wide and 72" long. The mattress must be clean and not less than 5" thick or 4" of synthetic construction. The use of beds with springs, cranks, rails, or wheels including hospital beds, rollaway beds, cots, hide-a-beds, bunkbeds, stacked beds, and day beds is strictly prohibited; and
  - j. Beds or other furniture capable of being used to barricade a door shall be secured to the floor or wall.
4. The following minimum standards apply to bathrooms:
- a. At least one functional toilet, lavatory, and bathing or showering facility must be provided for every three (3) youth residing in the ASD CSH;
  - b. At least one fully handicap accessible bathroom must be available;
  - c. Flush mounted safety grab bars must be installed in all showers and area(s) near the toilet;
  - d. Floor drains should be installed to address spillage during bathing and, possibly, during water play;
  - e. Non-skid surfacing or strips must be installed in all showers, tubs, and bathing areas;

- f. Bathrooms and toileting facilities must have a window that can be opened or must have forced ventilation;
- g. Toilets, bathtubs, and showers must provide privacy;
- h. Showerheads shall be recessed or have a smooth curve from which items cannot be hung and/or bear weight;
- i. Use of overhead metal rods, fixtures, privacy stall supports, or protrusions capable of carrying more than a thirty (30) pound load is strictly prohibited;
- j. Mirrors shall not be common glass. A polycarbonate mirror, fully secured and flat mounted to the wall, is required. Polished metal mirrors shall not be permitted;
- k. Toilet shall be tankless/flushometer-type, not residential with water tank and cover;
- l. Access to a bathroom shall not be through another youth's bedroom; and
- m. Toilet paper must be available for use at each commode.

**Y. FURNISHINGS AND FIXTURES**

- 1. Furnishings in the living room, bedroom, and dining room, including furnishings provided by the youth, must be maintained in good condition, intact, and functional;
- 2. Furnishings and housekeeping standards must be such that the residence presents a clean and orderly appearance;
- 3. Must provide an adequate closet or wardrobe; lighting fixtures sufficient for reading and other activities; bureau, bed, dresser, or equivalent made of durable materials not capable of breakage into pieces that could be used as weapons and must not present a hanging risk;
- 4. Must provide each youth with clean towels, including washcloths, at least twice weekly and more frequently if soiled; and
- 5. Must provide bedding for each youth, including two sheets, one pillow, one pillowcase, and a minimum of one blanket and bedspread. In addition, the ASD CSH must maintain a linen supply for not less than twice the bed capacity and must adapt the supply to meet the special needs of the youth.

**Z. PHYSICAL PLANT, HEALTH, AND SAFETY STANDARDS**

- 1. Must provide a safety and healthy environment for its youth, and, where subject to fire and safety standards promulgated by the Office of the Safety Fire Commissioner, must comply with those standards;

2. Must comply and remain in compliance with all state and local ordinances for fire safety in residences of that size and function. In the absence of or in addition to any such local ordinances, the following requirements must be met:
  - a. Wall-mounted electrical outlets and lamps or light fixtures must be maintained in safe and operable condition;
  - b. Cooking appliances must be suitably installed in accordance with approved safety practices;
  - c. Space heaters must not be used;
  - d. Fire screens and protective devices must be used with fireplaces, stoves, heaters, and air conditioning units;
  - e. If natural gas or heating oil is used to heat the residence, the residence must be protected with carbon monoxide detectors;
  - f. Active use of any fireplace is prohibited. Fireplaces should be deconditioned prior to occupancy;
  - g. Must have at least one readily accessible, charged, 5 lbs. multipurpose ABC fire extinguisher on each occupied floor and in the basement. Extinguishers must be checked annually by a fire safety technician and monthly by the staff of the ASD CSH to ensure they are charged and in operable condition;
  - h. Exterior doors must be equipped with locks that do not require keys to open the door from the inside;
  - i. An automatic extinguishing system (sprinkler) shall be installed per city/county requirements for residential settings not governed by other federal, state, and county rules and regulations if applicable; and
  - j. An approved smoke alarm with battery backup shall be installed properly in all sleeping areas, hallways, and all normally occupied areas on all levels of the residence per safety code. When activated, the smoke alarms must initiate an alarm that is audible in the bedrooms. All smoke alarms shall be tested monthly, with the documented outcome. The facility shall be inspected annually to meet fire safety code and copies of inspections should be maintained. Note: For youth with special support needs, such as hearing impairment or deep sleepers who have difficulty waking to a traditional alarm, an alternate safety plan must be addressed in policy and implemented in their bedrooms, such as the use of a Smart Strobe Light smoke alarm or an alarm designed to give reliable early warning of the presence of smoke when both audible and visual alarms are required. Strobe-type smoke alarms are not recommended for youth with seizure disorder/epilepsy.
3. Water and sewage systems must meet applicable federal, state, and local standards and regulations;

4. Floors, walls, and ceilings must be kept clean and in good repair, preferably constructed of non-absorbent materials;
5. Kitchen and bathrooms must be cleaned by ASD CSH staff with disinfectant and maintained to ensure cleanliness and sanitation;
6. The storage and disposal of biomedical and/or hazardous waste must comply with applicable federal and state rules and standards;
7. The storage and disposal of garbage, trash, and waste must be accomplished in a manner that will not permit the transmission of a disease, create a nuisance, or provide a breeding place for insects or rodents. Waste must be removed from the kitchen as necessary and from the premises at least once weekly;
8. Due to the nature of this service, no pets of any kind are allowed on the premises;
9. Poisons, caustics, and other dangerous materials must be stored in a clearly labeled and appropriate container; safeguarded in an area away from medication storage, food preparation, and other storage areas; and secured in locked storage. Youth are prohibited from handling any of these substances;
10. Must be equipped and maintained to provide sufficient hot water. Hot water provided for use by youth must not exceed 120° Fahrenheit at the fixture, unless a cooler temperature is required by the needs of the youth. A water temperature monitor or scald valve must be installed where necessary to ensure the safety of the youth;
11. Must have clearly accessible route(s) for emergencies throughout the residence;
12. Must establish procedures and mechanisms for alerting and caring for youth in case of emergencies and for evacuating them to safety. An evacuation plan with clear instructions shall be available and posted within each ASD CSH;
13. Youth who needs assistance with ambulation shall be provided bedrooms with access to ground-level exits to the outside;
14. Temperature throughout the residence must be maintained by a central heating system or its equivalent at ranges that are consistent with the youth's health needs. No youth must be in any area of the residence that falls below 65° Fahrenheit or exceeds 82° Fahrenheit;
15. Must possess a readily available supply of first aid materials including bandages, antiseptic, gauze, tape, thermometer, and gloves;
16. No weapons shall be kept in the ASD CSH. Kitchen utensils that could be used as a weapon, such as knives, should be kept in locked storage; and
17. Staff will have access to 24/7 transportation.

## AA. SUPPORT SERVICES

1. Each ASD CSH must provide room, meals, and crisis services that are commensurate with the youth's needs, to include special diets. Services should be provided by appropriately qualified staff members;
2. Personal hygiene assistance must be given to youth who are unable to keep themselves neat and clean;
3. The Program Manager or designee must teach each youth the techniques of standard precautions, as appropriate to the youth's ability, or must support each youth in the performance of the techniques of standard precautions including washing hands after toileting, sneezing, or any other activity during which the youth's hands may become contaminated;
4. The routine of the ASD CSH must be such that the youth spends the majority of their time outside of sleeping hours in areas other than their bedrooms. Activities/positive coaching or modeling training must be provided to increase positive replacement behaviors according to each youth's plan or care and behavioral support program;
5. The Program Manager or designee must be available to any person within the ASD CSH, including each youth served;
6. ASD CSH provider will adhere to Community Service Standards in the creation of a basic Infection Control Plan, reviewed annually for effectiveness and revision, to address:
  - a. Standard precautions;
  - b. Handwashing guidelines;
  - c. Proper storage of personal hygiene items; and
  - d. Specific common illnesses/infectious diseases likely to be emergent in the particular service setting;
7. ASD CSH provider will also maintain policies, procedures, and practices for controlling and preventing infections in the service setting, as required by the Community Service Standards, through 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 infection and contamination of the environment; and
  - e. Guidelines for food preparation.

## **BB. NUTRITIONAL SERVICES**

1. A minimum of three (3) regularly scheduled, well-balanced meals must be available seven (7) days per week. Meals must be served in the early morning (breakfast), at midday (lunch), and in the evening (dinner), with the last meal served no earlier than 5:00 PM and no later than 7:00 PM;
2. ASD CSH shall provide each youth with meals and snacks of serving sizes dependent upon the nutritional guidelines established by the United States Department of Agriculture Childcare Program; recommended daily diet allowances, Food and Nutrition Board, National Academy of Sciences; or a diet established by a registered dietician. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least two nutritious snacks must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu;
3. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety;
4. Food received or used must be clean, wholesome, free from spillage, adulteration, and mislabeling, and safe for human consumption;
5. ASD CSH must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment, which, in such case, a copy of required certification related to health, safety, and sanitation is available;
6. ASD CSH must maintain a three-day supply of non-perishable foods and water for emergency needs for all youth and staff, to include food for special diets when applicable;
7. ASD CSH must arrange for and serve special/modified diets based on medical or religious reasons as needed. Modifications due to medical reasons shall require a written physician's order with a copy maintained in the youth's record; and
8. Meal planning should demonstrate choice and participation of the youth, as safe and appropriate.

## **CC. QUALITY ASSURANCE AND STANDARDS COMPLIANCE**

1. Provider will develop and maintain performance indicators and outcome measurement data as part of their performance management system that will assist DBHDD to monitor and generate monthly reports of the ASD CSH to make quality improvement decisions based on the collected data. The provider's performance data system shall, at minimum, include the following performance indicators and outcomes:
  - a. Names of youth supported in each ASD CSH;
  - b. Total number of youth at each ASD CSH on the last day of each month ("occupancy rate");

- c. Total number of new admissions and discharges each month (“admission and discharge data”);
  - d. Average length of stay in each ASD CSH;
  - e. Total number of hours of training provided to youth, families, and/or caregivers monthly;
  - f. Total number of hours of training provided to ASD CSH direct support staff monthly;
  - g. Total number of reportable critical incidents to DBHDD;
  - h. Staff vacancies and new hires each month;
  - i. Total number of hospitalizations (separated by medical vs. behavioral necessity); and
  - j. Total number of calls for law enforcement assistance monthly.
2. The provider must develop a well-defined performance improvement plan and an internal risk management system that addresses the performance areas found in the DBHDD Provider Manual for Community Developmental Disability Providers, Community Service Standards.
3. The provider must participate in data collection and generate monthly performance reports for submission to the Autism Project Coordinator and DD Crisis Manager. . In addition to monthly data reports, providers may be required to provide additional data/ad hoc reports as requested by DBHDD.

**Part II**  
**Section 4**

**Request for Conversion  
(Appendix: A)**

**Provider Manual**

**For**

**Community Developmental Disability Providers**

**Fiscal Year 2022**



**Georgia Department of Behavioral Health  
and Developmental Disabilities  
October 2021**

**D·B·H·D·D**



**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 2022**



**Georgia Department of Behavioral Health  
and Developmental Disabilities  
October 2021**

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## 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 child care 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.

### VI. PLANNING LIST (Waiting Lists)

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

### VII. SERVICES TO PERSONS RESIDING IN INSTITUTIONS

In most instances, services to persons residing in institutions are the responsibility of staff of the facility. Accordingly, Social Services Block Grant 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, Social Services Block Grant services may be delivered to eligible persons.

### IX. DOCUMENTATION OF SERVICE PROVISION

1. Contractors are responsible for the documentation of service delivery in compliance with the terms of the provider contract.
  - **Reporting of Services - Services delivered must be reported in compliance with the Terms of the provider contract.**

## X. NOTIFICATION OF THE CONSUMER OF SERVICE TERMINATION

- A. Notification to the consumer 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 a consumer 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 consumer 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 consumer 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 consumer 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 consumer moves to another State and the move is documented by the agency.
  4. The consumer 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.

## XI. CONSUMER GRIEVANCES

Providers shall make a grievance and appeal process available to aggrieved consumers in compliance with Federal regulations governing the Social Service Block Grant, 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 2022

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](#).



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