Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY DEVELOPMENTAL DISABILITY PROVIDERS

OF

STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICES

FISCAL YEAR 2025

Effective Date: ***April 1, 2025*** **(Posted:** ***March 3, 2025*****)**

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

INTRODUCTION

This Provider Manual has been designed as an addendum to your contract/agreement with DBHDD.

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SUMMARY OF CHANGES TABLE

UPDATED FOR APRIL 1, 2025

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

Item #	Topic	Location	Summary of Changes
1.	Effective Date Change from January 1, 2025, to April 1, 2025, and Quarter changed from 3rd to 4th	Page 1 et. seq	N/A
2.	Operational and Clinical Standards for Crisis Service and Diagnostic Center (CSDC)	Pages 107-177	New Chapter

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

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

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

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

Questions or issues related to policy and service delivery should be directed to your Provider Relations team: https://dbhddapps.dbhdd.ga.gov/DBHDDPIMS/(S(kdypqpyee0iou1tmt44kfgiz))/Home_Ext.aspx

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

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

Item#	Topic	Location	Summary of Changes
1.	Provider Manual for Community Developmental Disability Providers, 02-1201	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/14254341/latest
2.	Community Mortality Review Committee, 04-108	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17372681/latest
3.	Background Checks for DBHDD Network Provider Applicants, 04-104	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17497595/latest
4.	Background Checks for Individual Provider Applicants, 04-111	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17498175/latest
5.	State-Funded Supported Employment Services, 02-301	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17586936/latest
6.	Enhanced Supports Services Submission and Review Procedures, 02-804	gadbhdd.policystat.com	**REVISED:** https://gadbhdd.policystat.com/policy/17595819/latest

INTRODUCTION

Welcome

Thank you for your participation as a provider in the Georgia system of services and supports for individuals with Intellectual and/or Developmental Disabilities (I/DD). A network of providers with the ability to deliver quality state-funded services and supports is a primary asset in ensuring the ability to maintain the health, safety, welfare and quality of life for individuals with I/DD residing in the communities across the state of Georgia. The Georgia Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities is glad that your agency has made the choice to participate as a provider of state-funded services and supports. We look forward to working with your agency to assist individuals with I/DD in having a successful experience with community life.

Development/Update and Posting of the Provider Manual for Community Providers of State-Funded Developmental Disability Services

Development: This manual was developed by the staff of the Division of Developmental Disabilities in the Department of Behavioral Health and Developmental Disabilities (DBHDD) to assist community providers of state-funded developmental disability services. The FY 2025 Provider Manual for Community Providers of State-Funded Developmental Disability Services has been designed as an addendum to the provider's contract with DBHDD to provide each provider with the structure for supporting and serving individuals with I/DD residing in the state of Georgia. Members of the DD Advisory Council and other stakeholders, including providers, individuals with I/DD, family members and advocacy organizations, were involved in review of this manual. We extend our sincere thanks for their patience and willingness to devote time and energy to the completion of the Provider Manual for Community Providers of State-Funded Developmental Disability Services. If any conflict is found to exist between requirements found in this manual and requirements found in applicable state or federal law and rules and regulations, the requirement found in law and rules and regulations will prevail until resolution of the conflict is achieved.

Updates: Any updates will be made quarterly to the Provider Manual for Community Providers of State-Funded Developmental Disability Services. Primary responsibility for assuring updates to this provider manual rests with the DBHDD, Division of Developmental Disabilities. Ongoing input from the DD Advisory Council and other stakeholders is welcome in recommending updates to this provider manual.

Posting of Provider Manual:

Purpose of the Provider Manual

Basic Purpose: The purpose of this manual is to outline the basic principles and requirements for delivery of quality state-funded services and supports to individuals with I/DD. State-funded services are intended to be temporary and/or transitional and not a permanent source of funding for individuals eligible for Medicaid waiver funding. For other individuals eligible for state-funded services and receiving these services, continued receipt of services is dependent upon available funding and continued need by the individual for the services. All community providers who participate in state-funded service delivery must have an executed DBHDD contract which requires compliance with this manual. The chapters of the manual provide the requirements for state-funded developmental disability services other than those in the Family Support Program.

Family Support Services: DBHDD policies for the Family Support Program are indexed in Family Supports for Developmental Disability Services – All Procedures, 02-401 which is located at http://gadbhdd.policystat.com/.

Provider Resources: There is information throughout the manual which references additional provider resources such as best practice guidelines; state and federal statutes, rules and regulations; other tools and manuals; and websites. These types of materials are available to assist providers in the development of policies and practices that meet the requirements specified in this manual and promote a good system of service delivery.

Relationships with Individuals Receiving State-Funded DD Services: The individual receiving state-funded DD services is the most important participant in the state-funded system. It is essential that providers have the ability to develop and maintain effective working relationships with individuals, their families, their legal representatives and advocates who may assist them in exercising their rights. Information in the manual outlines requirements and resources intended to promote respectful, effective relationships between individuals (and those assisting or representing them) and the providers delivering the state-funded services and supports.

Relationships with Other Providers of Services and Supports: Information included in the manual is intended to assist providers in developing relationships with other types of providers and in accessing/maximizing resources available through other programs available within the state. This information is intended to promote the ideal that individuals who participate in different programs must be treated in a holistic manner. In other words, the services and supports described in this manual will not meet all the social and healthcare needs of people with developmental disabilities. It is essential that providers develop an understanding of how the state-funded DD services fit within the broader system of state healthcare, educational and social programs. Effective integration of state-funded DD services described in this manual with external services and natural supports is

a goal that the state will continue to work toward.

Vision, Mission and Values

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.

The expectations and requirements that follow are applicable to any community provider of state-funded DD services that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served. Individual 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.*

CHAPTER 1

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT OF STATE-FUNDED SERVICES

1. INTRODUCTION

This manual provides the requirements for state-funded developmental disability services other than those in the Family Support Program. This chapter covers requirements for eligibility, enrollment, and disenrollment for state-funded developmental disability services.

The standards that follow are applicable to DBHDD or organizations that provide 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.

1.1 ELIGIBILITY FOR STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICES

This section provides the standards for the eligibility of individuals for Developmental Disability State-Funded Services.

A. **Individual Eligibility and Priority for Developmental Disability State-Funded Services**: If a service is funded with only state funds, access to services is not guaranteed. The amount of money available for state-funded services is limited. The ability of DBHDD to offer state funded services is dependent upon available funding and the current priorities set for these funds. Current priorities for state-funded services for individuals with I/DD, in order of priority, are:

1. Bridge for individuals on the planning list for DD Waiver services; and

2. Eligible individuals with urgent, complex support needs and documented absence of other supports.

The Regional Field Office admissions staff in conjunction with the State Office determines the individual's priority for state-funded services in accordance with the above priorities.

B. **State-Funded DD Services and Waiver Eligibility**: Individuals who meet the eligibility criteria for Developmental Disabilities (DD) Home and Community Based Waiver services are eligible to receive state funded developmental disability services. DD waiver eligibility criteria are specified in the Department of

Community Health, New Options Waiver (NOW) Program and Comprehensive Supports Waiver (COMP) Program, Part II Policies and Procedures, Chapter 700. The NOW and COMP policies and procedures are available on the Georgia Medicaid Web Portal, which is located at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx.

C. **Eligibility Criteria for State-Funded DD Services**: Individuals who do not meet the developmental disability waiver criteria or found eligible for state funded Family Support Services may receive state funded developmental disability services depending upon the availability of funding, if the following criteria are met:

1. **Most in Need**: **As determined by the current prioritization process.** The meeting of the Most in Need criteria must be supported and documented as part of the eligibility determination by the Regional Field Office admissions staff.

AND

2. **Diagnosis or Sufficient Evidence of a Developmental Disability**: The individual has an established developmental disability diagnosis or determination of sufficient evidence of a developmental disability, as assessed by a professional licensed to make the diagnosis or determination, with origin prior to the age of 22 years that resulted in substantial impairments in general intellectual functioning or adaptive behavior.

D. **Eligibility for Family Support Services**: The eligibility for Family Support Services is specified in Chapter 1 of this manual and in Family Support Services for Developmental Disability Services - All Procedures, 02-401.

E. **Lawful Presence**: Verification of lawful presence in United States is required for adults seeking DD Services from community providers of DD services. In accordance with Georgia law, all programs and services receiving funding from DBHDD or other state, federal or local funds are required to verify that adults who receive DD Services other than DD Emergency Services are lawfully present in the United States. Refer to Verification of Lawful Presence in United States for Individuals Seeking Services and Related Discharge Procedures, 24-109.

1.2 STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICE ENROLLMENT

This section provides standards for the application and enrollment for Developmental Disability State-Funded Services.

A. **Application for Services**: An individual or his/her representative applies for state-funded DD services by completing an application for I/DD that is available online on

the DBHDD website (dbhdd.georgia.gov) or by mail or electronically (fax or email) from a DBHDD Regional Field Office (see Appendix A for Regional Field Office contact information). Applications may be completed in several ways:

1. Applicants may complete and submit the application independently. Applications can be submitted via the case management system at https://idd.georgiacollaborative.com/IDDIndividualPortal/, and by mail or fax. See Appendix A.
2. Applicants can complete the application over the phone with the assistance of a Regional Field Office Intake and Evaluation representative.
3. Applicants can make arrangements to complete the application at the Regional Field Office with the assistance of a Regional Field Office Intake and Evaluation representative.

If an individual or his/her representative contacts a provider of DD services, providers will provide the individual/representative with the contact information for the Regional Field Intake and Evaluation (I&E) Office. The provider informs the individual/representative that the application process is completed through the DBHDD Regional Field Intake and Evaluation Office.

A Regional Field Intake and Evaluation Office representative provides the individual or his/her representative with an application packet upon request or will direct them to the case management system, https://idd.georgiacollaborative.com/IDDIndividualPortal/. All application packets include a blank Authorization for Release of Information, a checklist of what to return with a complete application, and a Region by County Identification Sheet. Complete application packets contains at least the following:

- The filled-out application
- a psychological evaluation
- a medical history
- a signed Authorization for Release of Information

Once a complete application is received by the Regional Field Intake and Evaluation Office, a DD waiver eligibility determination is made by the Intake and Evaluation psychologist. These individuals are placed on the planning list, and as indicated above, a current priority for state-funded DD services is a bridge for individuals on the planning list for DD services (see Planning Lists for Developmental Disability Services for Individuals Living in the Community, 02-101). Any individual determined not to be eligible for the DD waiver services is informed of fair hearing rights as indicated in the Department of Community Health, New Options Waiver (NOW) Program and Comprehensive Supports Waiver (COMP) Program, Part II Policies and Procedures, Chapter 700, which are available on the Georgia Medicaid Web Portal (https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx)

Additional review by the Regional Field Office admissions staff of an application for state-funded eligibility is dependent upon the following:

- Application packet includes evidence of a developmental disability and documentation supportive of most in need criteria; and
- Individual presents with urgent, complex support needs and documented absence of other supports.

The Regional Field Admissions staff or designee notifies the individual or his/her representative of the determination of available funding for the individual who meets eligibility for state-funded DD services. Situations arise where an individual's need for services becomes so severe and urgent that action must be taken immediately to address significant risks to health and safety. When the Regional Field Office learns of an individual's circumstances for which an immediate system response is required, the Admissions staff and Regional Services Administrator coordinate the response. This response includes coordination with the Division of Developmental Disabilities and other agencies as applicable to the individual's situation.

B. **Review Process for Ineligibility Determination for State-Funded Developmental Disability**: Individuals who apply for DD waiver services and are determined to be ineligible for DD waiver services are informed in writing of their fair hearing rights as specified in NOW and COMP Part II, Chapter 700 policies, which are available on the Georgia Medicaid Web Portal (https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx). Fair hearing rights are only applicable to ineligibility determination for DD waiver services. Individuals who apply for state-funded developmental disability services and are determined to be ineligible for the DD state-funded services may request a review of this ineligibility determination in writing to the DBHDD Regional Services Administrator for Developmental Disabilities (RSA-DD). The RSA-DD or designee coordinates a review of the ineligibility determination with DBHDD Division of DD State Office staff. The findings of the review of the ineligibility determination are provided in writing by the Regional Field Office to the individual/representative. The decision of the review will be final.

C. **DD Waiver Eligibility and State-Funded Services:** State-funded services are provided to individuals who are eligible for the DD Medicaid Waiver Programs, the New Options Wavier Program (NOW) or the Comprehensive Supports Waiver Program (COMP), as follows:

1. Individuals on the Planning List: Available state funds may be used as a bridge for individuals on the planning list for NOW/COMP Waiver Services. The receipt of state-funded DD service is dependent upon available funding, assessed priority, and DBHDD Regional Field Office approval.

2. Individuals Receiving NOW or COMP Services: Individuals receiving NOW or COMP services are not eligible for state-funded services. These individuals are

eligible to receive state-funded home and community-based crisis services and state-funded respite services in emergency situations. State-funded home and community-based crisis services are accessed by calling the single point of entry for the (GCAL) Georgia Crisis Response System for Individuals with I/DD (1-800-715-4225).

D. **State-Funded Services for Other Individuals**: Other individuals with I/DD may not be eligible for Medicaid but may be eligible for state-funded services. Individuals who do not meet the DD waiver criteria may receive state-funded developmental disability services depending upon the availability of funding, priority of need, and meeting the Eligibility Criteria for State-Funded DD Services for individuals not eligible for NOW/COMP services listed in Item C of Section 1.1 of this chapter. The Regional Field Office Intake and Evaluation staff in conjunction with the State Office determines the individual's priority for state-funded services in accordance with the priorities listed in Item A of Section 1.1 of this chapter.

E. **Referral to Planning List Administrator or State Services Coordinator**: If the individual is approved by the Regional Field Office for state-funded services as a bridge to waiver services, a referral will be made to the Planning List Administrator. If the individual will remain in long term state funded services a referral is made to a State Service Coordinator. The initial contact is made following Planning Lists for Developmental Disability Services for Individuals Living in the Community, 02-101. Responsibilities of Planning List Administrators and State Services Coordinators are described in Chapter 4 of this manual.

F. **Approval Process for Enrollment into State-Funded Services**: All individuals served by the provider are authorized by the Regional Field Office through the Intake and Evaluation process. Individuals authorized through the Intake and Evaluation process are provided state-funded services dependent upon available of funding and the current priorities set for these funds as listed in Section 1.1 of this chapter. With the identification of available funding for enrollment of state-funded developmental disability services, the individual/family is informed by the Regional Field Office of services approved. The Regional Field Office sends the individual/representative a list of providers servicing the area which also includes surrounding counties. The provider list must state the specific service(s) of the provider.

G. **Initial Individual Service Plan (IISP):** An Initial Individual Service Plan (IISP, formerly called the Temporary Individual Action Plan or TIAP) is developed prior to an individual receiving state-funded services, if services begin prior to a State Service Coordinator completing a full ISP. The IISP is developed by the provider with the required participation of the assigned Planning List Administrator or State Service Coordinator to provide short- term guidelines for state-funded services planned for the individual until a comprehensive ISP is developed. The intention is to expedite the enrollment process so that the individual will receive state-funded services immediately. Comprehensive Individual Service Plan (ISP) development is described in Chapter 4 of this manual. As indicated in Chapter 4, a comprehensive ISP should be

developed 90 days after the Initial ISP for individuals who will receive ongoing state-funded services.

H. **Referral to Providers**: The Regional Field Office obtains confirmation from the individual/representative of the choice of provider(s). Based upon individual/representative choice of provider, the Regional Field Office makes a referral to provider(s) and notifies the provider(s) of the approved state-funded service(s) authorized for the individual by Intake and Evaluation staff. Each provider evaluates referrals to determine the ability to meet the needs of the individuals. When able to provide services and meet the needs of the individual, the provider confirms the start date of services to the Planning List Administrator or State Services Coordinator. The Regional Field Office reviews the documentation submitted by the provider and informs the provider in writing the results of the review. Any concerns by the Regional Field Office about the provider's stated reasons for refusal to serve an individual are included in the written findings of the review.

1.3 STATE-FUNDED SERVICES REDUCTION, DISCONTINUANCE, AND DISENROLLMENT

This section provides the standards for reduction, discontinuance, and disenrollment for Developmental Disability State-Funded Services.

A. **Reporting of Referred Individual Receiving NOW/COMP Waiver Services**: The provider must report to the Regional Field Office of knowledge of an individual referred to Developmental Disability State-Funded Services who also receives NOW/COMP Medicaid Waiver funded services.

B. **Provider Notification of Disenrollment of Individual from State-Funded DD Services**: The Provider Agency for State-Funded Services is responsible for notifying the Regional Field Office in writing of any disenrollment of an individual from state-funded services no less than 30 days prior to the disenrollment. The written notification provides the reason for disenrollment (e.g., movement to another state, death, family decision, etc.). The Regional Field Office is responsible for recording the disenrollment in the data information management system and following up on any needed contract amendment.

C. **Disenrollment from State-funded Services Due to NOW/COMP Waiver Enrollment:** The Regional Field Office notifies the provider(s) of state-funded services in writing when an individual is enrolling into the NOW or COMP waiver. The Regional Field Office facilitates the individual's disenrollment from state-funded services. The provider works with the Regional Field Office in converting individuals who are eligible for the NOW/COMP Waiver from state-funded services to Waiver services.

D. **Review Process for DBHDD Regional Field Office Discontinuation or Reduction of State-Funded Developmental Disability Services**: If the individual/representative requests a review of the discontinuation or reduction of state-funded developmental disability services, the request for the review is sent in writing to the Regional Field Office for a review by the Regional Services Administrator for Developmental Disabilities (RSA-DD) or designee. The decision of the review may be based on, but not limited to, a change in available funding for state developmental disability services, changes in individual priority of need, or NOW/COMP waiver enrollment. The RSA-DD will confer with DBHDD Division of DD State Office staff before providing a decision on the review. The decision of the review will be final.

CHAPTER 2

STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICES

2. INTRODUCTION

There are a variety of state-funded services and supports for individuals with I/DD who meet eligibility for these services and are approved for these services as outlined in Chapter 1 of this manual. This chapter provides an overview of state-funded developmental disability services.

2.1 STATE-FUNDED SERVICES

State-funded services may be provided to an individual with a developmental disability determined eligible for these services and depending upon the availability of funding and the current priorities for these funds in accordance with Section 1.1 of Chapter 1 of this manual. Providers under contract with DBHDD provide state-funded services in accordance with the requirements of this manual and as specified in their contract. State- funded services are provided to authorized individuals who meet the DBHDD's criteria for state-funded developmental disability services and who have no other means of payment of these services, including State Medicaid Plan services for those receiving Medicaid. All individuals receiving state-funded services must be authorized by the Regional Field Office through the Intake and Evaluation process.

The following is a list of the state-funded services provided in accordance with the Individual Service Plans (ISPs) for individuals served:

A. **Community Access Services – The State Funded Community Access services have the same service descriptions and standards as the Community Access services described in Chapter 2000 of the Comprehensive Supports Waiver program manuals maintained by the Department of Community Health.** See COMPREHENSIVE SUPPORTS WAIVER PROGRAM PART III - CHAPTER 2000, SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY ACCESS SERVICES SCOPE OF SERVICES found on GAMMIS at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx for service delivery descriptions.

NOTE: *Community Access Participant-Directed is not a mode of service delivery for State Funded Individuals, and the Chapter 2000 provisions that are specifically for participant-directed services do not apply to State Funded services.*

These services will otherwise continue to be governed by the provisions of this

DBHDD Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services, including but not limited to the provisions of Chapters 1, 3, 4, and 5. Where there is a clear conflict between the provisions of this manual and the provisions of the Part III Comprehensive Supports manual, the provisions of this DBHDD manual shall control.

1. **Transportation and Community Access Services** – Individuals who have State-Funded Community Residential Alternative (CRA) services receive transportation from their State-Funded CRA providers, in accordance with the provisions of this manual and **Chapter 1700 of the Comprehensive Supports Waiver program manuals maintained by the Department of Community Health. For individuals who have State-Funded Community Access services but not State-Funded CRA services,** transportation requirements are as follows:

   a. Transportation to and from activities and settings primarily utilized by people with disabilities is included in Community Access services. This transportation is provided through Community Residential Alternative services for individuals receiving these services.

   b. Transportation provided through Community Access services is included in the cost of doing business and incorporated in the administrative overhead cost.

   c. The individual's family or representative may choose to transport an individual to a Community Access facility.

   d. Transportation is required between point of origin and activities in settings primary utilized by people with disabilities (a reasonable amount of transportation, defined as up to one hour per day, is billable). Point of origin is defined as any location that individuals are available for pick-up that is safe and appropriate for the individual based on the approved Individual Service Plan (ISP).

B. **Supported Employment Services** – Supported Employment services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to work in an integrated work setting. Supported Employment services are distinct from and do not occur at the same time of day as Community Access.

   The planned outcomes of Supported Employment services are to increase the hours worked by each individual toward the goal of full-time employment (i.e., the goal of forty (40) hours per week) and to increase the wages of each individual toward the goal of increased financial independence.

Supported Employment services are based on the individual's needs, preferences, and employment interests. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

State-Funded Supported Employment Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. State Funded Supported Employment services are designed to provide extended supports for supported employees with IDD who meet specific eligibility criteria, and to support them to maintain a job and career development.

2. Adaptations, supervision, and training required by individuals receiving Supported Employment services as a result of their disabilities, when these services are provided in a work site where persons without disabilities are employed.

C. **Community Living Support Services (CLS) – The State Funded CLS services have the same service descriptions and standards as the CLS services described in Chapter 2200 of the Comprehensive Supports Waiver program manuals maintained by the Department of Community Health.** See COMPREHENSIVE SUPPORTS WAIVER PROGRAM PART III - CHAPTER 2200 SPECIFIC PROGRAM REQUIREMENTS FOR COMMUNITY LIVING SUPPORT (CLS) SERVICES SCOPE OF SERVICES found on GAMMIS at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx for service delivery descriptions.

NOTE: *Community Living Support as a Participant-Directed is not a mode of service delivery for State Funded individuals, and the Chapter 2200 provisions that are specifically for participant-directed services do not apply to State Funded services.*

These services will otherwise continue to be governed by the provisions of this *DBHDD Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services*, including but not limited to the provisions of Chapters 1, 3, 4, and 5. Where there is a clear conflict between the provisions of this manual and the provisions of the Part III Comprehensive Supports manual, the provisions of this DBHDD manual shall control.

D. **Community Residential Alternative Services (CRA) – The State Funded CRA services have the same service descriptions and standards as the CRA services described in Chapter 1700 of the Comprehensive Supports Waiver program manuals maintained by the Department of Community Health.** See COMPREHENSIVE SUPPORTS WAIVER

PROGRAMPART III - CHAPTER 1700 SPECIFIC PROGRAM REQUIREMENTS FOR ADDITIONAL STAFFING SERVICES SCOPE OF SERVICES found on GAMMIS at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

These services will otherwise continue to be governed by the provisions of this *DBHDD Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services*, including but not limited to the provisions of Chapters 1, 3, 4, and 5. Where there is a clear conflict between the provisions of this manual and the provisions of the Part III Comprehensive Supports manual, the provisions of this DBHDD manual shall control.

E. **Respite Services – The State Funded Respite services have the same service descriptions and standards as the Respite services described in Chapter 3100 of the Comprehensive Supports Waiver program manuals maintained by the Department of Community Health, and also have the additional requirements set forth below.** See COMPREHENSIVE SUPPORTS WAIVER PROGRAM PART III - CHAPTER 3100 SPECIFIC PROGRAM REQUIREMENTS FOR RESPITE SERVICES SCOPE OF SERVICES found on GAMMIS at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

These services will otherwise continue to be governed by the provisions of this *DBHDD Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services*, including but not limited to the provisions of Chapters 1, 3, 4, and 5. Where there is a clear conflict between the provisions of this manual and the provisions of the Part III Comprehensive Supports manual, the provisions of this DBHDD manual shall control.

Additional Requirements for State-Funded Respite Services: Each Regional Field Office maintains a list of DBHDD contracted Respite provider agencies with which the region contracts for the provision of Respite. The contracted Respite provider agency has the following responsibilities:

a. Ensures that Respite Services are provided only in approved Respite sites that meet the specified physical standards and other requirements to provide state- funded Respite in this manual and in State Funded Respite for Individuals with Developmental Disabilities, 02-102.

b. Maintains a list of Approved Respite Sites and Persons Approved to Provide Respite (including addresses and contact information); and

c. Adds a site or approved person to the list **only** after having documentation

on hand that the site or approved person meets all requirements to provide state- funded Respite Services.

Note: State funds cannot be used to purchase or reimburse Respite Services provided by any person who is not included on the List of Persons Approved to Provide Respite.

F. **Behavioral Supports Services** – These professional consultation services assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations.

The intended outcome of Behavioral Supports Services is to increase individual skills and decrease the need to engage in challenging behaviors. The services emphasize a systems approach to behavioral interventions with an emphasis placed on early identification of problem behaviors. Specialized interventions are designed with a function-based approach that eliminates challenging behaviors and replaces them with alternative pro-social skills.

State-Funded Behavioral Supports Services include the following based on the assessed need of the individual and as specified in the approved ISP:

1. Functional assessment of behavior and other diagnostic assessment of behavior.

2. Development, training, and monitoring of Behavioral Support plans with specific criteria for the acquisition and maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors.

3. Intervention modalities related to the identified behavioral needs of the individual.

4. Individual-specific skills or replacement behavior acquisition training.

5. Family education and training on Behavioral Supports.

G. **Community-Based Crisis Services** – 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.

1. **Eligibility Community-Based Crisis Services** – GCRS serves children and adults with developmental disabilities aged 4 years and above who meet eligibility criteria as defined below. A person with developmental disabilities in need of crisis services is an individual who:

    a. Has documented evidence of a diagnosis of an intellectual disability prior to age 18 years or other closely related developmental disability prior to age 22 years, for individuals currently on the planning list or in DD services; screening indicative of a developmental disability for other individuals; **AND**

    b. Presents a substantial risk of imminent harm to self or others; **AND**

    c. Is in need of immediate care, evaluation, stabilization or treatment due to the substantial risk; **AND**

    d. Is someone for whom there currently exists no available, appropriate community supports to meet the needs of the person.

2. **Components of the Georgia Crisis Response System** – This system includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis.

    a. **Intake**: Entry into the system takes place through the Single Point of Entry (SPOE) system, the Georgia Crisis & Access Line (GCAL). Intake personnel determine if an individual meets the requirements for entry into the system.

    b. **Dispatch or Referral**: The SPOE initiates the appropriate dispatch or referral option. If a Blended Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services.

    c. **Crisis Services**: Crisis services occur through intensive on-site or off-site supports. These crisis supports are provided on a time-limited basis to ameliorate the crisis. 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.

    Note: For additional information on the requirements of the GCRS-DD, see the Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD) in the Provider Manual for Community Developmental Disability Providers located on the DBHDD website (https://dbhdd.georgia.gov/, Providers tab, Community Provider tab).

3. **GCRS-DD Services** include the following:

   a. **Blended Mobile Crisis Response** – Refer to Provider Manual for Community Behavioral Health Providers, 01-112 for definition and service requirements of Blended Mobile Crisis Response.

   b. **Intensive In-Home Support** – Intensive In-Home Support services include, but are not limited to, the following: Implementation of behavioral intervention strategies provided under the recommendations of the intensive in-home provider, safety plans, or behavioral support plans already established for the individual; provision of one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations as necessary to maintain safety; and when necessary accompanying the individual to appointments related to the crisis response. The provision of a staffing pattern up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing over 7 calendar days. 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. Assurance of appropriate training 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); **AND**

      ii. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable).

   c. **Intensive Out-of-Home Support** – 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 Individuals under the age of 19 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, A DBHDD compliance initial review and certificate is required to operate the DD crisis site.

   d. **Intensive Out-of-Home Support for Children and Adolescent (C&A)** – A C&A Home serve no more than four children and adolescent between 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. The C&A out- of -home site must receive an initial compliance

review and certificate is required to operate the C&A crisis site.

e. **Case Management by Crisis Provider** – Once the initial crisis has stablished, individuals receiving on site in-home and /or off site out -of-home crisis supports shall also receive case management provided by the crisis provider. This case management is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services that meets the needs of the individual and ensures follow up on recommended services. Note: 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.

Note: For additional information on definitions and service criteria of intensive in-home, intensive out-of-home, and case management, see the Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD) in the Provider Manual for Community Developmental Disability Providers located on the DBHDD website (https://dbhdd.georgia.gov/, Providers tab, Community Provider tab).

2.2 PROVIDER EXPECTATIONS RELATED TO STATE-FUNDED SERVICES

The following are provider expectations related to State-Funded Developmental Disability Services:

A. Ensures that State-Funded Services are delivered to individuals referred to the provider in accordance with Chapter 4 of this manual;

B. Accesses the Georgia Crisis Response Systems as a last resort and only if existing crisis procedures as part of the safety plans have been implemented unsuccessfully and/or the individual is an imminent harm to self or others and the current supports cannot maintain safety, and/or the individual is in need of immediate care, evaluation, stabilization or treatment due to risk, and the individual has no available, appropriate community supports to meet his or her needs;

C. Permits and assists as requested in a random sampling of individual records by DBHDD or an authorized designee to verify the eligibility of persons served, the appropriateness of State-Funded DD Services provided, and the quality of State- Funded DD Services provided;

D. Attends all Regional Field Office Provider Meetings for the regions in which services are provided;

E. Ensures that all individuals receiving State-Funded DD Services have been

identified eligible and referred for service by the Regional Field Office, Intake and Evaluation;

F. Acknowledges that the failure to follow the Regional Field Office process could result in denial of reimbursement or request for payback of received funds;

G. Works with the Regional Field Office in converting individuals who are eligible for DD waiver from state funded services to Waiver services;

H. Maximizes the utilization of all capacity to serve individuals;

I. Meets quarterly with the Regional Field Office at a meeting called by the Regional Field Office to review utilization and address the issues related to unutilized capacity; and

J. Cooperates with DBHDD's Quality Improvement Organization (QIO) in its implementation of DBHDD's Developmental Disability Quality Management System.

CHAPTER 3

RESOURCE ALLOCATION AND INDIVIDUALIZED SERVICE PLANNING OF STATE-FUNDED SERVICES

3. INTRODUCTION

If a service is funded with only state funds, access to services is not guaranteed. The state legislature must make funding available in the state budget to initiate and ensure continuation of state-funded services. The DBHDD, Division of Developmental Disabilities is responsible for determination of funding needs, setting priorities, and contracting and allocation of the limited state funds for services for individuals with I/DD. The Division of DD is committed to carrying out these functions in concert with providers, advocacy groups, and individuals and their families. Current priorities for state-funded services for individuals with I/DD are:

1. Bridge for individuals on the planning list for DD Waiver services;

2. Eligible individuals with urgent, complex support needs and documented absence of other supports.

Individuals with I/DD may receive state-funded services depending on availability of funding and priority of need. State-funded emergency respite services address urgent needs for services as approved by the Regional Field Office.

3.1 RESOURCE ALLOCATION OF STATE SERVICES FUNDS

This section provides standards for the resource allocation of state services funds by DBHDD Regional Field Offices.

A. **Regional Field Office Resource Allocation of State Services Funds** – Regional Field Office resource allocation of state funds for developmental disability services occurs as follows:

1. **Review of Utilization Management Data:** The Regional Field Offices conduct ongoing review of utilization management data on state-funded services for individuals with I/DD. The Regional Field Offices currently use data from required provider reporting specified in Chapter 6 of this manual for their utilization management of state-funded services.

2. **Re-distribution of State Services Resources:** Utilization management data provide the basis for decisions on the re-distribution of state services resources in accordance with the state priorities for these resources and to assure efficient

use of these limited resources. State services resources also may be re-distributed due to the inability of a provider to meet contract deliverables. The Regional Field Offices provide the State Office of Division of Developmental Disabilities with summary reports of their utilization management reviews and findings on provider contract deliverables. The Division of Developmental Disabilities reviews the Regional Field Office summary reports prior to the development of annual provider contracts for state-funded services.

3. **Contract Amendment or Termination:** The Division of Developmental Disabilities reserves the right to amend contracts during a state fiscal year based on utilization management data, contract deliverable reports, and/or the availability of funding. If a provider does not meet the stated service outcome expectations listed in DBHDD's contract, the provider will be notified and may be required or permitted to develop a plan of correction. Continued underperformance may result in contract modification or other contract action, including termination of the contract.

B. **Regional Field Office Referrals** – Regional Field Offices make referral to providers as follows:

1. The Regional Field Office makes a referral to a provider based upon the individual/representative choice of provider.

2. The Regional Field Office's referral notifies the provider of the approved service(s) authorized by Admissions staff.

C. **Provider Screening of Referrals**– The provider receiving a referral from a Field Office. Office conducts a screening of the referral as follows:

1. Providers will screen all referrals to determine if the individual's needs can be met within the program.

2. The provider evaluates referrals to determine what area of services they can provide to meet the needs of the individuals.

3. When able to provide services and meet the needs of the individual, the provider confirms the start date of services to the Planning List Administrator or State Services Coordinator as indicated in Chapter 1 of this manual.

4. The Regional Field Office reviews the documentation submitted by the provider and informs the provider in writing the results of the review. Any concerns by the Regional Field Office about the provider's stated reasons for refusal to serve an individual are included in the written findings of the review.

D. **Subcontracting Limitations for Community Residential Alternative Services** – The evaluation by a provider of the capacity to serve an individual includes consideration of the following subcontracting limitations:

1. Subcontracting of Community Residential Alternative services is limited to Host Home Providers only.

2. The provider shall hold the Community Living Arrangement License or Personal Care Home Permit licensed by Healthcare Facility Regulations (HFR) for Community Residential Alternative services for all residential sites housing individuals with I/DD.

3. Only one provider agency may provide services in any home or residential site established to provide Community Residential Alternative for individuals with I/DD and Related Conditions.

E. **Maximization of Provider Capacity** – The provider is expected to maximize the utilization of all capacity to serve individuals.

1. The provider conducts self-assessments of capacity to serve individuals and assists/cooperates with Regional Field Office and state assessments of provider capacity.

2. The Regional Field Office and the provider meet quarterly at a meeting called by the Regional Field Office to review the utilization and address the issues related to unutilized capacity.

3. Changes may be made to adjust fund and service allocations to meet the needs of individuals based on the agreement by both parties.

3.2 INDIVIDUAL SERVICE PLANNING

This section provides standards for Individual Service Planning for state-funded intellectual/developmental disability (I/DD) services.

A. **Individual Service Planning Process** – Individual Service Planning for state-funded I/DD services is the process through which the needs, goals, desires, and preferences of an individual are identified, and strategies are developed to address those needs, goals, desires, and preferences.

1. The process for the development of the Individual Service Plan allows the individual to exercise choice and control over services and supports and assures assessment and planning for any issues of risks as applicable for the state-funded services provided;

2. Individual Service Planning maximizes the resources and supports present in the individual's life and community;

3. The planning process should enable and support the individual, and as appropriate, his or her family/representative, to fully engage in and direct the process to the extent he or she chooses;

4. Individual Service Planning assures that the individual, and as appropriate, his family/representative, has choice about how needs are met;

5. The planning process produces an organized statement of proposed services to guide the provider(s) and the individual throughout the duration of state-funded service;

6. Providers of state-funded developmental disability services are required to deliver services as specified in the Initial Individual Service Plan (IISP) or the Comprehensive Individual Service Plan (ISP). Compensation for services is based on the delivery of authorized services specified in the IISP or ISP.

B. **Individual Service Plan** – The organized statement, or Individual Service Plan (ISP), is the product of the Individual Service Planning.

1. The ISP is based on what is important to and for the individual; it includes the individual's hopes, dreams, and desires as well as what works and does not work for the individual;

2. The ISP captures, from the individual's point of view, decisions and choices that are being made by the individual as well as decisions with which he/she needs support and assistance.

C. **Initial Individual Service Plan** – The intention of an initial ISP is to expedite the enrollment process so that the individual will receive state funded services immediately. The standards for the Initial Individual Service Plan (IISP) are as follows:

1. An initial ISP should be developed before an individual receives state-funded services;
2. The initial ISP is developed by the provider with the required participation of the assigned Planning List Administrator to provide short-term guidelines for state- funded services planned for the individual until a comprehensive ISP is developed.

D. **Comprehensive Individual Service Plan** – The standards for the Comprehensive Individual Service Plan (ISP) are as follows:

1. A comprehensive ISP should be developed 90 days after the initial ISP for

individuals who will receive ongoing state-funded services (the completion of the comprehensive ISP within 90 days is the responsibility of the Planning List Administrator or the State Services Coordinator as indicated below);

2. The ISP is developed by the Regional Field Office Planning List Administrator or State Service Coordinator along with the provider(s) and the individual and/or family/representative;

3. The ISP must be person centered to maximize the individual's potential to achieve independence, community integration, and a meaningful life;

4. The goals/objectives established in the ISP must be tailored to the individual's desire and needs. Services in the ISP must reflect the individual's choices.

E. **Responsibilities of Planning List Administrators and State Services Coordinators** – The standards for the responsibilities of Planning List Administrators and State Services Coordinators are as follows:

1. The initial contact is made by the Planning List Administrator or State Services Coordinator within 10 business days of notification that an individual has been approved to receive state services.

2. The Planning List Administrator or State Services Coordinator is responsible for the development of the comprehensive ISP 90 days after the initial ISP for individuals who will receive ongoing state-funded services.

3. Individualized Service Planning Responsibilities of the Planning List Administrator or State Services Coordinator: These responsibilities include the following:

   a. Scheduling and facilitating the development of the written, comprehensive Individual Service Plan (ISP);

   b. Ensuring the state-funded services are person centered and addressing what is important to and for the person;

   c. Meeting overall quality management standards for the ISP to include, but not be limited to, the specification of the desired outcomes of state-funded services (goals);

   d. Identifying the state-funded services and supports, including the frequency and amount, that are appropriate to meet the needs of the individual;

   e. Reviewing any identified risks and addressing those risks in the ISP;

f. The Planning List Administrator or State Services Coordinator submits the comprehensive ISP for approval to designated Regional Field Office staff within 10 days of the ISP meeting via the web-based system.

4. ISP Review Responsibilities of the Planning List Administrator or State Services Coordinator: These responsibilities include the following:

   a. Conducts review of ISP for state-funded developmental disability services consistent with timelines required for that plan, but no less than once annually following the initial plan development date and more often if needed;

   b. Informs the Planning List Administrator Supervisor for Developmental Disabilities or designee of any urgent needs for additional services, such as Emergency Respite;

   c. Provides information on changes in need and additional services requested to the Planning List Administrator Supervisor and Admissions Manager to review requests for additional services based on availability of funding and priority of need and with communicated understanding to individual/family and provider that state funded I/DD services are not an entitlement;

   d. Amends the comprehensive ISP when an increase or reduction in services is indicated due to change in the individual's needs;

   e. Schedules the meeting for the annual ISP review no later than 45 days prior to the expiration date and facilitates the development of the written, comprehensive ISP;

   f. Ensures services are person centered and address what is important to and for the person;

   g. Reviews services and supports and revises as appropriate to meet current, individual needs;

   h. Assures written, comprehensive ISP meets overall quality management standards to include, but not be limited to, the specification of the desired outcomes of state-funded services (goals);

   i. Submits annual ISP for approval to designated Regional Field Office staff within 10 business days of meeting via web-based system.

5. Planning List Administrators and State Services Coordinators establish a working relationship with and knowledge of local community resources to support individuals with I/DD and their families.

6. The Planning List Administrator or State Services Coordinator provides information to the individual/family on local community resources during the comprehensive ISP development process and ongoing as indicated by the changing needs of the individual.

7. The State Services Coordinator and Planning List Administrator jointly assure that individuals on the planning list and their families access available State Medicaid Plan Services while waiting for waiver services and receiving bridge state-funded services.

8. Planning List Administrators and State Services Coordinators provide the monitoring for individuals receiving state funded I/DD services; additional information on monitoring is provided in Chapter 5 of this manual.

F. **State-Funded Developmental Disability Provider Responsibilities for Individualized Service Planning** – The provider has the following responsibilities related to the individualized service planning for persons served:

1. Ensures that direct support staff and other staff participate fully in the development of Individual Service Plans in partnership with individuals and families, and the State Services Coordinator;

2. Plans and provides services that are person centered and geared to give individuals real and meaningful choices about service options;

3. Completes an HRST at least 90 days prior to the annual ISP, updates the HRST when a person experiences significant change in health and/or function, uses recommendations to provide education and training if a person's level is 3 or greater, and assures that the provider's nurse reviews and approves by signature the HRST.

4. Refers unmet individual needs to the State Services Coordinator as indicated and/or requested by the individual served.

G. **Planning Requirements for Individuals with Identified Recurring Challenging Behavior** – When an individual has an identified recurring challenging behavior reflected in his or her Individual Service Plan (ISP) in the Health and Safety Section, a Behavioral Support Plan (BSP) that reflects positive and proactive supports must be in place to resolve the challenging behavior(s). Funding for individuals receiving State Funded Behavior Supports Consultation Services is included or added to the contract based on a Regional Field Office approved comprehensive ISP indicating the need for a BSP.

H. **Planning Requirements for Individuals with Identified Challenging Behavior and Health and Safety Risks** – For an individual with identified challenging behaviors that pose health and safety risks as reflected in his or her Individual

Service Plan (ISP) in the Health and Safety Section, a safety plan involving crisis procedures must be in place that identifies how behavioral crisis related to the challenging behavior(s) will be safely managed. Use of 911 should not be a primary intervention in the safety plan and should only be used if crisis procedures do not ameliorate the risks. However, 911 may be necessary when high risk situations occur that cannot be safely ameliorated by use of crisis procedures such as when the individual is wielding a deadly weapon, or in the occurrence of an injury requiring emergency medical intervention.

CHAPTER 4

QUALITY MANAGEMENT OF STATE-FUNDED SERVICES

4. PURPOSE

The purpose of a Quality Management Program is to monitor and evaluate state contracted services in order to continuously improve the quality of care for all individuals served through a state-funded contract.

It is the intention of DBHDD to provide guidance to state-funded service provider agencies in developing a comprehensive and continuous quality management (QM) process to improve the quality of services for individuals with I/DD. No two organizations are identical; they provide different services to different populations in different geographical areas and have different stakeholders and different organizational cultures. Providers considers these differences when including outcomes and performance indicators in your Quality Management Plan (QMP), when deciding on data collection, and when including goals and objectives in your Quality Improvement Plan. Provider agencies are free to develop a QM plan that best serves their agency, but all QM plans address the quality requirements found in the most recent DBHDD ***Community Service Standards for Developmental Disability Providers***.

4.1 WHAT IS QUALITY AND QUALITY MANAGEMENT?

The Department of Behavioral Health and Developmental Disabilities (DHBDD) defines "quality" as the degree to which a health or social service meets or exceeds establish professional standards and the needs and expectations of the individuals we serve.

Quality management is a dynamic system of processes or steps which gauge the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Quality management encompasses three functions:

- Discovery: Collecting data and direct individual experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.

- Remediation: Taking action to remedy specific problems or concerns that arise.

- Continuous Improvement: Utilizing data and quality information to engage in actions that lead to continuous improvement in state-funded developmental

disability services.

A. **Beginning**

The first step toward developing your organization's Quality Management Strategy is developing or reviewing your organization's vision and mission. Your organization should be clear about what it does, how it expects to improve, and the desired outcomes. Your organization may also develop a statement of values or guiding principles. Additionally, effective QMPs include establishment of an infrastructure within the organization which will support your quality enhancement efforts and stakeholder input either from your Board of Directors or through focus groups, individual interviews, or a Quality Improvement Council.

B. **Quality Improvement Council**

A Quality Improvement Council is a mandatory, external advisory group whose role is to assist your organization in developing meaningful outcomes and performance indicators and setting priorities for quality improvement.

Ideally, the membership of your Quality Improvement Council will be composed of stakeholder representatives. You should strive to include people to whom your organization provides services, their families, representatives from advocacy organizations, and community leaders. The exact composition is determined by the population you serve, advocacy groups that are active in your geographic area, and the interest and commitment that you can obtain from local leaders in government, business, religious, and community organizations.

The Quality Council will help you to better support people with developmental disabilities and better serve your community by assisting your organization to:

1. Identify quality outcomes and performance indicators;

2. Assess performance;

3. Prioritize quality enhancement goals and objectives; and

4. Evaluate implementation and effectiveness of your quality enhancement plan.

C. **Quality Improvement Committee**

Quality is every employee's responsibility, but each agency designates some **internal** staff to be responsible for quality management activities and assisting other staff to fulfill their quality responsibilities. This group of staff can be referred

to as an agency's "Quality Improvement Committee." The size of the committee would depend on the size of the organization. In a small organization, the committee may be one or two persons. In a large organization, there may be an entire unit or section devoted to coordinating quality management activities.

The functions of the Quality Improvement Committee will vary somewhat from organization to organization, but typical functions include:

1. Development of various discovery methods which allow an agency to collect information and data related to the quality of its services;

2. Working with information technology staff in the development system to support the collection of information and so that data may be aggregated and analyzed for trends and patterns;

3. Analyzing data and creating reports which summarize trends and patterns that emerge;

4. Facilitating the review of quality data by internal and external groups which provide recommendations to executive management;

5. Partnering with staff who have responsibility for implementing quality improvement efforts;

6. Evaluation of the implementation of quality improvement efforts;

7. Gathering data to evaluate effectiveness of quality efforts; and

8. Providing training, technical assistance, and support to all staff on the organization's Quality Management Plan.

4.2 QUALITY OUTCOMES AND DEVELOPING PERFORMANCE INDICATORS

An important part of your Quality Management Plan is the identification of quality outcomes and performance indicators. A good place to start in this identification would be a review of the seven (7) focus areas of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. Your organization develops a quality outcome specific to your organization but which also addresses each focus area.

A. CMS Quality Framework

The CMS Quality Framework's seven (7) focus areas are:

1. Participant Access: Are the preferred services of the people that you support available to them; how quickly can they be obtained?

2. Participant-Centered Service Planning and Delivery: Do the individualized support plans of the people that you support reflect their needs and preferences; are these services delivered?

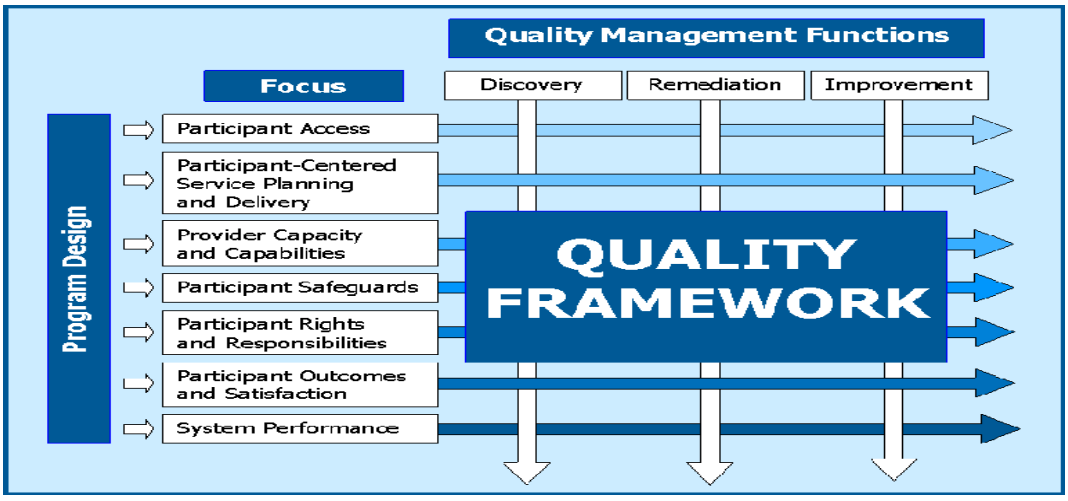
3. Provider Capacity and Capabilities: Does your organization have the capacity and capabilities to meet the needs and preferences of the people you support; does your agency meet the requirements of all applicable federal and state regulations?

4. Participant Safeguards: Are the people you support free from abuse, neglect, exploitation, and extortion; are potential risks identified and strategies developed to mitigate risks taking into account the preferences of the person receiving supports; do the people you support receive needed medications and health services?

5. Participant Rights and Responsibilities: Are the people you support informed of their rights and responsibilities; are they supported to exercise their civil rights; are all restrictions reviewed and approved by a human rights committee before implementation?

6. Participant Outcomes and Satisfaction: How satisfied are people with the services that your organization provides; are the people that you support achieving their short-term personal goals and long-term dreams; how do the people that you support fare on quality of life indicators?

7. System Performance: How efficient and effective are your services; how well does your performance align with your vision, mission, values, and guiding principles; do you keep abreast of proven and promising practices and update your practices, as appropriate?



B. Quality Outcomes

Quality outcomes are the results of program operations or activities and may be direct or

indirect, for example, improved health vs. changed attitudes or beliefs.

Performance indicators are designed to measure the extent to which performance objectives are being achieved on an ongoing basis. One outcome may be that "people have the best possible health." Performance indicators to measure how well your organization is supporting people to have the best possible health might include: number of emergency room visits, number of major illnesses or accidents, percentage of people who have a physical exam each year, percentage of people who have breast or colon cancer screenings, mortality rates, etc.

C. **Strategies for Quality Outcomes and Performance Indicators**

The following strategies will help your organization to develop quality outcomes and performance indicators:

1. Review your mission, vision, values, and guiding principles;

2. Obtain input from your Quality Improvement Council, your Board of Directors, your staff, and other stakeholders;

3. Review information about what individuals and families want from the services that your organization provides, such as results from surveys or focus groups;

4. Review requirements that you must follow, such as licensing regulations and contract requirements;

5. Determine the quality outcomes that you and your stakeholders would like to see for the individuals your agency supports and for your agency as a whole;

6. Review the seven (7) focus areas to see if you have identified quality outcomes in each area;

7. For each quality outcome, determine what your performance indicators will be; that is how you will measure how well you are doing.

D. **Other Considerations in Development of Measures**

Other considerations as you develop your measures include:

1. **Reliability:** Is your measure reliable; does it measure something consistently?

2. **Validity:** Is your measure valid; does it measure what it is supposed to measure?

3. **Sampling**: Is your sample size large enough to generalize your results within a

desired confidence level, and is your sample representative of the population that your organization wants to measure?

4.3 DATA COLLECTION AND ANALYSIS (DISCOVERY)

There is a tendency for organizations to collect many various types of information and data. However, an agency should ask itself, "What am I doing with this data?" or "What is the data really telling me?" Problems arise when they do not use this information and data to learn about the quality of their services or to drive their quality enhancement efforts. The proper collection and use of data can help you build a plan and focus resources on the things that need attention.

A. Identifying Data

Identifying data is a two-step process:

1. Identifying existing data.

2. Identifying data that are needed.

B. Identification of Data Sources

After you have developed your quality outcomes and performance indicators for each outcome, your next step is to identify data sources for the performance indicators. You may already be collecting the needed data for certain indicators, but you may need to identify potential data sources and collections methods as well.

Some typical types of existing information and data may include:

1. **Satisfaction Surveys**: These may include both customer and staff satisfaction.

2. **Regulatory Reviews**: These may include licensing results or any other external monitoring that was conducted such as accreditation, standards compliance, etc.

3. **Critical Incident Reports**: These include all incidents that are required to be reported both internally and externally, including abuse, neglect, or exploitation reports.

4. **Complaints and Grievances Reports**: These include all complaints made about your services and their resolution.

5. **Internal Reviews**: These may include any assessment completed by your organization to determine how well your organization is adhering to internal policies

or external regulations, e.g., chart reviews, timeline adherence, turnover information, etc.

C. **Organization of Your Data**

A list is compiled of the data that you have currently at your disposal. The Quality Improvement Committee reviews the data to determine:

1. What is it telling you?
2. Is it useful to determine the quality of your services?
3. How often is it collected?
4. Who collects the data and who submits it?
5. Where does it go?
6. Is the data aggregated and if so how often?
7. Is the data analyzed to determine patterns and trends, and if so, how often?

D. **Identification of Needed Data**

Your performance indicators, management, and policies and procedures will determine the information you need to collect. DBHDD and licensing standards and requirements will also determine what you collect within your organization.

E. **What Data Is Missing?**

After you determine what data you have, make a list of what information and data you need. You can then compare the list of needed data with the list of currently collected data, and determine what data is missing.

F. **Filling in the Gaps**

Once you have identified the additional data that needs to be collected, your next step is to decide:

1. How will this information be collected?
2. How will this information be stored (a database or other format) that supports analysis?
3. How will the data be used?

G. Collecting Data

Once you have identified the data that is currently available, identified the data you need (the gaps), and how to fill the gaps, you have the beginnings of a data management plan. You should regularly and frequently review your data management plan to determine if you need to make:

1. Any changes in the frequency of collection;

2. Any changes in how you collect the data;

3. Any changes in what data is to be collected; and

4. Any revisions to your data sources.

H. Data Aggregation and Analysis

The definition of "aggregate" is to gather together in a mass constituting a whole. By aggregating data, you can more easily identify areas that are not distinctive but more generally affect the quality of your services. For example, when you look at individual data (e.g., one critical incident report for a person), you respond to the immediate safety issue and initiate strategies to reduce the chance of a similar incident occurring in the future for that person. If several similar types of critical incidents are occurring for several of the people you support (a trend), you will need to take a more comprehensive approach, i.e., developing staff training programs or changing policies and procedures to prevent or reduce these types of critical incidents from reoccurring. Data analysis means to process information or data that has been collected in an effort to draw valid conclusions. It is a systemic way of applying statistical techniques to describe, summarize, and compare data using narratives, charts, graphs, and/or tables. Analyses often involve looking for trends and patterns.

I. Trends and Patterns in Data

Trending means examining data over a period of time to identify general tendencies for increases or decreases in the data**.** An example would be analyzing mortality rates to see if mortality rates have been decreasing or increasing over the past several years. Patterns, on the other hand, signify relationships. For example, are people reporting less satisfaction with availability of respite services in the rural areas that you serve as compared to the urban areas? Another example would be staffing patterns and the difference in the satisfaction with services that are being delivered.

4.4 ASSESSING THE QUALITY OF YOUR SERVICES (REMEDIATION)

You have determined what data is needed, collected what you could, and have analyzed your findings. Now you should be able to identify the things that your organization does well (what's working) and those things that need improvement (what's not working).

A. Making a List of What is Working and What is Not Working

Following the process for organizing our data, make a list of what is working and what is not working. Compare the lists to determine if there are conflicts between the lists. If there is a conflict, continue drilling down in the data to figure out why. Some reasons for conflicts may be:

1. The way data is collected or reported;

2. The reliability or validity of one or more of the measures; or

3. The sample selection methodology for one or more of the measures.

Once you determine the cause of the conflict, revise your data collection methodology and start over with the process.

B. Prioritizing Areas Needing Improvement

Now it's time to prioritize the areas you have found needing improvement. You should prioritize according to the:

1. Mission and vision of your organization;

2. Safety and well-being of the people in services; and

3. Expectations and desires of your stakeholders (which include individual, DBHDD, licensure requirements, and others).

C. Other Considerations in Prioritizing Areas Needing Improvement

While you are prioritizing, you should also consider:

1. Availability of resources to improve performance in each area;

2. Time it will take to realize improved performance; and

3. Benefits to your organization and to the people that you support.

4.5 DEVELOPING A QUALITY IMPROVEMENT PLAN (IMPROVEMENT)

In the preceding sections, you learned about your current data system and you prioritized your opportunities for improvement. Your next step is to develop your Quality Improvement Plan (QIP).

A. QIP Development

Your QIP should:

1. Provide a systematic, organized way to focus your efforts on improvement;
2. Specify desired outcomes, both at the individual level and the organizational level;
3. Assist staff in identifying and concentrating on actions needed for improvement; and
4. Provide a mechanism to communicate service delivery expectations.

B. Questions Answered By QIP

Your QIP should also answer the following questions. As an organization:

1. Where are we now?
2. Where do we want to be?
3. How are we going to get there?
4. When will we get there?

C. QIP Components

Your QIP should include the following components:

1. Goals.
2. Objectives.
3. Activities/Action Plans.
4. Benchmarks.

4.6 WRITING GOALS, OBJECTIVES, ACTION PLANS, AND BENCHMARKS

A. Goals

Goals are related to the mission and vision statements and be based on the services and supports that your organization provides. Goals are written in broad, general term, and project an "ideal." Goals are not specific or measurable. Goals are not the continuation of what already exists, but rather express what the organization hopes to bring about through its quality enhancement activities.
An example of a goal would be, "Our individuals will be safe and healthy."

B. **Objectives**

Objectives are the stepping stones that assist you in realizing your goals. Objectives are how you achieve your goals. Objectives are written in an active tense and use verbs such as "plan," "write," "conduct," "produce," as opposed to "learn," "understand," "feel." Objectives should be realistic targets for the organization and should always answer the following question, "Who is going to do what, when, why, and to what standard?" An objective for the goal above might be, "By June 20xx, organization XYZ will have a 10% reduction in the number of hospitalizations for preventable conditions.

A tool that is very helpful in writing objectives is the acronym *SMART*. *SMART* encompasses five important elements to develop valid and meaningful objectives.

1. *S*pecific – What exactly are you going to do and for whom?
   The organization states a specific outcome, or a precise, clearly defined objective to be accomplished. The outcome are stated in numbers, percentages, frequency, reach, scientific outcome, etc.

2. *M*easurable – Is the objective measurable and can you measure it?
   The objective can be measurable and the measurement source must be identified. If the objective cannot be measured, the question of the cost of non-measurable activities must be addressed. All activities are measurable at some level.

3. *A*chievable – Can you get reach the objective in the proposed timeframe?
   The objective or expectation of what will be accomplished must be realistic given your organization's capacity, time period, resources, etc.

4 . *R*elevant – Will the objective lead to the desired results?
   The outcome or results of the objective directly supports the outcomes of the organization's plans or goals.

5. *T*ime-framed – When will you accomplish the objective?
   The target date for achieving the objective is clearly be stated. This target date will give you the capability to organize your quality activities and efforts around process improvement.

4.7 ACTIVITIES/ACTION PLANS

A. Development of Activities and Action Plans

After you have identified your objectives to achieve your goals, identify one or more activities (and action plans for each activity) to address each objective. Activities and action plans explain exactly how you are going to achieve your objective. For example, to reduce hospitalizations for preventable conditions, you might have several activities, such as developing protocols, training staff, developing tracking mechanisms, etc. The action plans for each activity will identify who does what and in what sequence.

Activities and action plans should:

1. Tell how the objective will be achieved;
2. Be specific and detailed;
3. List exactly what work needs to be done;
4. Include targeted completion dates; and
5. Identify the person(s) responsible for each action step listed.

B. Status Reports on Implementation

The person identified as responsible for each activity on the plan is required to periodically provide a regularly occurring status report on implementation of the various steps. These status reports is provided to management and communicated to all stakeholders as appropriate, so that they may be kept abreast of the implementation of the various quality improvement activities.

4.8 BENCHMARKS

Benchmarks enable you to compare progress toward achieving your benchmark (where you want to be) as compared to a baseline (where you are now). Benchmarks is utilized to evaluate the effectiveness of your actions. Evaluation of the achievement of your objectives is critical to the success of your Quality Improvement Plan.

4.9 QUALITY IMPROVEMENT PLAN (QIP)

A. Identifying Opportunities for Improvement

Your QIP provides your organization with a well thought out process to systematically identify opportunities for improvement and to resolve problems. It

also provide means to detect small or developing problems and fix them before they get out-of-hand and to detect potential problems and institute actions to prevent them from occurring at all.

B. **Implementing the QIP**

Even more important than having a Quality Improvement Plan is the implementation of that plan. A plan is just a piece of paper unless the activities and action steps on the plan are actually implemented. Implementation serves two purposes: to improve current or create new processes which will result in improved performance on quality outcomes; and to maintain a culture of quality improvement in your organization.

Each quality improvement step you take should show that quality enhancement works, how it works, why it works, and what benefits are achieved through quality improvement.

C. **Evaluating QIP Implementation**

An integral part of your Quality Management Strategy is evaluating implementation fidelity (Are you doing what your plan said you would do?) and plan effectiveness (Are you achieving your desired results?).

As implementation begins, the strategic planning for quality management and improvement has been completed. To make sure of this, ask yourself these questions:

1. Has quality been defined by all stakeholders?

2. Have outcomes been prioritized?

3. Have goals, objectives, activities and action steps, and benchmarks been developed?

4. Have valid, measurable performance indicators been selected?

5. Is my data collection process complete?

If you can answer "yes" to these questions, then implementation can begin.

4.10 EVALUATION

A. **Monitoring and Evaluating the QIP**

1. Evaluation involves monitoring the implementation of your QIP and determining its effectiveness. Evaluating the fidelity of your plan is just a fancy way of determining if you are doing what you said you would do. Are the activities and actions occurring

according to your plan? Are you meeting your timelines? Are you collecting data so that you can measure your progress toward meeting the goals and objectives that you have established?

2. By evaluating or monitoring your plan and your data you can ascertain if you are doing better since implementing the improvement steps. Bar charts, graphs, or other statistical processes can be used to analyze data collected. Your data will help you determine your progress in achieving your objectives which will lead to meeting your goals, which ultimately will result in increased quality of the services and supports you provide.

B. **Revising the QIP**

Your plan should never be set in stone. If your evaluation shows that the activities and action steps within your QIP are not feasible or that they are not achieving the result that you expected, you will need to revise your QIP. All parts of your QIP are subject to revision.

4.11 REVIEWING AND UPDATING YOUR QUALITY IMPROVEMENT PLAN

An organization's quality management and improvement strategies must be dynamic. Goals, objectives, improvement strategies, and data must be continuously reviewed and updated. Your Quality Enhancement Plan will not be an "annual" plan in the sense that it is only reviewed once a year. Each quality improvement activity remains in your plan for as long as it takes to implement the activity and to assure the effectiveness of the activity in improving performance; this may be for several months or just a few weeks. Details of the plan (e.g., specific action plans, target dates, etc.) are revised as needed. Steps that prove to be ineffective are reconsidered. New goals, objectives, and activities are added, as appropriate.

When reviewing and updating your plan, ask yourself:

A. Do we need to revisit our Outcomes and Performance Indicators?

B. Is our Quality Council working for us? Do we need to modify its functions, change membership, or alter frequency of meetings?

C. Is our quality infrastructure effective? Do we need to make any changes to better support staff in their various responsibilities related to the provision of quality services to the elderly and people with disabilities?

D. Are our discovery methods effective in providing us with the information we need to manage our organization and provide quality services?

E. Do our information technology systems meet our needs or do we need to update our systems?

F. Do we need to make any changes in the data reporting, analysis, and review processes?

G. Are our remediation and quality enhancement processes effective? Do we need to change anything? These reviews and revisions of your Quality Improvement Plan and Quality Management Strategy will enable your quality efforts to evolve over time so that your organization will be prepared to meet new challenges and opportunities as they arise.

CHAPTER 5

REIMBURSEMENT, REPORTING AND RECORDS OF STATE-FUNDED SERVICES

5. INTRODUCTION

The provider of state-funded developmental disability services must have an executed, signed contract for those services with DBHDD prior to reimbursement for services rendered. Providers of state-funded developmental disability render services in accordance with the applicable *Community Service Standards for Developmental Disability Providers* established by DBHDD as defined in the most current version of the DBHDD Provider Manual for Community Developmental Disability Service Providers, 02-1201.

Providers of state-funded developmental disability services are required to deliver services as specified in the Initial Individual Service Plan (IISP) or Comprehensive Individual Service Plan (ISP). Compensation for services is based on the delivery of authorized services specified in the IISP or ISP.

This chapter specifies the procedures for reimbursement for state-funded developmental disability services and specific reporting and record requirements for these services in addition to the applicable standards in the most current provider manual.

5.1 REIMBURSEMENT OF STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICES

The provider submits billing through Carelon Provider Connects, the statewide billing system for State Funded claims. Billing is based on what is approved in each person's ISP. A tutorial for the billing process can be found at https://www.georgiacollaborative.com/providers/archive/#webinars. Additional information on reporting by the provider is in the section on billing and associated reporting in this chapter.

Reimbursement for state-funded developmental disability services is by category as follows:

A. Community Access Group Services (CAG) (UAS Expense Code 401)

1. Payment Stipulations:

a. DBHDD's contract with the provider of Community Access Group Services

stipulates that the contractor will provide authorized services to individuals who meet the Department's criteria for state supported developmental disability services and have no other means of payment for this service. Eligibility criteria for state-funded developmental disability services are outlined in Chapter 1 of this manuals.

b. The provider agrees to render services based on the frequency and duration specified in the Individual Service Plan for each authorized individual.

c. On an exceptional basis, for individuals receiving Community Access Group Service, the planned provision and utilization of services may be less frequent but must be so indicated in the individual's ISP and approved by the Regional Field Office.

d. Payment requests for Community Access Group Services provided to any one individual shall not exceed an annual amount of $21,900.00 without prior review and authorization by the Regional Field Office. The provider can bill by the unit rate of $14.60 per hour.

e. All individuals served by the provider are authorized by the Regional Field Office through the admissions process.

2. **Payment Terms:**

The provider shall be paid an hourly rate of $14.60 per hour for direct services, or the provision of documented indirect Intervention Services specifically on behalf of the individual as prescribed in the ISP, up to the authorized amount for Community Access Group Services for each individual. Indirect Intervention Services consist of design and development of activities in any location outside the individual's own or family home or any other residential setting that assist the individual to learn, use, and/or maintain adaptive skills required for active community participation and independent functioning, which includes services provided on behalf of a specific individual.

The total annual payment for **Community Access Group** is specified in DBHDD's contract with the provider. The table below indicates reimbursement rates for CAG Services based on Category/Tiers:

Service Description	**Unit Rate**	**Unit of Service**	**Payment** Not to Exceed Annually Per Individual
Community Access Group Services	$3.65	15 min	$21,900.00

Community Access Group Services – Category 1 - Facility	$3.65	15 min	$21,900.00
Community Access Group Services – Category 1 - Community	$3.65	15 min	$21,900.00
Community Access Group Services – Category 2 - Facility	$3.65	15 min	$21,900.00
Community Access Group Services – Category 2 - Community	$4.18	15 min	$25,080.00
Community Access Group Services – Category 3 - Facility	$3.65	15 min	$21,900.00
Community Access Group Services – Category 3 - Community	$5.23	15 min	$31,380.00
Community Access Group Services – Category 4 - Facility	$3.65	15 min	$21,900.00
Community Access Group Services – Category 4 - Community	$7.42	15 min	$44, 520.00

B. **Community Individual Services (UAS Budget Code – 442):**

1. **Community Access Individual (UAS Expense Code 402):**

DBHDD's contract with the provider of Community Access Individual (CAI) Services specifies the number of individuals to receive CAI Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disability outlined in Chapter 1 of this manual and have no other means of payment for these services.

For the provision of Community Access Individual Services, the provider is reimbursed an hourly rate of $42.20 per hour up to $15,192.00 per annual ISP.

C. **Supported Employment (UAS Budget Code – 443):**

1. **Supported Employment Services (UAS Expense Code 407)**

DBHDD's contract with the provider of Supported Employment Services specifies the number of individuals to receive Supported Employment Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disability outlined in Chapter 1 of this manual and have no other means of payment for these services.

For the provision of Supported Employment Services, the provider is reimbursed $616.90 per month for each individual receiving a minimum of two face-to-face contacts for job coaching and/or job development during the month. Reimbursement for individuals receiving Supported Employment services shall

not exceed the annual amount of $7,402.80.

D. **Residential Services (UAS Budget Code – 444):**

1. **Community Living Supports (CLS) Services (UAS Expense Code 412):**

DBHDD's contract with the provider of Community Living Supports (CLS) Services specifies the number of individuals to receive CLS Services from the provider per month either through direct services, or the provision of documented indirect intervention services specifically on behalf of the individual as prescribed in the ISP. These individuals must meet the eligibility criteria for state-funded developmental disability outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month. The contract also specifies the annual amount of funding. CLS services are reimbursed in 15-minute unit increments using three distinct categories: basic, extended, and shared CLS defined as follows:

a. Basic CLS is defined as service delivered during visits of 11 or fewer units (2.75 hours) of service per visit. Note: CLS service delivered in two or more distinct visits per day may be billed under Basic CLS to accommodate travel required between visits.
b. Extended CLS is billed for visits of more than 12 units (3.00 hours) per visit.
c. Shared CLS reimbursement includes two- and three-person group rates. Shared CLS is designed to accommodate voluntary home sharing of individuals, allowing one staff person to provide CLS services to groups of two or three individuals. The table below indicates reimbursement rates.

Service Description	**Unit Rate**	**Unit of Service**	**Payment** Not to Exceed
CLS – 1 Person (Basic)	$9.98	Per 15 Minutes	$83,520.00
CLS – 1 Person (Extended)	$9.28	Per 15 Minutes	$83,520.00
CLS – 2 Person (Basic)	$5.49	Per 15 Minutes/Per Individual	$83,520.00
CLS – 2 Person (Extended)	$5.10	Per 15 Minutes/Per Individual	$83,520.00
CLS – 3 Person (Basic)	$3.99	Per 15 Minutes/Per Individual	$83,520.00
(CLS – 3 Person (Extended)	$3.71	Per 15 Minutes/Per Individual	$83,520.00

2. **Community Residential Alternative Service (CRA) (UAS Expense Code 411)**

DBHDD's contract with the provider of Community Residential Alternative Services (CRA) specifies the number of individuals to receive CRA Services from the provider during the contract year and the annual amount of funding. These individuals must meet the eligibility criteria for state-funded developmental disability outlined in Chapter 1 of this manual and have no other means of payment for these services during the calendar month. CRA services are as indicated in the ISP.

The provider is reimbursed the daily rate noted below for provision of CRA Services for each individual being served per month with the monthly amount not to exceed amount noted below. Reimbursement for Community Residential Alternative Services shall not exceed an annual maximum amount noted below per individual:

Service Description	**Unit Rate**	**Unit of Service**	**Payment** Not to Exceed per Month	**Payment** Not to Exceed Annually Per Individual
Community Residential Alternative Services – Host Home, Category 1	$163.33	1 Day	N/A	$56,185.52
Community Residential Alternative Services – Host Home, Category 2	$220.11	1 Day	N/A	$75,717.84
Community Residential Alternative Services – 3-Person Residence, Category 1	$294.16	1 Day	N/A	$101,191.04
Community Residential Alternative Services – 3-Person Residence, Category 2	$323.26	1 Day	N/A	$111,201.44
Community Residential Alternative Services – 3-Person Residence, Category 3	$382.32	1 Day	N/A	$131,518.08
Community Residential Alternative Services – 3-Person Residence, Category 4	$507.05	1 Day	N/A	$174,425.20
Community Residential Alternative Services – 4-Person Residence, Category 1	$248.35	1 Day	N/A	$85,432.40
Community Residential Alternative Services – 4-Person Residence, Category 2	$292.42	1 Day	N/A	$100,592.48
Community Residential Alternative Services – 4-Person Residence, Category 3	$341.79	1 Day	N/A	$117,575.76
Community Residential Alternative Services – 4-Person Residence, Category 4	$447.57	1 Day	N/A	$153,964.08
Community Residential Alternative Services – 5-Person Residence, All Categories	$186.94	1 Day	N/A	$64,307.36

3. **CRA Host Home Payment:**

a. Administrative Cost and Payment to Host Home Provider.

The following are requirements for administrative costs of the Community Residential Alternative (CRA) provider agency and the agency's payment to the Host Home provider:

i. Host Home Budget and Payment Details:

- The budget and agreed payment details to the Host Home provider for each individual in each Host Home enrolled by the DBHDD provider agency must support the amount of payment to the Host Home Provider, which allows for the provision of the CRA services specified in the ISP of the individual and ensures the health and safety of the individual in the Host Home arrangement.

- A copy of the budget and agreed payment of the Host Home provider must be submitted and approved as part of pre-placement package to the Regional Field Office staff prior to any individual moving into a Host Home. Budget and payment details must be revised and re- submitted to the Regional Field Office staff whenever there is an enhancement or decrease in the individual's residential allocation as well as on an annual basis. A copy is maintained in the individual's record.

- Individual budget details submitted must include but is not limited to the individual's name and Medicaid number (if applicable), address and contact information of the Host Home.

ii. CRA Provider agencies and Host Home Providers must comply with Supervision and Protection of Personal Funds and Belongings in Intellectual and Developmental Disability Residential Services, 02-702. Management of Day to Day living expenses shall include but is not limited to:

- The CRA Provider provides individuals who reside in agency operated Host Homes with an agreement regarding day-to-day living expenses upon admission, annually, or as needed. This agreement shall be reviewed at the annual ISP and shall include a statement of all associated housing and food costs; and any estimated medical, dental, and clothing fees or charges assessed to the individual, to the extent that those funds are available. See the Day to Day Living Expenses Budget Agreement (Attachment C) for an example of a day to day living expense agreement. Providers are encouraged to use this form, but a provider may also develop their own form so long as the form is substantially similar to Attachment C.

- CRA Provider shall notify the individual and Host Home Provider, in writing, 60 days prior to changes in charges. Copies of the day-to-day living expenses agreement are maintained in the record of

the individual served.

- Day-to-day living expenses agreement must be signed by the individual/authorized representative, provider agency and agency operated host home provider serving the individual. The signed copy is maintained in the individual's record.

E. **Support Services (UAS Budget Code 445)**: Reimbursement for the category of Behavioral Supports Services occurs under Support Services as follows:

1. **Behavioral Supports Services (UAS Expense Code 421):**

a. **Behavior Supports Services Level 2**

i. Contractor will provide Behavior Support Services to authorized individuals during the contract year who meet the Department's criteria for state supported I/DD services, and who have no other means of payment for these services.

ii. For the provision of Behavior Support Services Level 2, the Contractor shall be paid a rate of $36.68 per 15 minutes per individual. This funding covers development of behavior support plans and services.

b. **Behavior Supports Services Level 1**

i. Contractor will provide Behavioral Support Services to authorized individuals during the contract year who meet the Department's criteria for state supported I/DD services, and who have no other means of payment for these services. Behavior Support Services Level 1 Contractor must be supervised by an approved Behavior Supports Services Level 2 Contractor to render services.

ii. For the provision of Behavior Support Services, Level 1, the Contractor shall be paid a rate of $24.36 per 15 minutes per individual. This funding covers delivery of components of data collection and monitoring of behavior support services.

F. **Respite Services (UAS Budget Code 446):**

DBHDD's contract with the provider of Respite Services Indicates that the provider shall be paid a monthly reimbursement of expenses for the provision of Respite Services not to exceed a specified annual amount. In addition, DBHDD's contract with the provider includes the following:

1. **<u>Scheduled Respite</u>**

DBHDD's contract with the provider of Respite Services stipulates that the contractor will provide authorized services to individuals who meet the Department's criteria for state supported developmental disability services outlined in Chapter 1 of this manual and have no other means of payment for these services. The provider agrees to render services based on the frequency and duration specified in the Individual Service Plan for each authorized individual.

2. **Unscheduled Respite**

DBHDD's contract with the provider of Respite Services stipulates that the contractor will provide authorized services to individuals who meet the Department's criteria for state supported developmental disability services outlined in Chapter 1 of this manual and have no other means of payment for these services. The provider agrees to render services based on the frequency and duration specified in the Individual Service Plan for each authorized individual.

The Unscheduled Respite Service is intended to be short term for an individual experiencing a crisis who requires a period of structured support and/or programming. Unscheduled Respite may also be necessitated by unavoidable circumstances, such as death of a caregiver or loss of residential placement. Unscheduled Respite may be provided In-Home or Out-Of-Home. The Regional Field Office approves Unscheduled Respite Services only when the current support or residential placement is unstable or unavailable, and no other formal or informal supports are available to the individual. A specific plan to transition the individual back to his or her permanent home is presented at the time of admission. The plan is developed and implemented by the Planning List Administrator (PLA), State Services Coordinator, Support Coordinator (SC), or Regional Field Office designee when applicable. Individuals will NOT be placed (except in extreme emergency) without a specific plan for discharge (including date, location and responsible party).

G. **Other Services:**

DBHDD's contract with the provider of other services (e.g., crisis services and special projects) specifies the reimbursement procedures for these services. These contracts define the other services and any specific expectations for the delivery of these services beyond the general expectations for all state-funded developmental disability services.

5.2 STATE-FUNDED DEVELOPMENTAL DISABILITY BILLING AND ASSOCIATED REPORTING REQUIREMENTS

A. The billing and associated reporting requirements for state-funded DD services are as follows:

1. The provider submits billing through Carelon Provider Connects. Billing is based on what is approved in each person's ISP. A tutorial for the billing process can be found at https://www.georgiacollaborative.com/providers/archive/#webinars.

2. The provider submits the original MIER (Monthly Income and Expense Report) to DBHDD's contract person by the 10th of the month via secure email for individuals who do not have a Prior Authorization in the case management system, IDDC.

3. Supported Employment providers submit monthly programmatic reports by the 10th day of the month. Reports is submitted via secure email to the following address: supportedemployment@dbhdd.ga.gov.

B. **Reimbursement Issues for State-Funded Developmental Disability Services**: The provider of state-funded developmental disability notifies the Regional Field Office of any issues with reimbursement of state-funded developmental disability. The Regional Field Office works with the provider to assess and rectify, as indicated, issues in the reimbursement for state-funded developmental disability services.

C. **Reimbursement Adjustments**: Failure to follow standards for state-funded services in this manual may result in reimbursement adjustments.

5.3 STATE-FUNDED DEVELOPMENTAL DISABILITY SERVICES REPORTING

The provider of state-funded DD services submits reports as required and requested by the Regional Field Office. These reports may include an annual report that provides a statistical summary of expenditures, and individual service and outcome data. Monthly reporting and other requirements of the contract between the provider and the State of Georgia, Department of Behavioral Health and Developmental Disabilities must be met.

A. **Quality Improvement Reporting** – The provider maintains a well-defined approach for assessing and improving quality as defined in Chapter 4 of this manual. An organizational quality management program should be in place to measure performance, identify deficiencies, and improve quality systematically. The provider shall have established indicators for safety, outcomes and quality of services, and individual satisfaction. The provider generates quarterly quality management reports, including measurement of quality indicators, trend analysis, and quality improvement activities. All QM plans, QIPs, and quarterly QM reports must be maintained by the provider and readily available for DBHDD quality assurance purposes. The quarterly reports must be generated following the schedule below:

Quarter	FY 25	Report Due
1st Quarter	July 1 - September 30	October 16
2nd Quarter	October 1 - December 31	January 17
3rd Quarter	January 1 - March 31	April 17
4th Quarter	April 1 - June 30	July 17

B. **Services Records** – The provider is responsible for maintaining records in accordance with the applicable standards established by DBHDD as defined in the most current version of Provider Manuals for Community Developmental Disability Providers, 02-1201. Records are to be maintained in an easily accessible place for monitoring/auditing purposes.

C. **Regional Field Office Updates** – In addition to reporting requirements as specified in DBHDD policy, the Stated Funded DD Service Provider/Agency must:

1. Notify the Regional Services Administrator for Developmental Disabilities (RSA-DD) within two (2) hours of any deaths and/or high-visibility incidents (as defined in Reporting Deaths and Other Incidents in Community Services, 04-106 for all individuals receiving state-funded services to the Regional Service Administrators-DD or designee and to the Individual's Planning List Administrator or State Services Coordinator. This notification is in addition to reporting requirements specified in the DBHDD policy.

2. Submit to the Regional Field Office, DBHDD Contracts Office, and the DBHDD Provider Network Office updated agency and/or contact information.

3. Enter accurate and/or update current required provider information in the Georgia Developmental Disabilities Provider Information website. The address of this website is as follows: www.georgiacollaborative.com.

CHAPTER 6

OPERATIONAL AND CLINICAL STANDARDS FOR GEORGIA CRISIS RESPONSE SYSTEM (GCRS-DD)

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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 in 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 18 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
        - Handle with Care Behavior Management System, Inc. www.handlewithcare.com
        - Mindset http://interventionsupportservice.com/
        - Safe Crisis Management www.jkmtraining.com
        - Safety- Care (QBS, Inc.) 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.

G1. 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:

Presents with <u>no</u> plan or access to supports[1]	**Presents <u>with</u> a plan and access to supports**[2]
1. Clinical/supervisory staff will meet with the individual to explore reasons for wanting to leave the crisis home. 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. 3. Clinical/supervisory staff will review replacement behaviors and/or coping skills with the individual and use de-escalation strategies to address the situation. 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. 5. Clinical/supervisory staff will document the individual's response to all interventions.	1. Clinical/supervisory staff will meet with the individual to explore options as identified by the individual. 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. 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. a. Crisis provider should offer intensive in-home for a period post-discharge if the environment allows for such intervention. 4. Clinical/supervisory staff will document the individual's response to all interventions.
Required communication from the crisis provider:	
1. Clinical/supervisory staff will **call and email** 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. a. If an individual requests discharge to a homeless shelter, the I/DD Crisis Manager should be notified within an hour of this request. 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.	

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.

[1] 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

[2] Expresses a ***plan*** to discharge, with access to resources, money, and/or supports

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 IDDC.

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 GRCS-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.

Chapter 7

OPERATIONAL AND CLINICAL STANDARDS FOR

AUTISM SPECTRUM DISORDER CRISIS SUPPORT HOMES

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 and emerging adult (hereinafter referred to as a "youth") between the ages of 10 through 21; **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 ; **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[3], 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

[3] 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.

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 Autism Project 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. Autism Project Manager, 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, Case Expeditor, and/or Planning List Administrator 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 Support Coordinator, Case Expeditor, and/or Planning List Administrator 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 Autism Project Manager, IDD Crisis Stabilization Services Manager, and Director/Office of Crisis and Transition Services 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 Autism Project Manager, IDD Crisis Stabilization Services Manager, and Director/Office of Crisis and Transition Services: 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 Crisis and Transition Services, , and Autism Project Manager) 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.

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).

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 Autism Project 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, OPCSI issues a six (6) month provisional certificate. At six (6) months, the provider receives a full certification visit conducted by OPCSI, 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. Healthcare Plan that identifies and monitors risk issues on an ongoing basis; provider must adhere to https://gadbhdd.policystat.com/policy/10543686/latest

    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 Manager or designee. The BCBA and/or Program Manager will submit the Service Extension Form to the Autism Project Manager 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 Manager 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 Manager 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 Autism Project Manager.

4. All applicable practices regarding Limited English Proficiency and Sensory Impairment must be followed 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 will 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

Death 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 Crisis Service 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 30º nor more than 34º 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 the 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^{o} 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^{o} Fahrenheit or exceeds 82^{o} 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 IDD Crisis Stabilization Services Manager and Autism Project Manager. In addition to monthly data reports, providers may be required to provide additional data/ad hoc reports as requested by DBHDD.

Chapter 8

OPERATIONAL AND CLINICAL STANDARDS FOR CRISIS SERVICE AND DIAGNOSTIC CENTER (CSDC)

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SECTION 1: CSDC SERVICE OVERVIEW

A. SERVICES DESCRIPTION

The Crisis Service and Diagnostic Center (CSDC) is a center that provides two distinct services for adults, 18 years and above, with intellectual/developmental disability (IDD) and/or co-occurring IDD/Behavioral Health (BH) diagnoses. To support these individuals, the CSDC provides two distinct services:

1. CSDC Crisis Services. CSDC Crisis Services provide individualized support and short-term (no more than ninety (90) days) crisis services for up to sixteen (16) adults, 18 years and above, with intellectual/developmental disability and/or co-occurring IDD/BH diagnoses, who have been deemed pre-eligible for DBHDD-authorized NOW or COMP waiver services, and who are experiencing a psychiatric and/or a serious emotional/behavioral change that leads to a disruption of essential functions, and/or which may compromise the adult's ability to remain in their natural home/setting. Any individual requiring crisis services for more than ninety (90) days will be closely monitored with clear clinical justification for the continued need of the specialized service. Continued stay criteria and protocol (Section 2.E) are detailed within these standards.

2. CSDC Outpatient Clinic Services. The CSDC Outpatient Clinic Services provider serves individuals receiving CSDC Crisis Services, as well as individuals from the wider community. Some Outpatient Clinic Service requirements (Section 5) are detailed within these standards.

   The two services are located on the same property but with clear distinct part separation, as detailed below (Section B.1). Additionally, the CSDC supports the individual to prevent or reduce legal involvement, minimize extended stays related to behavior-based or psychiatric needs in emergency room departments, provide support for caregivers/providers by way of crisis intervention, and reduce multiple psychiatric hospitalizations. The intent of this service is to provide crisis services and support through the use of crisis intervention techniques and behavioral supports, multi-disciplinary evaluations, and interventions to meet the individual's needs on a time-limited basis.

   The intended outcomes for individuals receiving Crisis Services at the CSDC are:
   1) The crisis-related behavior is stabilized to the extent that the adult can safely return to his or her natural home/setting;
   2) The adult and caregiver/community provider have received/established referrals and assistance with linkage to any services and supports needed to maintain the individual's progress and to increase the likelihood that the adult will be able to

successfully remain in his or her own natural home/setting;
3) The adult's crisis-related behavior(s) is stabilized by way of diagnostic assessment, referral to clinically identified treatment/therapies, and medication administration/management/monitoring; and
4) The adult's caregiver/community provider received behavioral training on interventions for use in the natural home/setting and the support needed to use these interventions successfully.

The CSDC Crisis Services offer differential interdisciplinary interventions which must include the following, unless the exclusion is clinically documented:

1. Crisis support and intervention;
2. Diagnostic assessment;
3. Functional behavior assessment;
4. Biopsychosocial needs evaluation;
5. Service and support planning;
6. Medication evaluation, administration, management, and monitoring;
7. Linkage to identified ancillary services while the individual is admitted;
8. Psychiatric/Behavioral Health Treatment;
9. Applied Behavior Analysis (ABA) and other crisis-oriented behavior support interventions;
10. Nursing Assessment and Care;
11. Brief individual, group, and/or family counseling;
12. Formal/natural support training in ABA and/or other behavior support interventions;
13. Clinical consultation with community-based service providers;
14. Referrals to needed community-based services and supports; and
15. Discharge planning and linkage to other services as needed, and follow-up.

B. DISTINCT PART SEPARATION OF SERVICES

The organizations that provide the Crisis Services and Outpatient Clinic Services must ensure appropriate distinctions between these services, to include but not limited to physical, financial, administrative, and programmatic separation. The CSDC is separated by the Crisis Service and Outpatient Clinic Service- both are located on the same property but with clear distinct part separation, as detailed below:

1. The 16-bed Crisis Service program will be fully operated through allocated state funding. In the event a Medicaid recipient is admitted to the 16-bed crisis service and also referred for a Medicaid billable service in the Outpatient Clinic Services, the Outpatient Clinic Services provider will bill the appropriate private (commercial) insurance and/or Medicaid. DBHDD funding for certain operational costs of the Outpatient Clinic Services program is outlined in its contract with the Outpatient Clinic Services provider.
2. The Outpatient Clinic Service program will utilize private (commercial) insurance, Medicaid reimbursement, private pay (as applicable), and DBHDD contract resources (if/and as allocated). Some operational standards for Outpatient Clinic Services are located in Section 5 within these standards.
3. Programmatic separation is maintained as follows:

    a. Physical Separation

        1. Due to the services being located on one property, providers must ensure that the services are easily identified as separate services, delivered by different providers, to those entering the property. Physical separation is evidenced by:

            i. Designation on campus maps and. when buildings are shared, clearly visible signs and other designations on parts of the building in which different services are delivered, and on floor plans that are readily available.

            ii. Clearly visible signs at entrances, in building space, and in common areas shall clearly indicate physical separation of the services.

    b. Financial Separation

        Financials are service-based (crisis service and outpatient clinic service), with separate budget and reporting structures. Allocation of any expense must follow Generally Accepted Standards Board.

    c. Administrative Separation

        1. The two services (crisis services and outpatient clinic services) are provided by separate legal entities.
        2. Each service provider entity maintains a separate list of staff who work to deliver the service provided by that entity.
        3. Staff work schedules must be separate for each service program and shall clearly indicate only the staff that work for that distinct service program.
        4. Staff may not be shared between service program at the same time of day, except in extraordinary circumstances or emergencies (e.g. as a result of a

severe weather condition). In such circumstances/emergencies, staff sharing shall not extend for more than three (3) consecutive calendar days; and both entities shall notify DBHDD in writing of the reasons for the staff sharing and the names and roles of the staff being shared. If it appears that the circumstance/emergency will extend for more than three (3) consecutive calendar days and that the staff sharing will also need to continue, then the entity in need of the shared staff must request a waiver of standards from DBHDD, and staff sharing may continue only if this waiver of standards is approved.

d. Service Separation

1. Each service provider entity shall obtain current licensure (as applicable) and certification, as required, for the type of program being operated. The 16-bed crisis service must comply with these Operational and Clinical Standards. The outpatient clinic service must also comply with the applicable Part I, Part II and Part III DCH manuals in the DBHDD policy NOW and COMP Waivers for Community Developmental Disability Services, 02-1202; however, the Provider has an independent duty to confirm which DCH manuals are applicable. The outpatient clinic service must also comply with Section 5 of these Operational and Clinical Standards.

2. Each service provider shall clearly communicate in its policies and procedures the nature of each program. In those policies and procedures, the distinction between the two programs shall be readily apparent as evidenced by elements including, but not limited to, service description, utilization criteria, program operations, organizational requirements, and reporting requirements.

3. Informational brochures, marketing materials, directory listings, and any form of advertising material in any type of media shall clearly identify each service (crisis services and outpatient clinic services) as a separate facility or program with a different purpose.

4. All individual files and records shall remain within the building and should be housed separately from files and records from other services.

SECTION 2 CRISIS SERVICES: ADMISSION, EXCLUSION, AND DISCHARGE CRITERIA

C. ADMISSION CRITERIA

The CSDC Crisis Services provider must use the following admission criteria.

1. The individual is an adult (18 years and above) who has an I/DD diagnosis verified by the DBHDD Division of Developmental Disabilities, and one of the following criteria has been met:

   a. The individual meets I/DD pre-eligibility criteria.[4] Eligibility criteria for state-funded developmental disability services are outlined in Chapter 1 of DBHDD's Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services (i.e. the individual has been evaluated by the DBHDD's Intake and Evaluation unit and an I/DD diagnosis was verified; however, the individual was not deemed to require NOW/COMP waiver services at the time of this initial evaluation or at any subsequent evaluations up to this point (individual may or may not have been placed on the Waiver Planning List as a result of these evaluations); or

   b. The individual is currently authorized for NOW or COMP waiver services;

AND

2. The individual is experiencing a severe crisis (behavior-based and/or psychiatric), which includes an increase in severe psychiatric symptoms or maladaptive behaviors, and/or a lack of sufficient adaptive skills to manage the crisis at the individual's current and/or lower level of care/support; and

   a. As a result of the crisis, the individual's safety and/or functioning have been significantly compromised beyond any safety/functional challenges that are typically present at the individual's non-crisis baseline, as evidenced by one or more of the following:

      1. Significant impulsivity, high acuity maladaptive behavior, and/or physical aggression that is imminently life threatening or gravely endangering to self or others; **or**

      2. At least one recent episode of a severe maladaptive behavior. If continued, the nature and severity of the behavior would significantly compromise and impact the individual's ability to safely remain in their natural home/community, or to be supported at a lower level of care; **and**

   b. The individual requires crisis behavior intervention and/or an increased level of support/monitoring (such as a need for additional and/or specialized staff

[4] **Please note**: In the event an individual is unknown to DBHDD, and a referral has been completed for consideration of admission to the CSDC, the Office of Crisis and Transition Services, Office of Eligibility, and the respective Regional Field Office Intake Coordinator will prioritize the intake process for a NOW/COMP waiver application. Pre-eligibility determination will be completed based on submission of a complete application packet (as outlined in Chapter 1 of DBHDD's *Provider Manual for Community Developmental Disability Providers of State-Funded Developmental Disability Services*). Once all required documentation has been received (including any additional requests), pre-eligibility determination will begin and be made within 3 (three) business days.

oversight) that cannot be achieved at a lower level of care, or within the milieu of a Crisis Stabilization Unit.

AND

3. The individual cannot be stabilized safely in other available treatment or service settings.

D. MEDICAL CLEARANCE GUIDELINES AND EXCLUSION CRITERIA FOR ADMISSION

The CSDC Crisis Services provider must use the following medical clearance guidelines and exclusion criteria.

1. Medical Clearance is defined as an assessment conducted by a physician, psychiatrist, Advanced Practice Registered Nurse, or Physician's Assistant involving physical examination and laboratory evaluation, when indicated, in order to determine whether serious underlying medical illness exists. The medical and laboratory assessment should be driven by the individual's clinical presentation and clinical history.

a. The CSDC ensures compliance with the CSDC medical clearance guidelines and exclusion criteria. See "CSDC: Medical Clearance Guidelines and Exclusion Criteria for Admission to Crisis Service and Diagnostic Center" **(Appendix A).**

b. If the referral source is Mobile Crisis Team (MCT) and the individual is in a community setting with medical clearance unavailable, the clinical presentation and clinical history may determine consideration of admission. The MCT will evaluate whether healthcare issues present that require medical assessment and treatment prior to admission to the CSDC. If there are no medical concerns noted, the MCT must contact the I/DD Crisis Stabilization Services Manager (or designee within the DBHDD- Office of Crisis and Transition Services). The I/DD Crisis Stabilization Services Manager (or designee) will contact the CSDC leadership and psychiatrist/APRN to determine if the individual is appropriate for admission.

c. Healthcare providers referring an individual for admission to a CSDC are expected to do so through utilizing the Georgia Crisis and Access Line (GCAL). The MCT is dispatched to the medical facility to assess appropriateness for the service. If individual is deemed appropriate for the service by MCT, the healthcare provider must meet the necessary medical clearance guidelines and exclusion criteria, see "CSDC: Medical Clearance Guidelines and Exclusion Criteria for Admission to Crisis Service and Diagnostic Center" **(Appendix A)**

d. Following review of the referral information, the CSDC psychiatrist/APRN takes one of the following actions:
   1. Accept the individual for transportation to the CSDC for admission;
   2. Deny the referral and provide reason for denial;
   or
   3. Request additional information.

e. The medical clearance guidelines and exclusionary criteria at Appendix A are not intended to replace good clinical judgment. In specific cases, more information or lab work may be requested, or specific labs may be omitted, depending on presenting problems and other medical conditions.

f. If, following the individual's arrival at the CSDC, it is determined that the CSDC cannot safely meet the individual's medical needs, the individual may be sent back to the referring hospital or to the closest hospital as appropriate. Any individuals who did not go to a medical facility prior to arrival at the CSDC and are determined to need medical attention, are sent to the nearest appropriate medical facility. In such circumstances, it is the responsibility of the CSDC to arrange appropriate medical transport. Once medical stabilization has occurred at the external medical facility, it is expected that the CSDC will give priority consideration to that individual. However, the CSDC shall establish medical clearance and confirm that the individual continues to meet CSDC admission criteria.

E. CONTINUING STAY CRITERIA

The CSDC Crisis Services provider must use the following continuing stay criteria.

1. Individual continues to meet admission criteria as defined above; **and**
2. Provider follows the Continued Stay Protocol as outlined below:

   a. Continued Stay Protocol: The service is time-limited and should not exceed ninety (90) days. Extensions beyond ninety (90) days are the exception and not typical.

   i. At time of 8- week (60 day) treatment team meeting, for all individuals, the provider must complete and submit to DBHDD a "CSDC: 60 day Notification and Request Form" (**Appendix B)**, Part A, that includes (at minimum): name of individual, date of admission, date of 60 days length of stay (LOS), current treatment plan, behavioral data (graphs w/ phase change lines), discharge recommendations, and any barriers to discharge (if applicable). In the event the

treatment team indicates a clinical recommendation for continued treatment beyond 90 days, a clinical rationale must be included in the "CSDC: 60 Day Notification and Request Form."

ii. The 60 Day Notification and Request Form Part A must be sent to the I/DD Crisis Stabilization Services Manager (or designee) and is due within 24 hours of the 8- week treatment team meeting.

iii. For all individuals recommended for LOS Extension at the 8-week treatment team meeting, at the subsequent 10 week treatment team meeting the provider must update the "CSDC: 60 Day Notification and Request Form" by completing Part B to add a request for Continued Stay, with updated clinical rationale to include any change since Part A was completed.

iv. The "CSDC: 60 Day Notification and Request Form" Part B must be sent to the I/DD Crisis Stabilization Services Manager (or designee) and is due within 24 hours of the 10- week treatment team meeting.

v. Extensions beyond ninety (90) days must be requested in increments of seven (7) days, and should follow the weekly treatment team review schedule, with request for extensions submitted to DBHDD within 24 hours of subsequent weekly treatment team meetings. Part C of the "CSDC: 60 Day Notification and Request Form" must be updated and submitted with each extension request. Extensions are approved only when behavioral and/or psychiatric discharge criteria have not been met (Section 2. F.). Part C of the 60 Day Notification and Request Form must be updated and submitted every seven (7) days until the individual is discharged.

vi. As soon as the provider and staff indicate the need for extension and initiate the written extension request, the I/DD Crisis Stabilization Services Manager (or designee) reviews all necessary information on the individual and will participate in weekly treatment team meetings to monitor the individual's progress and address clinical barriers to transition. The I/DD Crisis Stabilization Services Manager (or designee) will approve or deny the extension within 24 hours of receipt with written notice (inclusive of clinical justification) to the provider.

Note: See note at end of Section F, "Discharge Criteria," concerning discharge planning for individuals. The CSDC crisis services provider must work to timely discharge individuals into appropriate placements.

F. DISCHARGE CRITERIA

An individual may be discharged from CSDC crisis services only if <u>all</u> of criteria 1 through 12 below are met, <u>or</u> if criterion 13 below is met. (See Section Q.3), below, for discharge

planning requirements.)

1. Individual no longer meets admission criteria, and an adequate discharge/continuing support/care plan has been established; **and**
2. Individual has achieved medical clearance by the APRN (or designee) and no acute issues have been determined; **and**
3. Individual has achieved psychiatric stabilization through a review of the individual's medication regimen to include (if applicable):
    a. Consideration of presentation and potential cause by previously unknown identifying medical condition or diagnosis; and
    b. Identification of inappropriate drug interactions; and
    c. Identification of over medication and need for titration; and
    d. Identification of additional medications; **and**
4. Individual has achieved a reduction in the frequency, duration, and intensity of crisis-related behaviors (determined by the Board-Certified Behavior Analyst) such that the individual can be safely supported in his/her natural home/setting; **and**
5. Interdisciplinary team has identified the clinical needs (based on a review of the identified clinical needs determined at admission, as well as throughout their treatment); **and**
6. Clinical outpatient provider has been identified and secured for follow-up appointment; **and**
7. Follow-up appointments have been scheduled with outpatient providers; **and**
8. BCBA-D or BCBA have conducted training (onsite) on the Crisis Plan and Behavior Support Plan with the following supports as applicable to the individual:
    a. Behavior Support Services (BSS) provider and/or community BCBA who will be involved in direct support for staff working with the individual at discharge; and
    b. Community Residential Alternative (CRA) provider staff who will be directly supporting the individual; and
    c. Community Living Supports (CLS) provider staff who will be directly supporting the individual (if applicable); **and**
9. Training for natural and formal support persons has been planned, in accordance with the following:

a. The staff of the CSDC will provide training for the individual's natural and formal support persons.

b. The CSDC will ensure that natural/formal support persons are able to participate in training regardless of their proximity in relation to the CSDC.

c. This training shall, at a minimum, result in the following basic, introductory-level knowledge and competencies:

i. Knowledge regarding the individual's complete diagnoses;
ii. Knowledge regarding the positive behavior support plan developed on the unit;
iii. Knowledge and competence regarding how to respond to challenging behaviors;
iv. iv. Knowledge and competence regarding how to prevent challenging behaviors;
v. Knowledge and competence regarding how to advocate for the individual's needs; and
vi. Knowledge and competence regarding how to respond and implement the crisis safety plan.

10. If Intensive In-Home (IIH) services are identified as a need for discharge, the interdisciplinary team has completed a IIH referral and receive approval from the DD Crisis Manager (or designee);

11. A discharge meeting has occurred, and has included the interdisciplinary team and family supports/community providers, to discuss clinical outpatient recommendations and referrals, family supports and involvement, and individual daily living supports; **and**

12. DBHDD's Case Expeditor has completed the Transition Process for Crisis Services Diagnostic Center Discharges into Waiver Services to facilitate transition of the individuals from the CSDC, if the individual is to receive DBHDD-authorized waiver services. The assigned Case Expeditor will be in communication (from admission to discharge, once per week at minimum) with the CSDC Case Manager, the Transition Services Manager, and the I/DD Crisis Services Manager.

OR

13. Individual and/or individual's legal guardian (if applicable) requests discharge against medical advice.

Note: In appropriate cases, an individual who does not meet all discharge criteria may be discharged to a less restrictive setting within the DBHDD crisis continuum, to include

intensive Out of Home Support, as well as Emergency Respite Services. In order for such a discharge to a less restrictive setting to occur, the following conditions must be satisfied:

i. At a minimum, the individual must have met all clinical and behavioral discharge criteria for consideration.
ii. The interdisciplinary team must complete a referral based on the *most appropriate* identified program (to include clinical stabilization summary and behavioral data to support readiness).
iii. The individual must meet *all* admission criteria for the least restrictive setting. A determination will be made by the appropriate program manager (or designee) of the referred program.
iv. The CSDC must notify the I/DD Crisis Stabilization Services Manager of any individuals under consideration and referrals to any less restrictive settings.

G. SERVICE EXCLUSIONS

The following services may not be provided simultaneously with the CSDC service:

1. Psychiatric Residential Treatment Facility (PRTF);
2. Crisis Stabilization Unit (CSU);
3. Inpatient hospitalization;
4. Any other intellectual/developmental disabilities (I/DD) residential and/or behavioral health (BH) residential services.

SECTION 3: PROGRAM OPERATIONS REQUIREMENTS

H. STAFFING REQUIREMENTS

The CSDC crisis services provider must employ the following staff:

a) A full-time equivalent (FTE) Program Director, who serves to lead in the daily operations and compliance with reporting requirements and standards set forth by DBHDD policies.

b) A full-time equivalent (FTE) Psychiatrist (Board Certified), who serves to assist in admission referrals and assessments, psychiatric stabilization through review of medication regimen, identifying medical condition or diagnosis, identifying drug interactions, over medication and/or need for titration, or any additional medications while also providing a range of therapies. The Psychiatrist is also required to participate in all discharge planning and care coordination meetings.

c) A full-time equivalent (FTE) Advanced Practice Registered Nurse (APRN) practicing within the scope of State law. The APRN must be family medicine or internal

medicine trained. A psychiatrist must provide oversight to the APRN for daily decisions and responsibilities at the CSDC.

d) A full-time equivalent (FTE) Nursing Administrator who is a Registered Nurse or higher (APRN).

e) Registered Nurses (RNs), in sufficient number to ensure that a Registered Nurse is always present at the facility and that there is a ratio of at least 1 nurse to 8 individuals served. For the purposes of maintaining this ratio, a second nurse may be a Licensed Practical Nurse (LPN), as long as there is at least one RN on duty.

f) One full-time equivalent (FTE) Board Certified Behavior Analyst- Doctorate (BCBA-D) or a doctoral- level BCBA, who serves as the lead for all Applied Behavior Analysis (ABA) aspects of treatment. In the event that a BCBA-D or a doctoral-level BCBA is unable to be secured, a Board Certified Behavior Analyst (BCBA) with five or more (5+) years of experience with IDD/BH individuals in crisis can serve as the lead for all Applied Behavior Analysis services delivered at the CSDC.

g) Full-time equivalent (FTE) Board-Certified Behavior Analysts (BCBAs) AND additional part-time equivalent (PTE) BCBAs, who provide on-site oversight to direct care staff during awake hours (first and second shift, 7 days a week). An on-call schedule for emergencies/consultation must be maintained to ensure BCBA coverage for third shift, 7 days a week. The CSDC must maintain the ratio of 1 BCBA (or designee) to 8 individuals served. Functions performed by the BCBA must be performed within the scope of their practice and aligned with their professional standards. In the event that a BCBA is unable to be secured, a Board Certified Assistant Behavior Analyst (BCaBA) may serve in this role to support the Applied Behavior Analysis services delivered at the CSDC.

h) A part-time equivalent (PTE) therapist with I/DD experience, to provide support to families during family trainings, family meetings, and mental health/co-occurring counseling/therapeutic services to individuals admitted (as deemed necessary by the clinical team). The therapist responsibilities may function as part of the Case Manager position.

i) A full-time equivalent (FTE) Case Manager (minimum of a bachelor's level in a human services field with experience in providing case management services). The Case Manager is responsible for functions involving the successful discharge and transition of each individual back to their natural home/setting 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 caregiver/family has the support needed for a successful transition. The Case Manager will communicate regularly with the

individual's team in the community, as well as with the CSDC Case Expeditor provided by DBHDD.

2. Staff-to-individual-served ratios must be established based on the needs of individuals served and in accordance with these standards:
   a. A minimum of one (1) direct care staff member per one (1) individual served must be present at time of admission. At admission, a higher staff-to-individual ratio (2:1) can be determined, but the staff-to-individual ratio at admission cannot be lower than 1:1.
   b. After admission or at any time throughout the individual's stay, the interdisciplinary team may determine that a lower or higher level of support is needed. In that event, the treatment team must review documentation to determine if a minimum of two (2) staff members per one (1) individual served (a 2:1 ratio, which is a higher level of support) or Line of Sight (a lower level of support) is deemed appropriate based on the needs, medical necessity, behavioral needs, and safety of the individual and staff.
   c. The I/DD Crisis Stabilization Services Manager must be notified and given justification of any increased or decreased staffing ratio within 24 hours of the decision.
   d. The BCBA-D or BCBA on staff, at time of determination of a change in level of support, must implement staff fading procedures/techniques into the Treatment Plan, Behavior Support Plan, and Crisis Plan.
   e. Every two (2) days following a determination of a 2:1 staffing ratio, the treatment team must review documentation to determine if a 1:1 staffing ratio is deemed appropriate based on the needs, medical necessity, behavioral needs, behavioral progress, and safety of the individual and staff. Outcome and justification of any continued need for a 2:1 staffing ratio for any individual must be submitted to the Division of Developmental Disabilities immediately following determination.
   f. If staff ratio changes occur at admission on the weekend or treatment team meetings to address staff ratio changes occur on the weekend, professionals can participate via teleconference.
   g. A 1:1 staff-to-individual ratio is defined as:
      Staff is to be specifically assigned (non-shared) to one individual for the sole purpose of offering personalized, enhanced supports to the individual. The staff support delivers observation and attentiveness to the physical, medical, behavioral, and emotional needs of an individual with ability to act and/or react in any situation to support the individual's needs. Staff must be able to intervene and prevent actions that are unsafe to the individual or others. The staff must maintain proximity to the individual in accordance with and as

defined within the individualized Crisis Plan and Behavior Support Plan. The 1:1 staff support is exclusively focused on the individual and should not be engaged in any other activity at the time the 1:1 supports are mandated. Each individual admitted to the CSDC will maintain this level of direct staff support unless otherwise deemed appropriate for a 2:1 staffing ratio as outlined above.

h. Line of Sight is defined as:

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, staff must be assigned/designated based on most appropriate for the safety of the individual and staff. Staff must be able to intervene and prevent actions that are unsafe to the individual or others. The staff must maintain proximity to the individual in accordance with and as defined within the individualized Crisis Plan and Behavior Support Plan.

3. Direct care staff may consist of a combination of Registered Behavior Technicians (RBTs), Behavior Intervention Specialists (BISs), and Direct Support Professionals (DSPs). Additional clinical staff such as nurses, clinicians, and BCBAs cannot count towards the direct care staffing ratio. Functions performed by an RBT must be performed within the scope of their practice and aligned with their professional standards. RBTs, BIS's, and DSP's must be supervised by either the BCBA-D or the BCBA on staff.
4. Functions performed by all licensed clinicians must be performed within the scope of practice allowed by State law and Professional Practice Acts.
5. The program must have a written 24-hour staffing plan for each service/function, which includes psychiatrist, APRN, nursing, BCBAs, and direct care staff, and must address the following:
   a. The staff-to-individual served ratio must be established based on the stabilization needs of individuals and not be less than specified elsewhere in this document or policy.
   b. The plan must define, by position, all roles, and responsibilities to meet the needs of the daily service provisions and special ancillary operations, consultative specialists, partnerships, and/or facility management.
   c. The plan should include supervision plan, staff credentials, position function, and staffing patterns.
   d. The plan should also address staff retention strategies and methodology that will be used to review staffing needs periodically to determine the need to adjust based on the demographics of the population served.

6. The service must meet model-integrity as to every key position. It is understood that there may be periodic vacancies of key clinical/programmatic positions, specifically, Psychiatrist, APRN, BCBA-D or BCBA, Case Manager, Nurse Administrator, and RBT's and BIS's. In this event, the CSDC provider must submit written notification to the I/DD Crisis Stabilization Services Manager and Director/Office of Crisis and Transition Services 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. Whenever a required position will be vacant for more than two (2) weeks, the CSDC must request a waiver of any applicable requirements of these CSDC Operational and Clinical Standards by submitting a written request using the same process described in Requests for Waivers of Service Requirements Contained in DBHDD Provider Manuals or PolicyStat, 04-107.
7. 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-D position, if the provider cannot comply with either item (a) or (b) above, a combination of one or more licensed psychologists and a BCBA or BCaBA may be used to provide short-term coverage for the BCBA-D 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 I/DD Crisis Stabilization Services Manager and DBHDD's Director of the Office of Crisis and Transition Services: documentation that recruitment is underway and other options were first exhausted. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising.
8. 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, as well as maintenance of valid or current license or certification.

I. REQUIRED COMPONENTS

1. Referrals to CSDC crisis services will be accepted only from Mobile Crisis and, in special circumstances, at the request of the DBHDD Division of Developmental

Disabilities. DBHDD's I/DD Crisis Services Manager (Office of Crisis and Transition Services), or designee, will review all referrals and notify the CSDC crisis services provider to proceed with admission accordingly. The CSDC provider will admit all individuals approved for this service.

2. Prior to admission, the CSDC provider must obtain a Consent to Treatment signed by the individual or the individual's court-appointed legal guardian (if applicable). The Consent to Treatment must include (at minimum):

    a. Guardianship information (if applicable)—i.e., does the individual have a court-appointed guardian? If so, a copy of the Letters of Guardianship must be included in the admission file;

    b. Statement addressing any medication administration (including psychotropic medication);

    c. Services to be delivered and how services are determined as a need;

    d. Urgent/emergency measures (i.e., manual hold/restraint, "STAT" medication) needed in this setting for the safety of the individual and staff;

    e. Consent for the CSDC Outpatient Clinic provider and its staff to provide services to the individual as needed;

    f. Signature of individual and/or legal guardian.

3. Prior to admission, the CSDC provider must obtain Releases of Information signed by the individual or the individual's legal guardian (if applicable). The Releases of Information must be in accordance with HIPAA and, where applicable, 42 C.F.R. Part 2, and must be signed by the individual or (if applicable) court-appointed legal guardian. Required releases include (at minimum):

    a. Authorization that allows the CSDC Crisis Services program provider to release information to the CSDC Outpatient Clinic program provider; and

    b. Authorization that allows the CSDC Outpatient Clinic program provider to release information to the CSDC Crisis Services provider.

4. The program provides short-term behavioral/psychiatric stabilization, diagnostic, and evaluation services, but shall <u>not</u> be designated by DBHDD as an emergency receiving facility or act as such.

5. The program must be surveyed and certified by DBHDD.

6. The provider must develop and maintain policies and procedures for the CSDC.

7. The CSDC provider must notify DBHDD's Office of Deaf Services (ODS) of any individual who is about to be admitted, or who has been admitted, who is deaf or who has significant hearing loss. Such notification shall be made using the process set forth

for use by behavioral health providers in DBHDD Policy Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, 15-111. The CSDC provider will collaborate with ODS in obtaining communication assessments and securing appropriate accommodations for these individuals.

8. All services provided within the program must be delivered under the supervision of a Psychiatrist practicing within the scope of State law. A Psychiatrist, must conduct an assessment of new admissions, address issues of care, and write orders as required.
9. The program provider is expected to obtain, and maintain in perpetuity, National Association of the Dually Diagnosed (NADD) accreditation.
10. The program provider is expected to obtain, and maintain in perpetuity, National Association of the Dually Diagnosed certification for 10% of staff in each category (Direct Support Professionals, Clinicians, and Specialists). Staff must maintain the certification requirements set forth by NADD to remain in compliance.
11. The program provider shall maintain a written individualized daily schedule of recreational, treatment, and education options throughout twelve waking hours each day to include treatment and educational opportunities responsive to the developmental health, mental health, and physical health issues represented by individuals receiving services.
12. All areas of the program that are accessible to individuals served must be ADA accessible.
13. The program provider will build and maintain formalized referral arrangements with the CSDC outpatient clinic and with providers of specialized services that are commonly medically necessary for individuals served by the CSDC crisis services program, to include the following:
    a. Medical Services that are not part of the typical medical services performed as part of the program;
    b. Dentistry;
    c. Neurology;
    d. Physical Therapy;
    e. Occupational Therapy;
    f. Speech Language Pathology;
    g. Endocrinology;
    h. Ophthalmology;
    i. Podiatry;
    j. Audiology;

k. OB/GYN;

l. Specialized laboratory services that are not part of the typical lab work performed as part of the program;

m. Treatment related genetic testing;

n. Nutritional;

o. Allergy/Immunology;

p. Specialized Neuropsychological/Psychological Assessment; and

q. Any other necessary specialty service as indicated by clinical assessment should be researched by the clinical team to ensure obtainment of identified clinical service.

14. The provider must maintain a team-based approach for all treatment team planning and decisions made for the individuals at the CSDC.

15. The provider must notify the I/DD Crisis Stabilization Services Manager (Office of Crisis and Transition Services) immediately upon the arrival of the individual. The I/DD Crisis Stabilization Services Manager will notify the Transition Services Manager (Office of Crisis and Transition Services) and the appropriate DBHDD Regional Field Office of an individual's admission upon notification from the provider.

16. The provider must remain in contact with the I/DD Crisis Stabilization Services Manager (Office of Crisis and Transition Services), the appropriate DBHDD Regional Field Office, the CSDC Case Expeditor, Transition Services Manager, Support Coordinator or Intensive Support Coordinator (if applicable), Planning List Administrator (if applicable), and caregiver/guardian (if applicable) for communication and coordination throughout the individual's admission to the program. Coordination of needed services, supports, or living arrangements post-discharge will occur by the Case Expeditor, Case Manager, and Planning List Administrator or Support Coordinator/Intensive Support Coordinator.

J. CLINICAL OPERATIONS

1. For all admitted individuals, this service must target the crisis-related symptoms, behaviors, manifestations, psychosocial factors, and skills-development related to the identified issue(s). The I/DD diagnoses, as well as any behavioral health diagnoses must be considered to determine necessary treatment for stabilization.

2. Review of referral, completed by the Psychiatrist or APRN, program director, and BCBA-D or BCBA, must be completed within 24 hours, and admission to the CSDC must occur within 48 hours of the referral.

3. Immediately upon admission, the CSDC must implement its internal policies and procedures for managing crisis situations, based upon the individual's presenting behaviors and needs. The CSDC's internal policies and procedures must be consistent with these CSDC Operational and Clinical Standards.

4. Upon admission, each individual will be assigned to a DBHDD representative, Case Expeditor, who will follow the Transition Process for Crisis Services Diagnostic Center Discharges into Waiver Services to facilitate transition of individuals to be waiver served from the CSDC. The assigned Case Expeditor will be in communication (from admission to discharge, once per week at minimum) with the CSDC Case Manager, the Transition Services Manager, and the I/DD Crisis Services Manager.

5. Individual must be assessed, using a History and Physical (H&P) assessment, to be completed by the APRN within 24 hours of admission.

6. Medical Care:

    a. A nurse must complete a nursing assessment for each individual within eight (8) hours of admission to identify physical health needs and deliver care for minor physical health challenges. The nurse performs ordered and indicated medication management functions (i.e., transcription of orders or medication reconciliation) and other assessments/evaluations as needed within their scope of practice. A LPN is to practice under the supervision of a RN. Treatment rendered to individuals admitted to the CSDC and provided by an LPN requires the oversight of the RN in accordance with oversight procedures/requirements as outlined in Registered Nursing Oversight in I/DD Community Settings, 02-808.

    b. A Healthcare Plan or a Risk Mitigation Plan must be developed as clinically indicated based on the nursing assessment and/or other applicable assessments/evaluations.

    c. The individual is transferred to more medically staffed services if needed. The attending psychiatrist determines whether the individual is medically and clinically appropriate for this level of care.

    d. The referral includes, at a minimum, vital signs, chief complaint, history, current medications, and observations.

7. The program provider must engage in an Admission Meeting, within 48 hours of an individual's admission, to include court-appointed legal guardian (if applicable), Program Director and/or BCBA-D (BCBA), Case Manager, Physician, Nurse Director, the I/DD Crisis Stabilization Services Manager (or designee), and the assigned Support Coordinator or Planning List Administrator. In special cases, it may be beneficial to include a representative from the individual's residential provider (if any). If intake

occurs on a weekend, professionals can participate via teleconference or the next business day.

List of attendees and topics discussed during the admission meeting must be recorded and kept in the individual's record. The meeting must take a holistic approach and discuss (at minimum): nursing care, dietary needs, medication management, behavior supports, therapeutic supports, level of staffing needs, case management, roles and responsibilities, presenting crisis, clinical specialty referrals, and discharge planning.

The CSDC must ensure that evidence of involvement by the individual and/or the individual's court-appointed legal guardian (if applicable) is documented by their signature, or that the individual's/guardian's refusal to sign is clearly documented.

8. The crisis service provider (as determined by the psychiatrist) can engage in an Interdisciplinary Treatment Meeting to include medical, nursing, behavior, social work, and healthcare professionals. Record of all staff participating in the development of the treatment plan must be obtained and filed. Professionals can participate via teleconference.
9. The treatment plan, developed by the interdisciplinary team, written by the Case Manager, within 72 hours of admission, and ongoing as updates are identified, during treatment team meetings, throughout duration of stay, must include:
    a. Biopsychosocial elements;
    b. Trauma-related experiences;
    c. Sensory assessment results;
    d. Identification of appropriate clinical services needed at the CSDC;
    e. Determination of the need for a psychiatric assessment;
    f. Determination for the need of medical care;
    g. All identified medical, behavioral, and clinical needs appointment scheduled within 24 hours;
    h. Results from the functional behavior assessment completed by the behavioral analysis team;
    i. Goals, objectives, and interventions included in the Behavior Support Plan and the Crisis Plan;
    j. Discussion of appropriate discharge (this discussion must begin at admission);
    k. Identification of and reconnections to natural supports;
    l. Linkage to clinically appropriate BH/IDD services; and

m. Coordination of IDD waiver supports with the individuals assigned Region and the Office of Crisis and Transition Services;
n. Identified risks of suicidality;
o. Discharge plan.

10. The provider must arrange a weekly treatment team meeting, for each individual admitted, to include at minimum (physician and/or psychiatrist, nursing, BCBA, and any other clinical staff requested by the physician and/or psychiatrist) to discuss any medical, behavioral, clinical, and/or biopsychosocial updates, as well as the progress/ behavioral data tracking information. Increase in frequency of treatment team meetings may be appropriate in instances of acute changes in care, challenges in service delivery, and incidents deemed reportable to DBHDD. The case manager must participate in any scheduled treatment team meeting to ensure the treatment plan reflects all updated information. Record of all staff participating in the treatment team meeting must be obtained and filed.
11. All services offered within the CSDC are provided under the direction of a psychiatrist, who preferably has training and experience working with the (IDD/MH) dually diagnosed population.
12. An on-call schedule must be maintained and available twenty-four hours/day, 7 days a week. The psychiatrist need not be required to be on site twenty-four hours a day; however, the psychiatrist must respond to staff calls immediately (delay not to exceed one (1) hour). An on-call schedule for emergencies/consultation must be maintained to ensure psychiatric coverage for third shift, 7 days a week. The on-call schedule may consist of the providers existing on-call schedule. Clinicians providing support to the CSDC must be cross-trained on the intent and requirements of the program.
13. A psychiatrist or APRN must make in-person rounds, for every admitted individual, once daily, seven days a week. Provision of rounds via telehealth in accordance with the following:
    a. Confidentiality of Patient Information and Documentation of Services
        i. Comply with HIPAA, the HITECH Act, 42 C.F.R. Part 2, and Georgia Mental Health Code (OCGA Title 37).
        ii. Advise individuals of the use of telemedicine/telepsychiatry practice and reassure individuals of the availability of onsite treatment/visits.
        iii. Documentation
            1. Completeness and timeliness of documentation of telemedicine services meet the requirements for clinical services provided in a traditional, in-person manner.

2. Documentation after consultation provided via telemedicine is completed in a progress note in the patient's file indicating (at minimum):
    a. Location of the consultant;
    b. Name of the consultant(s)
    c. Time and date, and
    d. Purpose, and outcome of the telemedicine session.
3. No video or audio recording of telemedicine services.

b. Frequency:

i. Provision of rounds via telehealth must not exceed 7 consecutive calendar days.

14. The functions performed by staff whose practice is regulated or licensed by the State of Georgia are within the scope allowed by State law and professional practice acts.
15. Obtain a Release of Information (ROI) where information related to substance abuse is involved, or as otherwise needed, for communication with the previous behavioral health inpatient, community providers, and aftercare treatment providers, in accordance with 42 C.F.R. Part 2 and HIPAA.
16. Laboratory and other diagnostic procedures must be performed as ordered by a physician. Any ordered labs that are sent outside the CSDC for testing must be sent out to a qualified laboratory for completion. If any labs completed on the CSDC site, the provider performing the lab must provide documented evidence of a current Clinical Laboratory Improvement Amendment Waiver and justification of need for order.
17. The BCBA-D or BCBA must begin a Functional Behavioral Assessment of each individual within thirty-six (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. If the individual has an existing BSS provider, the BCBA-D and/or BCBA must review the individual's existing Functional Behavior Assessment for reference.
18. The BCBA-D or BCBA must develop an individualized Crisis Plan of each individual within forty-eight (48) hours of admission, (or updated, if one already exists) and implement for each individual served by the CSDC's clinical team.

    CSDC staff involved in the implementation of the individualized crisis plan must ensure ongoing consultation with the BCBA during the BCBA's assessment and planning processes to ensure continuity between the Behavior Support Plan and other components of the Crisis Plan.

19. Behavior Intervention Services (only applicable to individuals who either (i) present with a need for behavior intervention services at the time of admission, or (ii) evidence a need for behavior intervention services at a later point during their stay):

    a. Within five (5) calendar days of admission, the results of a preliminary functional behavior assessment must be available to inform the development of an individualized behavioral support plan which is primarily focused on the crisis-related behavior.

    b. If clinically indicated, an adaptive behavior assessment can be completed during the initial assessment by the designated BCBA-D, BCBA, or BCaBA. A psychologist or social worker who has been trained on the following assessments may also complete the identified adaptive behavior assessment. The CSDC must use an established adaptive behavior assessment such as the Adaptive Behavior Assessment System, 3rd Ed. (ABAS-3) or the Vineland Adaptive Behavior Scales, 3rd Ed.

    c. Within nine (9) days of admission, the preliminary draft of an individualized behavioral support plan must be developed or updated. Note: If the individual has an existing BSS provider with a Behavior Support Plan, the BCBA-D and/or BCBA should review the document to assist in development of the Behavior Support Plans which must include the following elements:

        i. Background and Statement of Problem

        ii. Relevant Medical History/Medical Necessity

        iii. Functional Behavioral Assessment

        iv. Operational definitions of each challenging behavior and goal needs

        v. Measurable goals and objectives

        vi. Identified replacement behaviors and/or necessary skill acquisition

        vii. Description of data collection procedures and methods including staff responsible for data collection

        viii. Specific behavior strategies and methods of interventions for reduction of maladaptive behaviors, methods of treatment, and staff responsible to deliver the treatments ix. Any environmental modifications needed (if applicable)

        x. Data recording, data analyses, and fidelity/program monitoring

        xi. Generalization, Maintenance, and fading strategies

        xii. Staff Training/Caregiver Training

xiii. Risks and Benefits xiv. Consent xv. Data Collection Forms/Checklist

xiv. Staff Training Record/Roster

d. Behavior Support Plans and behavior-change programs will be conceptually consistent with behavior analytic principles. Treatment implementation, fidelity, and progress monitoring will be informed by quantitative data collected on the individual's behaviors while admitted to the CSDC crisis services program.

e. In accordance with a needs assessment, CSDC crisis services program staff must work to identify behavior supports that will be needed post-discharge. When post-discharge behavior intervention services are indicated, the BCBA-D or BCBA must engage with the behavior support/intervention service and provide all behavior analytic documentation implemented while receiving crisis services.

f. Intensive behavior training must be completed by the BCBA-D, BCBA, and staff working with the individual within 24 hours of the individual's BSP completion. If staff are not on a scheduled shift within the 24 hours, staff must be trained on the individual's BSP during their next shift.

20. The CSDC crisis services provider must have policies and procedures for identifying and managing individuals at risk of intentional self-harm. Consultation with the BCBA-D or BCBA must occur to address all historical or identified self-injurious behaviors.

21. 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):

    a. May be used in cases of a written physician's order (order not to exceed twelve (12) calendar months);

    b. The written physician's order must include the rationale and instructions for the use of the device;

    c. May be used ONLY for medical reasons and/or protection against injury, and NEVER for control of challenging behaviors unless permitted after review by DBHDD as provided in (e) below;

    d. Notification of use must be reported to DBHDD's I/DD Crisis Stabilization Services Manager, at admission or prior to implementation;

e. In cases where use is for treatment of challenging behaviors, a submission to DBHDD for Special Circumstance Review, approval, and monitoring; see Requests for Waivers of Service Requirements Contained in DBHDD Provider Manuals or Policystat, 04-107.;

f. Renewal order of device requires documentation to justify continued use for a period not to exceed twelve (12) calendar months;

g. Use of such adaptive supportive devices must be included in the treatment plan, crisis plan, behavior support plan, and discharge plan.

22. Manual Hold/Restraint may be used ONLY as an emergency safety intervention of last resort, where an individual's behaviors are affecting the physical safety of the individual and others. Episodes of manual hold/restraints, regardless of injury, must be reported to DBHDD via the incident reporting database (Image) in accordance with Reporting Deaths and Other Incidents in Community Services, 04-106 and Investigating Deaths and Other Incidents in Community Services, 04-118:

    a. All staff engaging in a manual hold/restraint on an individual must be trained by the nationally benchmarked crisis intervention program chosen by the provider.

    b. All use of prone manual or mechanical restraints is prohibited in all circumstances, even when used in accordance with nationally benchmarked techniques;

    c. Permitted Manual/Personal Restraints: A manual/personal restraint in use for 10 seconds or more should not exceed 15-minutes without evaluating whether restraint is needed after the person's behavior is no longer a danger to themselves or others, and use of personal restraint (including the length of time for which the restraint was used) 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;

    d. Use of manual/personal restraints must be outlined as an approved intervention in the individual's treatment plan, crisis plan, and behavior support plan.

23. The following restraint practices are prohibited:

    a. The use of chemical restraint for any individual.

    b. The combined use of seclusion and mechanical, and/or manual restraint.

    c. Standing orders for seclusion or any form of restraint.

    d. PRN orders for seclusion or any form of restraint.

e. Prone manual or mechanical restraints.

f. Transporting an individual in a prone position while being carried or moved.

g. Use of seclusion as part of a Behavior Support Plan (BSP) or Crisis Plan.

h. The use of handcuffs for an individual not under the jurisdiction of the criminal justice system.

i. The use of medication as a chemical restraint.

K. SUICIDE PREVENTION, SCREENING, BRIEF INTERVENTION, AND MONITORING

The CSDC Crisis Services provider must implement the following measures for suicide prevention, screening, brief intervention, and monitoring.

1. Screenings for Risk of Suicide or Harm to Others

    a. An initial screening for risk of suicide or harm to others is conducted for each individual presenting for admission. Please refer to the information below for risk of suicide. A clinician assesses each individual within twenty-four (24) hours of admission to the CSDC, documents the findings of the assessment(s), and writes orders for care.

    b. If a risk of suicide or harm to others was noted during admission, or if the individual indicates a risk of suicide or harm to others at any point during the individual's stay, the CSDC Crisis Services provider will perform ongoing screening for risk of suicide or harm to others. A clinician assesses the individual within twenty-four (24) hours of onset of risk of suicide or harm to others, documents the findings of the assessment(s), and writes orders for care. Clinicians provide further such screenings and assessments as needed throughout the individual's stay.

2. Use of Approved Suicide Screening Tools

    a. DBHDD requires the use of the C-SSRS. Clinicians may not administer and score/rate the C-SSRS until they have completed DBHDD approved training.

    b. All individuals who present at services are assessed for suicide risk, using the most appropriate of two (2) CSSRS tools:

        i C-SSRS Screener, Lifetime Recent- Clinical (**Appendix C**), or

        ii. C-SSRS Screener, Pediatric/Cognitively Impaired- Lifetime Recent- Clinical (**Appendix D**).

        iii. C-SSRS Screener, Versio'n Exploratoria- Reciente (Spanish)

(Appendix C1)

iv. C-SSRS Screener, Full Scale Pediatrica de la vida-reciente

(Spanish) (**Appendix D1**)

c. The C-SSRS uses information from a variety of informants including the individual who is being assessed, family members, caregivers, friends, hospital records and the agency screener. A "yes" response from any informant qualifies for inclusion in the analysis.

d. The C-SSRS is used to complete the Suicide Item on the Child and Adolescent Needs and Strengths (CANS) assessment tool – Trauma Comprehensive Version and the Adult Needs and Strengths Assessment (ANSA) tool.

e. Concurrent to administering the C-SSRS, the screener gathers information about current stressful life events and considers this in the decision pertaining to disposition and triage.

f. If at any time during treatment indicators of suicidal ideation or suicidal behavior are disclosed by, or suspected of, any individual (including those who were previously designated as low risk), a C-SSRS is conducted, a "Safety Plan Intervention" **(Appendix E)** is developed, and further assessment and triage conducted if necessary.

3. Screening Results

   a. Trained staff score and analyze the C-SSRS and rate the completed assessment.

   b. Any "yes" answer on questions 1 and 2, either recent or lifetime, automatically disqualifies the individual from being categorized as "low risk" and means the individual is given the most applicable C-SSRS Full Scale. NOTE: Individuals who have ever had suicidal thoughts in their lifetime cannot be considered low risk.

4. Assessment

   a. After the completion of a C-SSRS Full Scale, the next step is to complete the entire Suicide Risk Formulation as described in both the Assessing and Managing Suicide Risk (AMSR) and Safeside Prevention training curriculums. The Suicide Risk Formulation will be considered the assessment tool for compiling results from suicide screenings and further assessing the presence of suicide risk.
      i. The Suicide Risk Formulation is developed for all individuals as guidance for service provision as it includes assessment of stressors, impulsivity and other elements that are not covered in the C-SSRS.
   b. The entire Suicide Risk Formulation is completed, including the summary section. Suicide risk determined by use of the C-SSRS, the Suicide Risk

Formulation, and the suicide risk reported in the Child and Adolescent Needs and Strengths (CANS) assessment tool – Trauma Comprehensive Version or the Adult Needs and Strengths Assessment (ANSA) tool must agree with, not contradict, each other. If there appears to be a discrepancy, clinicians should rescreen, reassess until risk level is clear.

c. All suicide screening and assessment activities and results are documented in the individual's clinical record. Each record must contain a formulation of risk and how that level of risk was determined.

d. The provider flags the clinical record in a prominent place (preferably on the face sheet) to ensure that all staff associated with the individual are aware of suicide risk.

i. All individuals who have been hospitalized or have been served in a Crisis Stabilization Unit (CSU) with suicide ideation or suicide behavior are flagged "high risk for suicide" for at least four (4) months.

1. This flag is changed to "suicide history" if there has been no ideation or further suicide behavior within the four (4) months.

2. When a "high risk for suicide" flag is changed to "suicide history" it is important to note that the individual remains at moderate risk.

a. All individuals who have a history of suicide behavior any time in their lifetime are flagged with "suicide history."

ii. The CSDC initiates a “high risk for suicide” flag for all individuals who are in their care with suicide ideation or behavior and document this in the clinical record before the individual leaves the CSDC.

e. The CSDC verbally communicates that the flag exists when an individual is transitioning to another level of care or another provider.

f. Any clinician who finds and/or documents recent or past history of suicide ideation or attempts initiates a "suicide history" flag in the clinical record.

5. Safety Planning

a. Each provider has a written protocol for triage, directed by the results of the C-SSRS, Suicide Risk Formulation, and CANS / ANSA tool or the agency designated screening tool to determine stressors, taking into account past, current, and future stressful life events.

b. For each individual with a risk level of moderate or high and/or who has exhibited suicide behavior, the clinician completes an evidence-based “Safety

Plan Intervention" (**Appendix E**), in collaboration with the individual before they leave the visit where the screening / assessment takes place. A copy of this plan is provided to the individual and included in their clinical chart.

i. A "Safety Plan Intervention" **(Appendix E)**, occurs within twenty-four (24) hours prior to discharge.

c. The "Structured Follow-Up and Monitoring Procedure (B. Stanley and G. Brown)" **(Appendix F)** is the approved safety planning tool for DBHDD-affiliated providers.

d. For individuals identified and flagged in the clinical record as moderate or high risk of suicide, the safety plan is reviewed at every visit and updated as needed. A copy of the revised plan is provided to the individual and included in their clinical chart.

e. Every individual is asked the likelihood that they will use the safety plan and the safety plan is changed if the likelihood of using any part of the plan is low. This discussion must be documented in the record. A copy of the revised plan is provided to the individual and included in their clinical chart.

f. Strategies to reduce the individual's access to lethal means (e.g., firearms, medications, etc.) must be addressed in the safety plan, and emergency contacts / external supports are engaged to assist with safety. Outcomes of contacts with emergency and external supports are documented in the clinical record.

g. Individuals deemed to be clinically appropriate for the safety plan Intervention but who cannot or will not complete a safety plan are considered a danger to themselves and are further assessed for suicide risk.

h. All individuals are given a copy of their safety plan, in the form that best fits their needs, before leaving their first visit and each time the safety plan is updated. The provider keeps a copy of all developed or revised safety plans in the clinical record.

6. Treatment Planning

a. Individuals served in the community, who are at moderate or high risk for suicide must address the treatment of suicidality in the treatment plan.

b. The Suicide Risk Formulation and the summary section are always used when developing the Treatment Plan.

c. Whenever indicated and possible, providers use effective suicide-specific treatments, such as:
   i. Dialectical Behavior Therapy (DBT).

ii. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP).

iii. Collaborative Assessment and Management of Suicide (CAMS).

iv. Attachment-Based Family Therapy (ABFT).

7. Monitoring and Follow-Up

a. During intake or service transition, any individual identified as at risk for suicide is monitored by telephone, in person, or using technology (i.e., email or text) until they are safely in contact with ongoing services.

b. While access to ongoing care is sought, staff monitor for suicide risk within forty-eight (48) hours after the safety plan has been developed, and then weekly (documenting any action taken) until the individual is linked to ongoing care as evidenced by:

i. The individual's attendance at two (2) subsequent visits with their ongoing service provider, or

ii. The individual declines further monitoring (which must be documented in the clinical record) then providers give resources including the GCAL number and contact information for providers in the individual's area.

c. Individuals at risk for suicide in ongoing care are screened at each visit using the:

i. C-SSRS Screener- Since Last Visit **(Appendix G**), and/or

ii. C-SSRS Screener, Pediatric/Cognitively Impaired- Lifetime Recent-Clinical (**Appendix D**)

iii. C-SSRS Full Scale Pediatrica de la vida-reciente (Spanish) (**Appendix D1**)

iv. Structured Follow-Up and Monitoring Procedure (B. Stanley and G. Brown), (**Appendix F**), and/or

v. Collaborative Assessment and Management of Suicide (CAMS), Suicide Status Form (SSF) if using CAMS framework for care. Note: There is no attachment for the SSF because those trained in CAMS and eligible to use it will already have the form.

d. Staff incorporate one of the above four ongoing screening tools into their follow-up with individuals who miss scheduled appointments.

e. Staff ensure that regular monitoring is not perfunctory, by asking relevant questions directly related to the individual's circumstances, current and impending life events that are likely to influence their thoughts and negatively impact their mood, in order to effectively gauge risk of suicidal behavior.

f. All monitoring and follow-up activities and attempts, including the results of ongoing screenings, are documented in the clinical record within 24 hours.

g. Policies and procedures require constant visual observations of persons clinically determined to be actively suicidal;

h. Modifications or removal of suicide prevention interventions require clinical justification determined by an assessment and are specified by the attending psychiatrist and documented in the clinical record;

i. A registered professional nurse or other licensed/certified clinician may initiate suicide prevention interventions prior to obtaining a physician/psychiatrist's order, but in all instances must obtain an order within one (1) hour of initiating the intervention;

j. Staff is debriefed immediately following a suicide attempt, identifying the circumstances leading up to the suicide attempt;

k. The individual's Treatment Plan and Behavior Support Plan are updated following the debriefing of what led to the suicide attempt, including changes that could be made to prevent the situation from reoccurring or to better support the individual if future issues do occur;

l. Other high-risk behaviors (such as assaultive behaviors) are addressed in policies and procedures developed by the CSDC.

L. PHARMACY SERVICES AND MANAGEMENT OF MEDICATION

1. Individuals admitted to the CSDC crisis services program will receive pharmacy services from the CSDC outpatient services clinic. The pharmacy will fill all orders and medication needs identified. The pharmacy is certified and under the direct supervision of a registered pharmacist or provided by contract with a licensed pharmacy operated by a registered pharmacist.

2. The CSDC ensures access to prescription medications within eight (8) hours of the physician's order:

    a. STAT medication not maintained in the CSDC must be available for administration within one (1) hour of the order to give the medication.

    b. CSDCs may keep emergency drug kits in accordance with Georgia Rules and Regulations 480-24-.08.

3. The CSDC establishes and implements policies, procedures and practices that guide the safe and effective use of medications and shall, at a minimum, address and comply with the following:

    a. Medications and medical care orders are written, signed, administered, and implemented upon direct order from a physician/psychiatrist, or from a licensed physician assistant or nurse delegated by a physician in accordance with O.C.G.A. § 43-34-23 and O.C.G.A. § 43-34-25 or § 43-34-102;

    b. The CSDC ensures every order given by telephone is received by an RN or LPN and is recorded immediately with the ordering physician's/psychiatrists name and is reviewed and signed by a physician/psychiatrist within twenty-four (24) hours.

        i. Specific to the ordering of medication, documentation demonstrates evidence that an order was made by telephone including the content and date of the order.

    c. Medications are used solely for the purposes of providing effective treatment and protecting the safety of the individual and other persons, and are not used as punishment, or for the convenience of staff, or as chemical restraint;

    d. Standing orders are not permitted for any psychotropic medication ("standing order" means a physician's order that can be exercised by other health care workers when predetermined conditions have been met);

    e. Medication management policies and procedures follow Federal and State laws, and DBHDD policy, and are used to direct the management of medications brought by the individual, medication ordering, procurement, prescribing, transcribing, dispensing, administration, documentation, wasting or disposal, and security, to include the management of controlled substances, floor stock, and physician sample medications;

    f. There is documented evidence of oversight by the APRN, for the accounting of and dispensing of sample medications;

    g. The CSDC has a policy on informed consent on medication, including the right of the individual (and, if applicable, the legal guardian) to refuse medication. For an example of such a policy, the CSDC may refer to Informed Consent and Involuntary Administration of Psychotropic Medication in DBHDD Hospitals, 03-534, but the CSDC is encouraged to consult with independent professionals to develop a policy suited to the CSDC and in accordance with all applicable Federal and State laws, and DBHDD policy;

h. The CSDC has a process to identify, track and correct deviations in medication prescribing, transcribing, dispensing, administration, documentation, or drug security of ordering or procurement of medication that results in a variance;

i. The CSDC's policies and procedures describe actions to follow when drug reactions and other emergencies related to the use of medications occur, and emergency medical care that may be initiated by a registered nurse in order to alleviate a life-threatening situation; and

j. The CSDC's policies and procedures provide for daily checks of, and the maintenance of temperature logs for, all medication room refrigerators. Temperatures for the refrigerator are set between 36°F and 41°F.

M. ADMINISTRATION OF MEDICATION

Any psychotropic medications for individuals served in CSDC crisis services must be clinically justified. The use of psychotropic medications is meant to enable, not disable, the individual's ability to effectively or appropriately interact with the world around them. If required after a clinical assessment of the individual, medication is used as treatment for targeted symptoms of the individual's medical or psychiatric condition. "PRN" medications for psychotropic use (and excluding "PRN" medications for medical use) are prescribed only for specified and individualized symptoms. If "STAT" or "PRN" medication orders are written, this is done for the purpose of symptom management, not behavior management. Each "PRN" or "STAT" order is accompanied by a psychiatrist's rationale as to symptoms targeted.

1. Assessment of Capacity for Consent of Medication

   a. The CSDC ensures the documentation of the assessment of the individual's capacity to understand and consent to medication administration located in the Consent for Treatment received at admission.

   b. If appropriate CSDC staff determine that an individual lacks capacity to understand and consent to medication administration, and if the individual does NOT have a court-appointed legal guardian, then the CSDC:

      i documents the determination of lack of capacity in accordance with the requirements of the Georgia Medical Consent Law (O.C.G.A. Section 31-9-2); and

      ii contacts relatives or adult friends in the order of priority set forth in the Georgia Medical Consent Law (O.C.G.A. Section 31-9-2) in order to obtain consent for medication administration.

2. Obtaining Informed Consent

a. The psychiatrist/APRN is responsible for discussing the medication, reason for use, side effects, risks and alternatives with the individual (and guardian/relatives/friends if such persons will be giving consent on the individual's behalf) and for obtaining the signature of the individual (or guardian/relatives/friends if the individual lacks capacity to give consent) prior to the initial administration of psychotropic medication.

b. To ensure that maximum education is provided to the individual regarding the specific medications prescribed for them, the consent form includes the specific medications being prescribed at that time.

   When other psychotropic medications are prescribed by the psychiatrist, a new consent form is completed for the specific medication prescribed.

c. The psychiatrist is responsible for ensuring that the communication about medications is done in a manner commensurate with the individual's abilities of comprehension and understanding.

d. The psychiatrist/APRN is responsible for completing an "Informed Consent for Medication Form" **(Appendix H)** and ensuring that it is properly signed and placed in the individual's clinical record.

e. If the individual refuses to sign an Informed Consent for Medication Form but consents orally to treatment with psychotropic medication, the psychiatrist must have the individual's oral consent witnessed by two (2) staff members indicating in writing on the consent form that the individual has consented orally in the presence of two witnesses. Both the psychiatrist and the witnesses sign the consent form.

f. If the individual refuses to consent to the recommended medication, the psychiatrist must determine whether that refusal would result in the individual being unsafe to themselves or others.

3. Administration of Medication

   a. Medication must be administered by licensed medical personnel under the supervision of a psychiatrist or registered nurse in accordance with DBHDD policy, Federal law, and Georgia law.

4. Criteria for Administration of Emergency "STAT" Medication

   a. Administration of emergency "STAT" medication may be used ONLY as an emergency safety intervention of last resort, where an individual's symptom-related behaviors are affecting the physical safety of the individual and others. Administration of emergency "STAT" medication shall be done in accordance with O.C.G.A. Section 37-4-123.

b. Staff must apply all strategies commensurate with their training to de-escalate, motivate and otherwise engage the individual in positive behavior choices in order to avoid use of emergency "STAT" medication.

c. The BCBA-D (or designee) and Psychiatrist/APRN must collaboratively determine the need for administration of emergency "STAT" medication.

d. If the individual is determined to need an emergency "STAT" medication, the Psychiatrist/APRN must evaluate/assess to write an order for such instances.

e. The privacy of the individual should be protected by usage of calming rooms or private bedrooms either being not visible from the common areas, or if visible, administration of such medication should occur offset from main thoroughfares and afford restricted visibility.

f. A manual hold/restraint (used in accordance with the nationally benchmarked crisis intervention program chosen by the provider) may be deemed necessary in situations for administration of emergency "STAT" medications. The CSDC is required to report ALL orders written for emergency "STAT" medications when a manual hold/restraint is used in accordance with Reporting Deaths and Other Incidents in Community Services, 04-106 and Investigating Deaths and Other Incidents in Community Services, 04-118.

5. Individual Debriefing

a. Debriefing with the individual occurs as soon as possible after the episode of restraint used during emergency "STAT" medication administration. The individual participates with staff members involved in the episode (who are available) in a debriefing about the episode.

b. If the presence of a particular staff member would be ill advised for any reason, the staff member does not participate in the debriefing.

c. If the individual is not physically or mentally able to participate in the debriefing within 24 hours, a member of the staff documents the reasons on "Debriefing with Individual Following Use of Restraint in Crisis Services" **(Appendix I)** and reschedules the debriefing as soon as possible.

d. The debriefing is led by a staff member who was not involved in the episode.

e. Debriefing is conducted in a language that is understood by the participants of the debriefing. The following are issues to explore with the individual during the debriefing:

i. Discuss what led to the incident.

ii. Discuss what was helpful or not helpful prior to the episode requiring seclusion or restraint.

iii. Explore what could have been done differently in advance of the incident, during and after the incident.

iv. Ascertain whether the individual's physical well-being, psychological comfort and right to privacy were maintained.

v. Explore how the individual felt after being released from restraint.

vi. Ascertain what staff actions helped the individual gain personal control.

vii. Determine the need for supportive counseling for the individual for any physical or psychological trauma that may have resulted from the incident.

viii. Discuss what changes could be made to assist the individual in future instances when the individual might lose control, including changes to the individual's treatment plan, crisis plan, and behavior support plan.

f. Information obtained from the debriefing is used to modify the individual's treatment plan and used in performance improvement activities.

g. A member of the treatment team documents the debriefing on "Debriefing with Individual Following Use of Restraint in Crisis Stabilization Services" (**Attachment G**) and ensures that any findings relevant to the individual's care have been communicated to the individual's treatment team.

6. Staff Debriefing

a. Debriefing of staff involved in the episode of restraint used during emergency "STAT" medication administration occurs as soon as possible following the occurrence; a debriefing is held for staff to discuss all issues around the occurrence.

b. Review of all episodes of restraint used during emergency "STAT" medication administration and the subsequent debriefing must be completed by the psychiatrist/APRN and BCBA-D (or designee) within 24 hours of an episode.

c. The debriefing includes:

i. Assessing the roles and performance of individual staff during the episode;

ii. Reviewing findings from the debriefing that took place with the individual;

iii. Discussing the effectiveness of staff as a team;

iv. Determining in what way staff could be individually or collectively more

effective in future incidents;

v. Documentation of the staff debriefing is completed on "Debriefing with Involved Staff Following Use of Restraint in Crisis Services" (**Appendix J**); and

vi. Team review: Staff reviews the information included on "Debriefing with Individual Following Use of Restraint in Crisis Services" (**Appendix I**) and "Debriefing with Involved Staff Following Use of Restraint in Crisis Services" (**Appendix J**)

d. Clinical Record Documentation

i. Every episode or use of restraint is documented in the individual's clinical record. Attachments I, and J are placed in the individual's clinical record.

ii. Documentation must address all issues related to care provided to the individual while the individual was in manual hold/restraint.

N. NUTRITIONAL SERVICES

1. Meals Schedule

a. At least three (3) nutritious meals per day are served.

b. Nutritional snacks are available for all individuals between meals.

c. No more than fourteen (14) hours may elapse between the end of an evening meal and the beginning of a morning meal.

d. Individuals may eat or be served in shifts during daily operations.

e. Under no circumstances is food withheld for disciplinary reasons.

f. Meals or snacks must be provided to individuals who arrive and/or are admitted after scheduled meal hours.

2. Special Orders

a. Therapeutic diets are provided when ordered by a physician or physician extender.

b. The CSDC 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 individuals record.

c. Meal planning should demonstrate choice and participation from the individual, as safe and appropriate.

3. On-Site Food Preparation
    a. To prepare food on-site, the CSDC must have a satisfactory food service permit score, pursuant to Georgia Department of Public Health food service regulations, including Georgia Comp. R. & Regs. Chapter 511-6-1.
    b. Staff must adhere to proper hand hygiene standards for food preparation.
    c. A copy of the current food service permit must be on file at the CSDC.
    d. Access to the meal preparation area is prohibited for non-staff.
4. Off-Site Food Preparation
    a. The CSDC may utilize meal preparation services from an affiliated or contracted entity with a current food service permit (the "food service entity").
    b. The CSDC enters into a formal written contract between the CSDC and the contracted food service entity, containing assurances that the contracted food service entity meets all food service and dietary standards set forth in this manual.
    c. The CSDC must have a modified kitchen that includes a microwave, a refrigerator, an ice maker, and clean-up facilities if electing to have meals prepared off site.
    d. Access to the meal preparation area is prohibited for non-staff.
5. Food Safety
    a. The CSDC maintains a daily temperature log for the freezer(s) and refrigerator(s):
        i. Temperature for the refrigerator is set between 34°F and 41°F (1°C to 5°C).
        ii. Temperature for the freezer is set between 0°F and 10°F (-17°C to -15°C).
    b. Food, drinks, and condiments are dated when opened and discarded when expired.
    c. The CSDC maintains a three-day supply of non-perishable emergency food and water at all times for the maximum bed capacity and supporting staff.

O. EDUCATIONAL REQUIREMENTS

The CSDC may provide services to adults ages 18-21 who are still enrolled in educational services. For a holistic approach to treatment and continuity of services while at the CSDC, the educational needs that must be addressed include:

1. IEP developed by the school system should be an integral part of the behavioral treatment and programming at the CSDC when the individual is anticipated to be absent from school.
2. Collaboration with school staff, or evidence of an attempt to contact the school staff, must occur within 48 hours of admission to implement educational supports that are outlined in the current IEP, to include service goals training.

P. ENVIRONMENT OF CARE REQUIREMENTS

The CSDC Crisis Services provider must meet the following environment of care requirements.

1. Areas Accessible by Individuals Receiving Services

   a. Maintain an environment that is clean and is in good repair.

   b. Maintain an environment that is safe and free of items that could be used for self-harm.

   c. Maintain a facility that has access to natural light and exterior views.

   d. The general architecture of the CSDC, along with tools and technology, provides for optimal line- of-sight observations from the nurses' station throughout the unit, mitigating hidden spots and blind corners.

   e. The CSDC Crisis Services facility is a locked facility.

   f. Interior finishes, lighting, and furnishings of the CSDC Crisis Services facility conform to applicable fire and safety codes as classified for Health Care Occupancy/Limited Care Facilities in the current edition of National Fire Protection Association's NFPA 101 Life Safety Code Handbook, Chapter 18/19: New and Existing Health Care Occupancies.

   g. Each furnishing, item of hardware, fixture, or protrusion of the CSDC Crisis Services facility is:

      i. Designed to release from its fixings to prevent a ligature if an abnormal load is applied, or the item is fixed in place; however, is free from points where a cord could be fastened to create a ligature point;

      ii. Made of materials which mitigate the risk of use as weapons or self-harm (hanging, cutting, etc.);

      iii. Intact and functional;

      iv. Maintained in good condition; and

v. Tamper resistant.

h. The ceiling and the air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances of the CSDC Crisis Services facility are of the tamper-resistant type.

i. Doors of the CSDC Crisis Services facility meet the following requirements:

i. The CSDC Crisis Services provider has a policy in effect to address locking doors in bedrooms and bathrooms which will address an individual's privacy and safety, and which addresses staff access, at all times, to supervise and monitor that individual's clinical status and safety;

ii. The CSDC Crisis Services provider has written risk management protocols in place to address situations in which an attempt might be made to prevent access to any area of the CSDC Crisis Services facility;

iii. If the CSDC Crisis Services facility is equipped with electronic locks on internal doors or egress doors, the CSDC Crisis Services provider ensures that such locks have manual common key mechanical override that will operate in the event of a power failure or fire.

j. Light switches and electrical outlets of the CSDC Crisis Services facility are secured with tamper-resistant type screws.

k. Sprinkler heads are to be flush mounted on ceilings lower than nine (9) feet. Sprinklers have institutional heads that are recessed and drop down when activated.

l. Security and safety devices of the CSDC Crisis Services facility are mounted, installed, secured in a manner which:

i. Mitigates the risk of use of weapons or for self-harm (hanging, cutting, etc.);

ii. Prevents interference; and

iii. Prevents any attempt to render inoperable with its purpose as a security device.

m. Upon request, the CSDC Crisis Services provider provides a means of locked storage for any individual’s valuables or personal belongings.

n. The CSDC Crisis Services provider maintains the environmental temperature between 65° F and 82° F (18° C to 27° C).

o. The interior of the CSDC Crisis Services facility is non-smoking (if the CSDC Crisis Services facility offers smoking, the facility designates a sheltered, outside space as a smoking area).

p. Lighting fixtures are recessed and tamper-resistant with Lexan or other strong translucent materials.

q. Windows are protected with Lexan or other shatter-resistant material that will minimize breakage.

r. Equipped and Maintained so as to provide a sufficient amount of hot water for individuals use.

s. Heated water provided for individuals' use is maintained between 110°F and 120°F (43°C and 48°C).

t. Consistent available drinking water for individuals' access using mechanisms which meet general expectation of infection control procedures.

u. Maintains safety equipment to include an Automated External Defibrillator (AED) and all other necessary medical safety supplies.

v. Provides laundry facilities on the premises for the individual's personal laundry.

w. Entrances and exits, sidewalks, and escape routes of the CSDC are constantly maintained free of all impediments and hazards.

x. The CSDC Crisis Services facility has at least one (1) operable, non-pay telephone which is private and accessible at reasonable times for use by individuals.

3. Designated Areas

The CSDC Crisis Services provider must maintain the following clearly designated areas:

a. Waiting and Screening Areas

i. A pre-admission waiting area of the CSDC Crisis Services facility, including restroom(s), that meets all safety requirements applicable to designated individual areas;

ii. A secure area where individuals can be held awaiting evaluation and/or observation prior to an admission determination being made; and

iii. A screening area where searches can be done in a private and safe manner, respecting individual rights and privacy.

b. Exam Rooms

i. A room where examinations and lab procedures are conducted safely while respecting the individual's confidentiality.

ii. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk for all exam room equipment and items.

c. Bedrooms

i. Beds and other heavy furniture capable of use to barricade a door are weighted or secured to the floor or wall;

ii. The use of beds with springs, cranks, rails or wheels, including hospital beds, roll-away beds, cots, bunk beds, stacked, hide-a beds and studio couches is prohibited; and

iii. Windows may be textured to provide privacy without the use of curtains or blinds.

d. Bathrooms

i. The CSDC Crisis Services facility has gender neutral bathrooms with proper ventilation;

ii. Exposed plumbing pipes are covered to prevent individual access;

iii. The CSDC Crisis Services facility has a minimum ratio of one (1) shower for each three (3) individuals receiving services and one (1) toilet and lavatory for each three (3) individuals receiving services;

iv. Individual shower stalls and dressing areas are provided;

v. The CSDC Crisis Services facility has a bathroom facility that is in compliance with the Americans with Disabilities Act (ADA) for use by individuals with physical disabilities. It includes a toilet, lavatory, shower and flush-mounted safety grab bars;

vi. The shower heads are recessed or have a smooth curve from which items cannot be hung;

vii. Overhead rods, fixtures, supports or protrusions are selected and installed in a manner which mitigates the risk of use of weapons or for self-harm (hanging, cutting, etc.).

viii. The toilet is secured and tamper resistant; and

ix. Mirrors are not common glass and must be fully secured and flat mounted to the wall.

e. Sensory Rooms

i. The CSDC Crisis Services facility must have a minimum of two (2) sensory rooms.

ii. All furniture must be weighted or secured to the floor to prevent the ability to barricade the door.

iii. Lighting must have optional dimmed lighting capacity.

iv. The CSDC Crisis Services facility must have procedures and precautions in place to minimize ligature and safety risk for all sensory room equipment and items.

f. Calming Rooms

i. The CSDC Crisis Services facility must have a minimum of two (2) calming rooms.

ii. Padding should cover all four of the walls.

iii. Lighting should have optional dimmed lighting capacity.

iv. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk for all calming room equipment.

g. Activity/Day Rooms

i. The CSDC Crisis Services facility must have a minimum of two (2) activity/day rooms.

ii. All furniture must be weighted or secured to the floor to prevent the ability to barricade the door.

iii. Lighting must have optional dimmed lighting capacity.

iv. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk for all activity/day room equipment and items.

h. Dining Area

i. The CSDC Crisis Services facility has a sufficient designated area to accommodate meal service. The eating area may double as a group or activity area.

ii. The area must include tables and chairs to meet the needs of individuals served and support staff.

iii. All furniture must be weighted or secured to the floor to prevent the ability to injure self or others.

iv. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk for all dining area equipment and items.

i. Outdoor Courtyard

The CSDC Crisis Services facility must include an outdoor courtyard meeting the following criteria.

i. Enclosed by a privacy fence no less than six (6) feet high, where individuals have access to fresh air and exercise. It provides privacy from public view and does not provide access to contact with the public.

ii. This area is constructed to retain individuals inside the area and minimize elopements from the area.

iii. The fenced area is designed for safety without blind corners to be readily visible by one staff member standing in a central location and designed to minimize elopement.

iv. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk for all recreational equipment.

v. A portion of the outdoor area is designed to provide cover from the elements so individuals may use the area in inclement weather vi. Seating, furnishings, and recreational items are designed to minimize risk to individuals.

j. Visitation Room

The CSDC Crisis Services facility must include a visitation room that meets the following criteria.

i. The area is constructed to retain individuals inside the area and minimize elopements from the area while engaging with visitors;

ii. The CSDC Crisis Services provider must develop a schedule that contains use of the visitation room and the amount of individuals and visitors to utilize the space at one time.

iii. The CSDC Crisis Services provider must have procedures and precautions in place to minimize ligature and safety risk. All heavy furniture capable of use to barricade a door are weighted or secured to the floor or wall.

iv. The area is constructed in such a way as to prevent the general public from accessing the unit to maintain the privacy of individuals served. There should be separate entrances for individuals accessing the room via the unit and for the general public accessing the room from off the unit.

Q. DISCHARGE PLANNING

See Section F.2, above, for discharge criteria. Discharge of any individual from the CSDC Crisis Services program must be planned in accordance with the following:

1. In all discharges from the CSDC Crisis Services program, the provider agency must provide case management; to include outreach and linkage to housing, aftercare and other resources as needed and/or assessed. The provider must participate in coordination and appropriate linkage to ongoing aftercare post discharge to include behavioral health, physical health, and any other necessary supports (i.e., I/DD supports, Whole Health and Wellness).
2. Discharge planning begins at admission, facilitated by the Case Manager. At a minimum, the final discharge plan must include the following:
    a. All requirements within Discharge Criteria identified within these standards (Section F.2) must be met;
    b. Identification of the individual's desired outcome and needs;
    c. Identification of natural supports;
    d. Risk assessment and safety planning in accordance with the required time frame;
    e. A review and assessment of prior treatments and discharge plans;
    f. Arrangement and identification of transportation from the CSDC.
    g. A ten (10) day supply of medications is prescribed and dispensed when individuals are discharged from the CSDC Crisis Services program. Less than a ten (10) day supply may be given only when there is:
        i. documentation by the discharging psychiatrist of a safety issue that would arise if a ten-day supply were dispensed by the CSDC; and/or

ii. a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.

h. A thirty (30) day prescription of medication must be provided to the individual upon discharge from the CSDC Crisis Services program. The CSDC Crisis Services program must obtain any prior authorization that is required for new medications for the individual prior to discharge.

i. Discharge meeting occurs to include the interdisciplinary team and family supports/community providers to discuss clinical outpatient recommendations and referrals, family supports and involvement, and individual daily living supports.

3. The discharge summary information is developed by the Case Manager and provided to the individual at the time of discharge and includes:

a. Criteria describing evidence of clinical and behavioral stabilization and discharge planning;

b. Significant findings relevant to the individual's recovery (strengths, needs, preferences);

c. Specific instructions for ongoing care and outpatient services to include their contact information;

d. List of set appointments for identified outpatient and DBHDD providers;

e. Individualized recommendations for continued care to include recovery supports and community services (if indicated);

f. Behavior Support Plan, Treatment Plan, and Crisis Plan;

g. Medication List to include: name of medication, dose, frequency, route, indication, instructions for altering if needed (i.e., mixed, crushed, administered with food). Any alterations must be delivered with a Doctor's order.

h. A ten (10) day supply of medications is prescribed and dispensed when individuals are discharged from the CSDC Crisis Services program. Less than a ten (10) day supply may be given only when there is;

i. documentation by the discharging psychiatrist of a safety issue; and/or

ii. a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.

i. A thirty (30) day prescription of medication must be provided to the individual upon discharge from the CSDC Crisis Services program. The CSDC Crisis Services

provider must obtain any prior authorization that is required for new medications for the individual prior to discharge.

j. Daily schedule (any specific order, or preferences to daily living and/or activities the individual engages in)

k. Contact information on acquiring access to community services.

l. Discharge summaries and other pertinent information must be shared with other entities with appropriate authorization and release of information documents.

4. Discharges against medical advice (AMA) require discharge summary information developed by the Case Manager and to be provided to the individual at the time of discharge must include the following:

    a. The clinical team has assessed the individual's need for ongoing care and if there is evidence of risk, then that risk must be documented and reported to the individual and the individual's court-appointed legal guardian (if applicable);

    b. The individual is provided an opportunity for continued care, treatments, and supports;

    c. Medication brought by the individual upon admission must be returned to the individual upon discharge as clinically appropriate;

    d. Significant findings relevant to the individual's recovery (strengths, needs, preferences);

    e. List of known upcoming appointments for identified outpatient and DBHDD providers;

    f. Individualized recommendations for continued care to include recovery supports and community services (if indicated);

    g. A ten (10) day <u>supply</u> of medications is prescribed and dispensed when individuals are discharged from the CSDC Crisis Services program. Less than a ten (10) day supply may be given only when there is;
        i. documentation by the discharging psychiatrist of a safety issue; and/or
        ii. a verified outpatient physician appointment is scheduled within five (5) days of discharge and transportation for this appointment is assured.

    h. A thirty (30) day prescription of medication must be provided to the individual upon discharge from the CSDC Crisis Services program. The CSDC Crisis Services program must obtain any prior authorization that is required for new medications for the individual prior to discharge.

i. Access of resources for continuity of care must be provided to the individual prior to their AMA discharge.

   i. A location of residence or continued treatment must be secured

      for AMA discharges;

   ii. Transportation must be established by the CSDC;

   iii. Psychoeducation (Education around follow up, medication safety, and medication compliance) must be reviewed with the individual.

   iv. Review of suicide prevention, screening, intervention, and monitoring for Safety Plans, and any appropriate actions or referrals based on that review.

   v. Discharge summaries and other pertinent information must be shared with other entities with appropriate authorization and release of information documents.vi. AMA discharges must be reported to DBHDD (Office of Crisis and Transition Services) and Regional Field Offices 72 hours prior to discharge.

R. QUALITY ASSURANCE AND STANDARDS COMPLIANCE

1. The CSDC Crisis Services provider shall develop and maintain performance indicators and outcome data as part of its quality management system.

2. The CSDC Crisis Services provider's quality assurance data system shall at minimum include the following performance indicators and outcomes:
   a. Name of each individual admitted to the CSDC Crisis Services;
   b. Admission and Discharge dates of each individual;
   c. Occupancy rate;
   d. Methods to assure inter-rater reliability of risk of suicide screening and assessment instruments;
   e. Methods to assure adherence to the risk of suicide training and procedures set out in this manual;
   f. Process for monitoring risk of suicide services and follow-up for individuals who are screened or assessed as having current or past suicidal ideation and/or behavior;
   g. List of clinical specialty service referred for each individual admitted;
   h. List of clinical specialty service delivered for each individual;
   i. Daily progress note and data for each individual;
   j. Record of daily activities;

k. Record of behavioral training to BSS, CRA, and/or CLS provider for each individual;
l. Record of completion of discharge planning meeting for each individual;
m. Length of Stay per individual; and
n. Record of re-admissions.

3. The CSDC Crisis Services provider and program must participate in data collection and generate monthly quality assurance reports for the crisis service provided for submission to DBHDD. Monthly reports must be generated by the CSDC and sent to DBHDD (I/DD Crisis Stabilization Services Manager) to assist in making quality improvement decisions based on data collected. In addition to the monthly data reports, the CSDC Crisis Services provider may be requested to provide additional data/ad hoc reports as needed.

4. The CSDC Crisis Services provider must develop an internal risk management system that addresses the Quality Improvement processes for assessing and improving quality of supports that 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.

5. Areas of risk to persons served and to the organization are identified and monitored based on services, supports, treatment or care offered including, but not limited to:
   a. Incidents and accidents:
      i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Compliance as required by Reporting Deaths and Other Incidents in Community Services, 04-106.
      ii. There is evidence that internal incidents not required to be reported to DBHDD are recorded and monitored.
         a. Health and Safety;
         b. 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.

c. Individual Rights Violations;
d. Practices that limit freedom of choice or movement;
e. Medication Management;
f. Infection Control;
g. 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;
h. Breaches of Confidentiality; and
i. Protection of Health and Human Rights of persons with developmental disabilities.

SECTION 4: ORGANIZATIONAL AND REPORTING REQUIREMENTS

S. ORGANIZATIONAL PRACTICES

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

a. Description of services to include:

i. The population served; and

ii. How individuals with I/DD or with co-morbid I/DD and BH challenges are strategically provided crisis services to address needs; and

iii. The services available to potential and current individuals; and

iv. A detailed expectation and outcomes for services offered; and

v. The types of assessments, use of evaluation tools, management of crisis situations, and development of behavioral/safety/crisis plans utilizing evidence-based practices.

b. Admission and discharge process;

c. Internal structures and protocols that support good practices such as:

i. Clearly stated current policies and procedures for all aspects of the operation of the organization;

ii. Policies and corresponding procedures that direct the practice of the organization;

iii. Staff trained in organization policies and procedures;

iv. Providing services according to benchmarked practices;

v. The level and intensity of services offered is within the organization's scope of services;

vi. The identified services are offered timely as required by individual need; and

vii. 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.

d. A formal code of conduct and other policies communicating appropriate ethical and moral behavioral standards and addressing acceptable operational principles and conflicts of interest.

i. An ethical tone is established at the top of the organization and has been communicated throughout the organization.

ii. 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.

iii. The code of conduct is acknowledged by signature of all employees and contractors at least annually.

iv. Appropriate disciplinary action is taken in response from departures from approved policies or violations of the code of conduct.

e. The program description identifies the minimum staff-to-individual served ratios for each specific service offered; and staff ratios reflect the needs of individuals supported, implementation of behavioral procedures, best practice guidelines and safety considerations.

f. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.

i. Licensure and other permits, when applicable, must be available at the agency or by the individual provider and open to view by the public;

ii. Accreditation/compliance with community standards requirements meet contractual requirements;

iii. 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.

g. A written budget which includes expenses and revenue and which serves as a plan for managing resources. Utilization of fiscal resources is assessed in the provider's Quality Improvement Processes and/or by the Board of Directors.

h. Staff P&P that outlines staffing qualification requirements, protocols for hiring practices, and competency and background checks. Note: the CSDC Crisis Services provider must adhere to Criminal History Records Checks for DBHDD Network Provider Applicants, 04-104

i. Utilization/development/revision of an individual'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.

j. Monitoring and evaluation of services to ensure that they demonstrate person-centered planning and respect for the individual's rights and choices. 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.

k. Risk management plan that identifies and monitors risk issues on an ongoing basis.

l. Transportation plan for admissions and discharges, as well as to and from community appointments when a referral is made by the interdisciplinary treatment team. 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.

m. Policies and procedures for all vehicles used in this service, 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 adults served that includes documentation of boarding and exit time of individual with to and from location of planning trip and not leaving individual 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.

n. Identification, detection, handling, and storage of individuals' belongings, as well as those that are determined to be contraband and potentially harmful.

o. A plan for ensuring that all applicable practices regarding Limited English Proficiency and Sensory Impairment will be followed in accordance with Nondiscrimination and Accessibility for Individuals with Disabilities and Individuals with Limited English Proficiency, 15-100. In addition, the plan must ensure the provider's compliance with DBHDD Policy "Accessibility of Community Intellectual and Developmental Disabilities Services for Individuals Who are Deaf and Hard of Hearing, 15-115" with regard to any individuals who are deaf, deaf-blind, or hard of hearing as defined in that policy.

p. Person-centered planning for stabilization and therapies that includes:

i. 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.

ii. Interdisciplinary evaluation to determine psychiatric, medical, and/or environmental factors potentially triggering the acute crisis. Recommendations made by the interdisciplinary team should be

included in the treatment plan, crisis plan, and behavior support plan so that all documentation is reflective of the individual as a whole.

iii. 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.

iv. Focus on the individual's strengths and attributes, with an assessment of past trauma and abuse, to guide the process for determining early interventions for how the individual would prefer to be approached if/when in crisis emits.

v. An environment structured to meet the individual's needs for space, privacy, and safety to minimize incidents.

vi. Collaboration of integrated holistic care to establish an effective behavior/safety/crisis plan for continuity of care that serves to compliment and provide for integrated supports across service settings once the individual is transitioned to their natural home/setting.

vii. Comprehensive discharge plans to include thorough analysis of needed supports (clinical and behavioral), safety/crisis plan, follow-up referrals/appointments, behavior support plans, and environmental recommendations in order to provide continuity of care when discharged and promote the sustainment of the individual in their natural home/setting.

T. DOCUMENTATION REQUIREMENTS

The CSDC Crisis Services provider will adhere to any documentation requirements set forth in its contract related to compliance, quality management, utilization management, etc., and will also comply with the following documentation requirements:

1. The notes for the program must have documentation including admission/discharge time, shift notes, and specific interactions.
2. Additionally, the provider must document the following in each individual's record:
    a. Specific activity, training, or assistance provided per shift, to include description of behavioral interventions;

b. Date and the start and end times when clinical ancillary services were provided offsite (including name of service);
c. Verification of clinical service delivery, including first and last names and titles (if applicable) of the staff providing the service/training;
d. Interdisciplinary treatment team meetings to include outcomes;
e. Nursing assessment;
f. History & Physical (H&P);
g. Psychopharmacological assessment (if applicable);
h. Session notes from any clinical service scheduled appointment and/or session.
i. Crisis Plan, Functional Behavior Assessment, Behavior Support Plan;
j. Progress towards goals outlined in the behavioral support plan and/or treatment plan per shift;
k. 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 (group activities), and other positive outcomes throughout shifts;
l. Behavior related data collection;
m. Nursing notes per shift (to include any medical needs such as bowel tracking, blood pressure, etc.);
n. Medication administration;
o. Doctor's orders; and
p. Documented discharge planning efforts and activities made by the Case Manager.

3. Provider maintains a record of evaluation for admission and outcome of the evaluation, including the date, time, name and credentials of the professional conducting the evaluation.
4. Provider maintains documentation of legal guardianship, whenever applicable.
5. Provider maintains assessments, to include psychiatric, physical health, nursing, psychosocial status, and behavioral.
6. Provider ensures documentation by the psychiatrist of the individual's response to care, including psychiatrist orders, rationale for changes in orders or levels of observation.
7. Provider ensures documentation of implementation of interventions, including the individual's response to the interventions.
8. Provider documents the location and type of treatment or education provided, including the date and time of treatment or education, the name and credentials of

the professional or other staff providing the service, and the response of the individual to the treatment or education.

9. Provider documents evidence of the individual's progress toward stabilization and recovery, or lack thereof.
10. Provider documents medical testing (if any), medical findings, and medical care needs and follow up or interventions provided.
11. Provider ensures documentation of continued stay justifications during all treatment team meetings.
12. Provider ensures documentation at least once per day by an RN as to the status of the individual.
13. Provider ensures documentation of events or incidents that affect care and treatment, including the individual's response. The CSDC reports all incidents meeting the definition of a reportable incident per Reporting Deaths and Other Incidents in Community Services, Policy 04-106.
14. Provider maintains a record of implementation of emergency safety interventions if implemented.
15. Provider documents the name and title of staff providing direct support care and behavioral interventions for every shift (includes the 1:1 staff and assigned BCBA). The RBT, BIS, or DSP should complete a progress note to include a summary of activities, implemented behavioral strategies, and behavioral data.
16. Provider documents discharge notes and aftercare plans, including the individual's status at discharge, ongoing needs, aftercare plan, and the date, time and method of discharge.
17. Records of all services provided to each individual will be maintained by provider for at least six (6) years following the date of discharge.

U. REPORTING AND BILLING REQUIREMENTS

The CSDC Crisis Services provider must comply with the following reporting and billing requirements.

1. Provider must provide monthly programmatic reports regarding individuals served and level of services provided as designed by the DBHDD.
2. Provider must participate in quality assurance and compliance reviews as facilitated by the DBHDD.
3. Provider must provide complete cooperation in all audits.

4. Provider must follow policies related to corrective action plans, including Corrective Action Plan Management 13-101.
5. Provider must participate in training and meetings as facilitated by the DBHDD.
6. Provider must respond to requests from individual's community providers, as well as Supervisory DBHDD staff.
7. Provider will maintain the ability to track the following data elements and provide reports to the Department as requested:
    a. Number of referrals received;
    b. Individual information;
    c. Number of admissions and discharges;
    d. Admission and Discharge Diagnoses;
    e. Type of Services provided and title of staff who provided the types of services;
    f. Number of beds in use;
    g. Lengths of stay;
    h. Return Admissions in less than 30 days;
    i. Individuals' involvement with courts (including criminal charges, probation orders or other court orders, pending court hearings, etc.);
    j. Average length of stay of individuals;
    k. Referral Sources;
    l. Referrals to medical facilities;
    m. Discharge Destinations;
        i. Medical Facility;
        ii. Host Home;
        iii. Licensed Group Home;
        iv. Residential Placement;
        v. Family Home;
        vi. Other-Specify;
    n. Housing status;
    o. Other data elements as requested; and
        i. Frequency and occurrence of readmissions

V. MEDICAID REQUIREMENTS

CSDC Crisis Services is not a Medicaid billable service.

W. CERTIFICATION REQUIREMENTS

1. There is currently no licensure required for the operation of CSDC Crisis Services. However, prior to operation, the CSDC Crisis Services provider must complete an initial DBHDD compliance review by the Office of Incident Management and Compliance (OIMC) of DBHDD's Division of Strategy, Technology, and Performance. If the provider is found in compliance with these Operational Standards and with applicable DBHDD policies, OIMC may issue a six (6) month provisional certificate to

be allowed to begin operations. Prior to the expiration of the provisional certificate, the provider receives a full certification visit conducted by OIMC, at which time the provider may be issued up to a one (1) year certificate. Certification reviews are ongoing and will be conducted prior to the expiration of any certification. The provider may be issued a certificate for up to five (5) years if determined to be in substantial compliance and fully operational. Except as expressly provided otherwise in these Operational and Clinical Standards or in the CSDC provider's contract with DBHDD, these review and certification procedures will be performed in accordance with Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02- 703.

2. The OIMC certificate is non-transferrable and is for the specific site.
3. At any time, DBHDD may conduct a special compliance review to assess the provider's compliance with the applicable DBHDD community service standards and CSDC standards referenced in this document. If at any time the OIMC determines that the CSDC does not meet certification requirements, they reserve the right to rescind the certification.
4. The Division of Developmental Disabilities (Office of Crisis and Transition Services) may also conduct announced and/or unannounced on-site reviews of the facility and services to determine the CSDC Crisis Services provider's compliance with the Operational and Clinical Standards in the operation of the CSDC Crisis Services.

X. STAFF TRAINING REQUIREMENTS

The CSDC Crisis Services provider's staff training must comply with the following 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 individuals 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 trainings that include, but are not limited to:

    a. Assessing the behavioral crisis (specific I/DD and/or co-morbid I/DD and MH 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 an individual who is subject of an emergency safety intervention;

f. Training in working with individuals with I/DD and/or co-morbid I/DD and MH 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. Prevention 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. Providers develop an annual strategic training plan that sets out a specific plan to train/re-train all staff in suicide prevention. This plan is to ensure that:

   i. Staff maintain proficiency in an evidence-based basic gatekeeper training program to enhance awareness and vigilance around the signs of suicide (e.g., Question, Persuade and Refer (QPR), SafeSide Prevention, and Safetalk).

   ii. Staff conducting screening, assessment, intervention and monitoring with individuals are trained in the basic competencies required in Assessing and Managing Suicide Risk (AMSR) or Safeside and are required to be trained or certified in the use of tools and/or interventions before they use them in practice. Documentation of

training is kept in their personnel file. AMSR and SafeSide Prevention: Behavioral Health are two of the trainings that can be utilized by providers.

a. Staff are required to participate in additional suicide prevention training as needed, but at least annually. Documentation of training must be included in their personnel file.

b. Providers are encouraged to provide training in evidence-based suicide prevention interventions such as, but not limited to, Applied Suicide Intervention Skills Training (ASIST), Collaborative Assessment and Management of Suicide Risk (CAMS), Cognitive Behavioral Therapy for Suicide (CBT-S) and Dialectical Behavior Therapy (DBT).

c. Staff are provided with updates on evidence-based suicide prevention at least annually from the DBHDD Office of Behavioral Health Prevention and Federal Grants.

iii. Clinical application of screening and assessment tools, intervention and monitoring of suicide is routinely reviewed in clinical supervision.

k. Documentation and retraining, if applicable, when implementation of emergency safety interventions results in an individual's injury.

l. 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.

m. Critical incident reporting as outlined in Reporting Deaths and Other Incidents in Community Services, 04-106.

n. Staff operating a vehicle to transport individuals are required to have defensive driving training and possess a valid Georgia driver's license.

Y. HUMAN RESOURCES

The CSDC Crisis Services provider's human resources practices must comply with the following requirements.

1. The CSDC Crisis Services provider develops and implements policies and procedures that address the hiring, training, promotion, and termination of staff.

2. The CSDC Crisis Services provider complies with all applicable laws and Criminal History Records Checks for DBHDD Network Provider Applicants, 04-104, governing criminal history records checks.

3. The CSDC Crisis Services provider defines the responsibilities, qualifications, and competencies of staff for all positions. Where a staff member has responsibilities that are addressed by any of the DBHDD policies listed in the CSDC Operational and Clinical Standards, the CSDC Crisis Services provider develops and implements policies and procedures to ensure that the staff member is trained as required by such policy or policies and obtains and maintains any certifications or other credentials required by such policy or policies.

4. The CSDC Crisis Services provider develops policy for sanctioning or removing staff or otherwise maintaining the safety of individuals when:

    a. Staff are determined to have deficits in required competencies and/or certifications or other required credentials; or
    b. Staff are accused of abuse, neglect or exploitation.

5. The CSDC Crisis Services provider has processes for managing personnel information and records.

6. The CSDC Crisis Services provider has procedures for verifying licenses, credentials, experience, and competence of staff, which procedures ensure that:

    a. Licenses and credentials of all staff members are current as required by the licensing and accrediting agencies responsible for issuing the staff members' respective licenses and accreditations; and

    b. All persons providing services comply with all applicable laws, rules and regulations regarding professional licenses, qualifications and requirements related to the scope of practice while providing services for the CSDC Crisis Services provider.

7. The CSDC Crisis Services provider ensures that all primary staff (direct care, behavioral service providers, and medical/nursing), and the scheduling and ratios of such staff, comply with the following criteria:

    a. All professional staff are properly licensed or credentialed in their professional fields as required by Provider Manual for Community Developmental Disability Providers, 02-1201;

    b. Professional staff are at all times present in numbers to provide adequate supervision to unlicensed and/or non-professional staff;

    c. Professional staff are at all times present in numbers to provide services, supports, care and treatment to individuals as required by the Provider Manual for Community Developmental Disability Providers, 02-1201;

d. All staff working in mental health, addictive diseases, and/or co-occurring disability services must complete standard training requirements, as set forth in the Provider Manual for Community Developmental Disability Providers, 02-1201.

i. Staff must demonstrate their competency and renew their CPR certification at least annually.

8. The CSDC Crisis Services provider ensures that, prior to direct contact with individuals, all staff, volunteers, and contractors are trained and show evidence of competence in their respective areas as defined Provider Manual for Community Developmental Disability Providers, 02-1201.

9. The CSDC Crisis Services provider ensures that, within the first thirty (30) days of providing direct care to individuals, all staff, volunteers and contractors receive training in their assigned duties as defined in Provider Manual for Community Developmental Disability Providers, 02-1201.

10. The CSDC Crisis Services provider has documentation of an annual training plan that ensures that each and every staff member who delivers therapeutic content is trained annually in at least one (1) clinical/programmatic content topic related to the delivery of care.

11. The CSDC Crisis Services provider ensures that all employees are tested for tuberculosis prior to direct contact with individuals and are retested at least annually thereafter.

12. The CSDC Crisis Services provider ensures there is full documentation showing implementation of this policy for all staff attached to the CSDC Crisis Services provider.

Z. RECORD MANAGEMENT

The CSDC Crisis Services provider must abide by all applicable state and federal laws regarding record retention and confidentiality and will take the following measures to that end.

1. Develop records management policies, procedures, and practices to manage and protect the confidentiality and protected health information of individuals' paper and electronic records.

2. Develop records management policies which support secure, organized records consistent with Federal and State law.

3. Maintain individuals' rights regarding the individuals' confidential and protected health information, and have policies and procedures that address:
    a. How individuals' rights are protected.
    b. Process for how individuals gain access to protected health information, including but not limited to how individuals:
        i. Request amendment(s) to the clinical record;
        ii. Request restriction of disclosure; and
        iii. Request an accounting of disclosures that have been made.
4. Confirm that each individual is given a Notice of Privacy Practices, regarding confidentiality of the individual's protected health information, that complies with the requirements of Health Insurance Portability and Accountability Act (HIPAA), including the process of:
    a. Permanently posting the Notice of Privacy Practices in the admissions area and in prominent locations where it is reasonable to expect individuals to be able to read the Notice. Additional copies are made available for distribution upon request;
    b. Providing copies of the Notice of Privacy Practices to the individual and his or her representatives, as defined by State law, upon the individual's admission.
5. Develop policies, procedures and practices that are compliant with the requirements of HIPAA regarding:
    a. Complaints regarding violation of confidentiality and privacy rights;
    b. Reports of breaches of HIPAA to DBHDD, and, as required by law, when applicable, to the individual, to the United States Secretary of Health and Human Services, and to the media;
    c. Sanctions of employees for violations of HIPAA; and
    d. Identifying business associates, as defined by HIPAA, of the CSDC Crisis Services provider and obtaining satisfactory assurances of the business associates' compliance with the requirements of HIPAA.
6. Ensure that the clinical record information about an individual contained in incident reports and any documents that are not part of the clinical record, and all information about an individual, whether oral or written, and regardless of how stored, is kept confidential.

7. Unless authorized by a valid written authorization signed by the individual, or by applicable law, the CSDC Crisis Services provider does not:

    a. Confirm or deny whether an individual is receiving or has received services from the CSDC; or

    b. Disclose any confidential or protected health information regarding the individual.

AA. RIGHTS AND CONFIDENTIALITY

All CSDC Crisis Services delivered should be in accordance with Individuals' Rights, 24-104 and Human Rights Council for Developmental Disability Services, 02-1101.

BB. ABUSE

It is expressly prohibited to mistreat, abuse, neglect, exploit, seclude, or apply physical restraint as punishment of, any individual, or to unlawfully restrict movement of any individual, in CSDC Crisis Services.

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. CSDC provider will comply with the definitions of seclusion and physical restraint contained in the DBHDD Provider Manual for Community Developmental Disability Providers, 02-1201.

CC. REPORTINGS AND INVESTIGATIONS OF DEATHS AND CRITICAL INCIDENTS

Death and/or critical incidents involving individuals served in CSDC Crisis Services 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.

DD. DISASTER PREPAREDNESS AND RESPONSE PLAN

In accordance with Disaster Preparedness, Response, and Disaster Recovery Requirements for Community Providers, 04-102, the CSDC Crisis Services 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 I/DD Crisis Stabilization Services Manager, Director of Office of Crisis and Transition Services, as well as the related Regional Field Office. The provider should refer to this manual for additional instructions.

EE. FIRE PREVENTION AND FIRE OR DISASTER SAFETY REQUIREMENTS

The CSDC Crisis Services provider must meet the following fire prevention, fire safety, and disaster safety requirements.

1. Develop and implement a fire prevention and fire/disaster safety plan that includes the following:

    a. Protocols for and documentation of practice of monthly fire drills are rotated so that each shift has had at least one (1) drill quarterly, including time taken to complete the drills and follow-up recommendations for drills that are unsatisfactorily completed;

    b. Disaster drill protocols for disasters such as flood, tornado, and hurricane are developed, are reviewed at least annually, and are practiced at least quarterly;

    c. Directions for evacuation of the CSDC Crisis Services facility utilizing posted evacuation routes;

    d. Preparation of the individuals served by the CSDC Crisis Services provider for evacuation;

    e. Monthly fire extinguisher inspection, and documentation of every such inspection, and recharging as indicated;

    f. Annual inspections of other safety mechanisms such as sprinklers, smoke alarms, emergency lights, kitchen range/hood, etc., and documentation of all such inspections;

    g. Provision for annual review and revision of the fire prevention and fire/disaster safety plan;

    h. Procedures for training staff in all emergency and disaster drills, and in the execution of the fire prevention and fire/disaster safety plan;

    i. Evacuation from any outside, enclosed or fenced in areas must be feasible and included in the safety plan.

2. The CSDC Crisis Services provider must comply with all Federal, State, local, and accreditation agency fire safety standards. Where such standards impose more stringent requirements than these Operating Standards, or where they impose additional requirements not contained in these Operating Standards, the CSDC Crisis Services provider must comply with those more stringent standards and/or additional requirements.

FF. PROTECTION AND SAFETY OF INDIVIDUALS AND OTHERS

The CSDC Crisis Services provider must take the following measures to ensure the protection and safety of served individuals and others.

1. Maintains procedures regarding authorized entry and/or exit between and from the facility services.
2. Maintains policies and procedures to protect and respect individuals' rights and privacy while conducting searches.
3. Clearly defines in policy, and exercises control of potentially injurious contraband items; and such control includes, but may not be limited to:
    a. Prohibition of flammables, toxins, ropes, wire clothes hangers, sharp-pointed scissors, luggage straps, belts, knives, shoestrings, glass or other potentially injurious items;
    b. Management of housekeeping supplies and chemicals, including procedures to avoid access by individuals during use or storage. Whenever practical, supplies and chemicals are non-toxic or non-caustic;
    c. Safeguarding use and disposal of nursing and medical supplies including drugs, needles and other "sharps" and breakable items.
4. Except as otherwise provided by law, weapons are prohibited at the CSDC Crisis Services facility. The CSDC Crisis Services provider posts notices regarding the prohibition of weapons at all entrances and has written protocols addressing the same.
5. Develops and implements policies and practices, consistent with DBHDD policy and with these Operational and Clinical Standards, that describe interventions to prevent crises and minimize incidents when they do occur, that are organized in a least to most restrictive sequence. The written policies and procedures include the following elements:
    a. Emphasize positive approaches to interventions;
    b. Protect the health and safety of the individual served at all times;
    c. Specify the methods for documenting the use of the interventions; the admission assessment contains an assessment of past trauma or abuse, how the individual served would prefer to be approached should he or she become dangerous to him or herself or to others, and the findings from this initial assessment guides the process for determining interventions.

GG. INFECTION PREVENTION AND CONTROL

The CSDC Crisis Services provider must meet the following requirements for infection prevention and control.

1. The policies developed, maintained, and implemented by the CSDC Crisis Services provider include, at a minimum, the following:

a. Standard precautions are defined and the use of personal protective equipment when handling blood, body substances, excretions and secretions are outlined;

b. Proper hand washing techniques are outlined;

c. Proper disposal of biohazards, such as potentially infected waste and spills-management, needles, lancets, scissors, tweezers and other sharp instruments is described;

d. Prevention and treatment of needle-stick/"sharp" injuries are outlined; and

e. The policies describe prevention and management of common illnesses such as, but not limited to:

i. Methicillin-Resistant Staphylococcus Aureus (MRSA),

ii. Colds and influenza,

iii. Gastrointestinal viruses,

iv. Pediculosis and tinea pedis, etc.

f. The policies describe specific procedures to manage infectious diseases, including but not limited to tuberculosis, hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Coronavirus or other infectious diseases.

g. Handling and maintenance of individual care equipment is described.

2. The infection control risk assessment and plan is reviewed annually for effectiveness and revised, if necessary.

3. There are written hygienic practices and procedures regarding:

a. Management of linens and minimizing healthcare-associated infections, including:

i. Collection, sorting, transport, washing and storage of soiled linens including clothing provided to individuals. The practices are based upon a cited expert source (such as the U.S. Centers for Disease Control and Prevention) and updated annually to ensure the procedures reflect evolving standard practice.

b. At a minimum, the facility:

i. Has immediately available a quantity of clean bed linens and towels, etc., essential for the proper care of individuals at all times; and
ii. Has collection, sorting, and cleaning procedures which are designed to prevent cross-contamination of the environment, individuals served, and personnel.

4. In relation to individuals who are carriers of an infectious illness, the transfer and the release of confidential information to select unit medical and nursing staff on a need-to-know basis is addressed.

5. Hand washing facilities provided in the kitchen, bathroom, examination and medication areas include hot and cold running water, soap dispensers, disposable towels and/or hand blowers.

SECTION 5: OUTPATIENT CLINIC SERVICE

HH. STAFFING REQUIREMENTS

1. The Outpatient Clinic must employ a part-time equivalent (PTE) Medical Director (Board Certified), who serves to assist in psychiatric stabilization through review of medication regimen, identifying medical condition or diagnosis, identifying drug interactions, over medication and/or need for titration, or any additional medications while also providing a range of therapies.

2. The Outpatient Clinic Service must have identified service providers for the following ancillary services. Development and execution of a written agreement must occur for each service. The written agreement must include (at minimum): contact information, billing information, service delivery parameters, rate, on-site schedule, and telework arrangement (if applicable).

    a. Internal Medicine;

    b. Neurology;

    c. Dental;

    d. Ophthalmology;

    e. Endocrinology;

    f. Audiology;

    g. Gynecologist;

    h. Podiatry;

    i. Specialized lab services;

j. Genetic testing;

k. Nutrition;

l. X-ray;

m. Allergist;

n. Occupational Therapy;

o. Speech Therapy; and

p. Physical Therapy.

II. MEDICAID REQUIREMENTS

1. The outpatient clinic must comply with all applicable provisions of the Part I *Policies and Procedures for Medicaid/Peachcare for Kids m*anual, found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx and all applicable Part II and Part III Policies and Procedures published by the Department of Community Health.

2. The sale of assets, merger, or change of control of the Provider or assignment of some or all of the Provider's corporate functions or services. In such an event, Provider must also comply with any applicable requirements in the Department of Community Health Medicaid Policies and Procedures manuals concerning sale of assets, merger, change of control, or assignment of corporate functions or services, including but not limited to Section 105.9 of the Part I Policies and Procedures for Medicaid/Peachcare for Kids manual, found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx as from time to time amended or re-numbered.

Appendix A

REGIONAL FIELD OFFICE OF DBHDD
CONTACT LIST

DBHDD Region 1	DBHDD Region 2	DBHDD Region 3
Elise Beumer	**Carol Love**	**Vivia Black**
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
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Suite 800	Building 3	Building 10
Cumming, GA 30041	Augusta, GA 30906	Decatur, GA 30034
Phone (678) 947-2818	Phone (404) 783-4445	Phone (404) 244-5050 or
FAX (678)-947-2817	FAX (706)-792-7740	(404) 244-5056
Toll Free 1-877-217-4462	Toll Free 1-877-551-4897	FAX (770) 414-3048

DBHDD Region 4	DBHDD Region 5	DBHDD Region 6
Timothy Hester	**Ramona Pullin**	**Kecia Cawthorne**
Regional Services Administrator – DD	Regional Services Administrator – DD	Regional Services Administrator – DD
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Phone (229)-225-5099	Phone: (912)-303-1649	Phone (706) 565-7835
FAX (229)-227-2918	FAX (912) 303-6309	FAX (706) 565-3565
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