SUMMARY OF PROPOSED CHANGES TO THE DBHDD COMMUNITY SERVICE STANDARDS FOR DEVELOPMENTAL DISABILITIES PROVIDERS

POSTED FOR PUBLIC COMMENT ON JUNE 27, 2013

This summary is designed to guide the review of new and revised content proposed by DBHDD Division of Developmental Disabilities.

General Description of Changes	Location	Detailed Information	Impact of the Changes
Reorganization of entire Community Service Standards	New Headings Pages1 & 13	Reorganized for clarity and redundancy. The headings are reduced from 19 to 2 new headings with subheadings under each headings. The 2 new headings are *Organizational Practices* and *Outcomes for Persons Served*. A number of standards are moved to different sections to better align with the intent of the standard.	Improved clarity for users
New requirements added	1.Polypharmacy Page 8 2. Community Integration Page 27	New requirements are added including more specific definitions for polypharmacy usage and community integration expectations.	The new requirements support services that are holistic and person-centered, and promote quality and accountability.
The critical areas are specified		The critical areas are reduced from 19 to 4 and identified as "critical" after each area.	To align the critical function areas with the NOW/COMP waivers.
Revision of Behavior Support Practice Section	Section B Pages 17 & 18	More focus on clinical support with one behavior plan and safety plan implemented across services for consistency and development of behavioral skills goals to serve as replacement behaviors.	A more holistic approach for consistency.
Adequate and Competent staff	Section E Page 10 Added new required trainings Page 13	Clarifies roles and responsibilites of the DDP and identifies new training requirements to include the following: suicide prevention, ethics and corporate compliance.	DDP plays an important role in the clinical oversight of the services identified in the ISP. The clarification is to improve the documentation of practice.
Informed Consent	Page 6	Clarifies definitions for implementation of informed consent.	Rights of the individual to be clearly informed.

To submit feedback/comments, utilize the 'Feedback/Comments Form'.

Part II

Section I

Community Service Standards for Developmental Disabilities Providers

VISION: A SATISFYING, INDEPENDENT LIFE WITH DIGNITY AND RESPECT

It is the vision of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that every person who participates in our services leads a satisfying, independent life with dignity and respect.

DEVELOPMENTAL DISABILITY SERVICES

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

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

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

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

ORGANIZATIONAL PRACTICES

A. PROGRAM STRUCTURE

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

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

3. The program description identifies the minimum staff to individual served ratios for each service offered. In addition, the program description needs to address the following considerations:
   a. Ratios reflect the needs of individuals supported, implementation of behavioral procedures, best practice guidelines and safety considerations.
   b. Ratios reflect considerations such as licensure waivers and special (exceptional) rates reflecting unique individual care needs, etc.
4. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.
   a. Appropriate licenses are obtained for residential services, if applicable;
   b. Licensure and other permits, when applicable, must be available at the agency or by the individual provider and open to view by the public;
   c. Accreditation/compliance with community standards requirements meet contractual requirements;
   d. All DD Providers must have current general liability insurance in the amount of $1 million per occurrence and $3 million aggregate; and
   e. The Provider must demonstrate full cooperation in allowing full and complete access by the Department 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.
5. There is a written budget which includes expenses and revenue that serves as a plan for managing resources. Utilization of fiscal resources is assessed in Quality Improvement Processes and/or by the Board of Directors.
6. The organization policy must state explicitly in writing whether or not research is conducted on individuals served by the organization.
   a. If the organization wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
      i. The agency's governing authority; and
      ii. The Assistant Commissioner of Division of Developmental Disabilities; and
      iii. The Institutional Review Board operated by the Department of Public Health (DPH) and its policies regarding the Protection of Human Subjects found in DBHDD directive herein (DBHDD Policy 25-101).
   b. The Research design shall include:
      i. A statement of rationale;
      ii. A plan to disclose benefits and risks of research to the participating individual;
      iii. A commitment to obtain written consent of the individuals participating; and
      iv. A plan to acquire documentation that the individual is informed that they can withdraw from the research process at any time.
   c. The organization using unusual medication and investigational experimental drugs shall be considered to be doing research.

i. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place;
ii. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
iii. The research design shall be approved and supervised by a physician;
iv. Information on the drugs used that shall be maintained include:
    a) Drug dosage forms;
    b) Dosage range;
    c) Storage requirements;
    d) Adverse reactions; and
    e) Usage and contraindications.
v. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications; and
vi. Drugs utilized shall be properly labeled.

d. If research is conducted, there is evidence that involved individuals are:
    i. Fully aware of the risks and benefits of the research;
    ii. Have documented their willingness to participate through full informed consent; and
    iii. Can verbalize their choice to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly.

7. Organizations that provide developmental disabilities services must participate in the Georgia Developmental Disabilities Provider information website. The address is www.georgiaddproviders.org.
8. **Children eighteen and younger may not be served** with adults in residential programs. Situations representing exceptions to this standard must have written documentation from the DBHDD Regional Office such as:
    a. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together.
    b. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.

B. OVERSIGHT OF CONTRACTED/SUBCONTRACTED PROVIDERS/PROFESSIONALS BY THE ORGANIZATION

1. The organization is responsible for the Contracted/Subcontracted Provider/Professional compliance with:
    a. Contract/Agreement requirements, documented and maintained for review;
    b. Standards of practice and specified requirements in the Provider manual for the Department of BHDD, including *Community Standards for All Providers;*
    c. Licensure requirements;
    d. Accreditation or Community Service Standards Quality Review requirements; and
    e. Quality improvement and risk reduction activities.
2. There is documented evidence of active oversight of the Contracted/Subcontracted Provider/Professional capacity and compliance to provide quality care to include monitoring of:
    a. Financial oversight and management of individual funds;
    b. Staff competency and training;

c. Mechanisms that assure care is provided according to the plan of care for each individual served; and
d. The requirement for a Host Home Study when contracting with a Host Home provider.

3. A report shall be made quarterly to the agency's Board of Directors regarding:
   a. Services provided by Contracted/Subcontracted Provider/Professional ; and
   b. Quality of performance of the Contracted/Subcontracted Provider/Professional.
4. A report shall be made to the DBHDD Regional Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
   a. Name and contact information of all contracted providers;
   b. The specific services provided by each contracted provider;
   c. The number and location of individual supported by each contracted provider; and
   d. Annualized amount paid to each contracted provider.

C. QUALITY IMPROVEMENT AND RISK MANAGEMENT

1. There is a well-defined quality improvement plan for assessing and improving organizational quality. The QI plan addresses:
   a. Processes for how issues are identified;
   b. What solutions are implemented;
   c. Any new or additional issues are identified and managed on an ongoing basis;
   d. The internal structures minimize risks for individuals and staff;
   e. The processes used for assessing and improving organizational quality are identified; and
   f. The quality improvement plan is reviewed and updated at a minimum annually and this review is documented.
2. Areas of risk to persons served and to the organization are identified based on services, supports, treatment or care offered including, but not limited to:
   a. Incidents:
      i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Investigation as required by DBHDD Policy, ***Reporting and Investigating Deaths and Critical Incidents in Community Services;***
   b. Accidents;
   c. Complaints;
   d. Grievances;
   e. Individual Rights Violations;
      i. There is documented evidence that any restrictive interventions utilized must be reviewed by the organization's Rights Committee;
   f. Practices that limit freedom of choice or movement;
   g. Medication Management;
   h. Infection Control;
   i. Behavior Support Plan tracking and monitoring;
   j. Breaches of Confidentiality; and
   k. Health and Human Rights of persons with developmental disabilities.
3. Indicators of performance are in place for assessing and improving organizational quality. The organization is able to demonstrate:
   a. The indicators of performance established for each issue:
      i. The method of routine data collection;
      ii. The method of routine measurement;
      iii. The method of routine evaluation; and
      iv. Target goals/expectations for each indicator;

b. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
c. The inclusion of cultural diversity competency practices is evident by:
    i. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
    ii. Staff honoring these differences and preferences (such as worship or dietary preferences in supporting the individuals daily; and
    iii. The inclusion of cultural competency in Quality Improvement Processes.
d. Distribution of Quality Improvement findings on a quarterly basis to:
    i. Individuals served or their representatives as indicated in the plan;
    ii. Organizational staff;
    iii. The governing body; and
    iv. Other stakeholders as determined by the governing body.

4. At least four individual records or the records of five percent (5%) of the total number of individuals served (whichever number is greater) are reviewed each quarter and the reviews are kept for a period of at least two years. Records of individuals who are "at risk" are included. Reviews include these determinations:
    a. That the record is organized; complete, accurate and timely;
    b. Whether services are based on assessment and need;
    c. That individuals have choices;
    d. Documentation of service delivery including individuals' responses to services and progress toward ISP goals;
    e. Documentation of health service delivery;
    f. Medication management and delivery, including the use of PRN and over the counter PRN medications; and their effectiveness;
    g. That approaches implemented for individuals with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings.* When a behavioral support plan is necessary, providers of developmental disabilities services develop these plans in accordance with the *Best Practice Standards for Behavioral Support Service* (www.dbhdd.georgia.gov); and

5. Appropriate utilization of human resources is assessed, including but not limited to:
    a. Competency;
    b. Qualifications;
    c. Numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; and
    d. Staff to individual ratios.
6. The organization has an advisory board made up of citizens, local business providers, individuals and family members. The Board:
    a. Meets at least semi-annually;
    b. Reviews items such as but not limited to:
        i. Policies;
        ii. Risk management reports; and
        iii. Assess budget and utilization of fiscal resources.
    c. Provides objective guidance to the organization.

D. MEDICATION AND HEALTHCARE MANAGEMENT (CRITICAL)

1. A copy of the physician(s) order or current prescription dated and signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
    a. Regular, on-going medications;
    b. Controlled substances;
    c. PRN (as needed) Over-the-counter (OTC) medications;
    d. PRN medications (does not include standing orders for psychotropic medications for symptom management of behavior); or
    e. Discontinuance order.
2. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner and there is documentation that include:
    a. Informed consent for the medication is obtained and a signed copy is maintained in the clinical record. It is the responsibility of the physician/designee to complete the informed consent;
    b. The treating psychiatrist or psychiatric nurse personally examines the individual to determine whether this person has the capacity to understand to consent for herself or himself;
    c. If the individual does not have the capacity to consent for herself or himself, an appropriate substitute decision maker is identified based on the Order of Priority outlined in Georgia Medical Consent Law;
    d. The risks/benefits is explained in language the individual can understand;
    e. Medication education provided by the organization's staff should be documented in the clinical record; and
    f. Education regarding the risks and benefits of the medication is documented.
3. The organization has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
    a. Prescribing:
        i. The physician's order or current prescription is defined as a prescription signed by one authorized to prescribe in Georgia; and
        ii. Electronic prescriptions (E-scripts and Sure scripts), if practiced
    b. Authenticating orders: Describes the required time frame for obtaining the actual or faxed physician's signature for telephone or verbal orders accepted by a licensed nurse.
    c. Ordering and Procuring medication and refills: Procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
    d. Medication Labeling: Describes that all medications must have a label affixed by a licensed professional with the authority to do so. This includes sample medications.
    e. Storing: Includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
    f. Security: Requires safe storage of medication as required by law including single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, and refrigeration and daily temperature logs. All controlled substances are double locked and there is documented accountability of controlled substances at all stages of possession.
    g. Dispensing: Describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified. Only physicians or pharmacists may re-package or dispense medications:

i. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
ii. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder".

h. Supervision of individual self-administration: Includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.

i. Administration of medications: Administration of medications may be done only by those who are licensed in this state to do so.

j. Recording: Includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature and title of staff member.

k. Disposal of discontinued or out-of-date medication: Includes via an environmentally friendly method of disposal by pharmacy.

l. Education to the individual and family (as approved by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.

m. All PRN or "as needed" medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individual's ISP. Additionally, the organization must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or refrigerated when transported to different programs and home visits.

4. Organizational policy, procedures and documented practices stipulate that:

a. If "health maintenance activities" are elected by an individual/guardian to be provided by Proxy Caregivers, the Licensed DD provider agencies, including co-employer agencies must:
i. Have a written informed consent in the individual's record that designate the selected proxy caregiver to receive training to provide the health care activities outlined in the physician's written order working under a nurse protocol agreement or job description;
ii. Demonstrate knowledge and skills to perform the health maintenance activities in the written plan;
iii. Health maintenance activities to be implemented by the proxy caregiver are clearly defined in the written care plan and provided to the proxy caregiver; and
iv. The organization's policy, procedures, and documented practices clearly define what health maintenance activities can or cannot be provided by the proxy caregiver and that delivery of such activities are specified for each individual. (Refer to Rules & Regulations for Proxy Caregivers for complete details of practice).

b. There are safeguards utilized for medications known to have substantial risk or undesirable effects, to include:

i. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments, and follow-up appointments with the individual's physician for any further actions needed;

ii. There is documentation of monitoring polypharmacy usage in order to ensure that intra-class and inter-class polypharmacy use for psychiatric reasons are justifiable, if applicable, using the following monitoring criteria:

a) Intra-class Polypharmacy monitoring reports includes individuals who are on more than one psychotropic medication in the same single class of medications (2 or more antipsychotics, antidepressants, mood stabilizers). E.g., The use of 2 anti-depressants to treat depression.

b) Inter-class Polypharmacy monitoring reports includes individuals who are on 3 or more different classes of medications (antipsychotics, antidepressants, mood stabilizers). E.g., The use of an antipsychotic, an antidepressant and mood stabilizer to treat someone with Schizoaffective Disorder.

c. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.

d. The organization defines requirements for timely notification to the prescribing professional regarding:
   i. Medication errors;
   ii. Medication problems;
   iii. Drug reactions; and
   iv. Refusal of medication by the individual.

e. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
   i. Appropriateness of the medication;
   ii. Documented need for continued use of the medication;
   iii. Monitoring the presence of side effects. (Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS) testing.);
   iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels.
   v. Ordering specific monitoring and treatment protocols for Diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
   vi. Maintain medication protocols for specific individuals in:
      a) Epinephrine for anaphylactic reaction;
      b) Insulin required for diabetes;
      c) Suppositories for ameliorating serious seizure activity; and
      d) Medications through a nebulizer.
   vii. Monitoring of other associated laboratory studies.

f. For organizations that secure their medications from retail pharmacies, there is a biennial assessment of agency practice of management of medications at all sites housing medications. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
   i. A written report of findings, including corrections required;

ii. A photocopy of the pharmacist's license or a photocopy of the license of the Registered Nurse; and
iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.

5. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
   a. Right person: Check the name on the order and the individual and include the use of at least two identifiers.
   b. Right medication: Check the medication label against the order.
   c. Right time: Check the frequency and time to be given of the ordered medication and double check that the ordered dose is given at the correct time. Confirm when last dose was given.
   d. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record document to ensure all are the same.
   e. Right route: Check the order and appropriateness of route ordered and confirm that the individual can take or receive the medication by the ordered route.
   f. Right position: The correct anatomical position for the medication method or route to ensure its proper effect, instillation and retention. If needed, individual should be assisted to assume the correct position.
   g. Right Documentation: Document the administration/supervision after the ordered medication is given on the MAR; and
   h. Right to Refuse Medication: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
6. A Medication Administration Record is in place for each calendar month that an individual takes or receives medication(s):
   a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
      i. Documentation by calendar month that is sequential according to the days of the month;
      ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
         a) Name of the medication;
         b) Dose as ordered;
         c) Route as ordered;
         d) Time of day as ordered; and
         e) Special instructions accompanying the order, if any, such as but not limited to:
            1. Must be taken with meals;
            2. Must be taken with fruit juice;
            3. May not be taken with milk or milk products.
      iii. If the individual is to take or receive the medication more than one time during one calendar day:
         a) Each time of day must have a corresponding line that permits as many entries as there are days in the month;
      iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
      v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing

discontinuation; followed by a mark through of all lines representing days and times that were discontinued.

b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
   i. Documentation by calendar month that is sequential according to the days of the month;
   ii. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
      a) Name of medication;
      b) Dose as ordered;
      c) Route as ordered;
      d) Purpose of the medication; and
      e) Frequency that the medication may be taken.
   iii. The date and time the medication is taken or received is documented for each use.
   iv. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
c. Each MAR shall include the legend that clarifies:
   i. The identity of the authorized staff's initials using full signature and title;
   ii. The reasons that a medication may not be given, is held or otherwise note received by the individual, such as but not limited to:

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

E. ADEQUATE AND COMPETENT STAFF (CRITICAL)

1. Unless otherwise specified by DBHDD Policy or within the contract/agreement with the Department, one or more professionals in the field must be attached to the organization as employees of the organization or as consultants on contract.
   a. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served. (Refer to Professional Designation Section.)
   b. When medical and/or psychiatric services involving medication are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, or psychiatrist.
2. DDP services must be rendered by a qualified individual DDP employed by or under contract with the agency. At least one agency employee or professional under contract with the agency must be a DDP. The DDP personnel file must include the following:
   a. A signed DDP job functions that meet the DDP requirements;
   b. A specified schedule and sufficient contract hours per week (not a PRN staff) to meet the assigned caseload must be maintained on site;
   c. There is documentation of attestation by the DDP that the scheduled or contracted hours do not conflict with his/her work with another provider agency;

d. There is documentation to verify the DDP's face to face visits of specified scheduled and contact hours in the individual's record;
e. At a minimum, the DDP for residential services must document on a monthly basis, a detail record review of each individual's health, safety, ISP goals progress and any recommendations identified. Where applicable, the adequacy of high intensity services should be included;
f. For services other than residential such as Community Living Support Services and Community Access Services, DDP visit are documented as indicated in ISP; and
g. For individuals on exceptional rate, there is documentation of additional direct service provision and oversight by the DDP, if applicable.

3. Organizational policy and practice demonstrates that appropriate professional staff shall conduct the following services, supports, care and treatment, including but not limited to:
   a. Overseeing the services, supports, care and treatment provided to individuals;
   b. Supervising the formulation of the individual service plan or individual recovery plan;
   c. Conducting diagnostic, behavioral, functional and educational assessments;
   d. Designing and writing behavior support plans;
   e. Implementing assessment, care and treatment activities as defined in professional practice acts; and
   f. Supervising high intensity services such as screening or evaluation, assessment, and residential behavior support services.
4. Providers must ensure an adequate staffing pattern to provide access to services in accordance with service guidelines and professional designations. Refer to Service Guidelines in this Provider Manual for specific staffing requirements.
5. The type and number of professional staff and all other staff attached to the organization are:
   a. Properly trained, licensed or credentialed in the professional field as required;
   b. Present in numbers to provide adequate supervision to staff;
   c. Present in numbers to provide services, supports, care and treatment to individuals as required;
   d. In 24 hour or residential care settings, at least one staff trained in Basic Cardiac Life Support (BCLS) and first aid is on duty at all times on each shift;
   e. DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity. Additional information regarding Proxy Caregivers can be found in Section V of this document; and
   f. Experienced and competent to provide services, supports, care and treatment and/or supervision as required.
6. The organization must have procedures and practices for verifying licenses, credentials, experience and competence of staff:
   a. There is documentation of implementation of these procedures for all staff attached to the organization; and
   b. Licenses and credentials are current as required by the field.
7. Federal law, state law, professional practice acts and in-field certification requirements are followed regarding:
   a. Professional or non-professional licenses and qualifications are required to provide the services offered. If it is determined that a service requiring licensure or certification by State Law is being provided by an unlicensed staff, it is the responsibility of the organization to comply with DBHDD Policy regarding Licensing and Certification Requirements and the Reporting of Practice Act Violations.
   b. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
8. Job descriptions are in place for all personnel that include:

a. Qualifications for the job;
b. Duties and responsibilities;
c. Competencies required;
d. Expectations regarding quality and quantity of work; and
e. Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.

9. a. There is evidence that a national criminal records check (NCIC) is completed for all employees, to include contractors/subcontractors and their employees and volunteers who work directly with the individuals, who provide services, supports, care and treatment to individuals served within the organization. **The applicant should submit fingerprints prior to employment or if circumstances justify delay, within 10 business days of the employee's start date.** DBHDD Policy 04-104, *Criminal History Records Check for Contractors* is followed and fingerprints are obtained by electronic fingerprint submission through Cogent Systems. See www.ga.cogentid.com;
b. There is mandatory disqualification from providing services for DBHDD for a minimum of five (5) years from the date of conviction, a plea of nolo contendere, or release from incarceration or probation, whichever is later. Refer to DBHDD Policy 04-104, *Criminal History Records Checks for Contractors* for a list of crimes that restricts employment as a DBHDD contractor or contractor's employee.
10. The organization has policies, procedures and documentation practices detailing all human resources practices, including but not limited to:
    a. Processes for determining staff qualifications including:
        i. License or certification status;
        ii. Training;
        iii. Experience; and
        iv. Competence.
    b. Processes for managing personnel information and records which should include but not be limited to:
        i. Criminal records checks (including process for reporting CRC status change);
        ii. Drivers license checks; and
        iii. Annual TB testing (for all staff providing direct support).
    c. Provisions for and documentation of:
        i. Timely orientation of personnel;
        ii. Periodic assessment and development of training needs;
            a) Development of activities responding to those needs; and
        iii. Annual work performance evaluations.
    d. Provisions for sanctioning and removal of staff when:
        i. Staff are determined to have deficits in required competencies;
        ii. Staff is accused of abuse, neglect or exploitation.
    e. Administration of personnel policies without discrimination.
11. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence in the following:
    a. Orientation requirements are specified for all staff and are provided **prior to direct contact with individuals** and are as follows:
        i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
        ii. HIPAA and Confidentiality of individual information, both written and spoken;
        iii. Rights and Responsibilities of individuals;
        iv. Requirements for recognizing and mandatory reporting suspected abuse, neglect or exploitation of any individual:

a) To the DBHDD;
b) Within the organization;
c) To appropriate licensing agencies (Healthcare Facility Regulation) and for in home services (Adult Protective Services); and
d) To law enforcement agencies.

b. Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive training in the following which shall include, but not be limited to:
   i. Person centered values, principles and approaches;
   ii. A Holistic approach for providing care, supports and services for the individual;
   iii. Medical, physical, behavioral and social needs and characteristics of the individuals served;
   iv. Human Rights and Responsibilities (*);
   v. Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
   vi. The utilization of:
      a) Communication Skills (*);
      b) Behavioral Support and Crisis Intervention techniques to de-escalate challenging and unsafe behaviors (*);
      c) Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization) (*); and
      d) The Georgia Crisis Response System (GCRS).
   vii. Ethnics, cultural preferences and awareness;
   viii. Fire safety (*);
   ix. Emergency and disaster plans and procedures (*);
   x. Techniques of Standard Precautions, including:
      a) Preventative measures to minimize risk of HIV;
      b) Current information as published by the Centers for Disease Control (CDC); and
      c) Approaches to individual education.
   xi. First aid and safety;
   xii. BCLS including both written and hands on competency training is required;
   xiii. Specific individual medications and their side effects (*);
   xiv. Suicide Prevention Skills Training (such as AIM, QPRP); and
   xv. Ethics and Corporate Compliance training is evident.

c. A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) in 11.b. (iv, vi, viii, ix, x, xiii).

12. The organization details in policy by job classification:
    a. Training that must be refreshed annually;
    b. Additional training required for professional level staff; and
    c. Additional training/recertification (if applicable) required for all other staff.
13. Regular review and evaluation of the performance of all staff is documented and conducted:
    a. The evaluation should at a minimum occur annually;
    b. Managers who are clinically, administratively and experientially qualified conduct evaluations.
14. It is evident that the organization demonstrates administration of personnel policies without discrimination.

OUTCOMES FOR PERSONS SERVED

A. INDIVIDUAL RIGHTS, RESPONSIBILITIES, PROTECTIONS (CRITICAL)

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

a. Geographic;
b. Architectural;
c. Communication;
    i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
    ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.
d. Attitudinal;
e. Procedural; and
f. Organizational scheduling and availability.

6. There is evidence of organizational person-centered planning and service delivery that demonstrates:
    a. Sensitivity to individual differences (including disabilities) and preferences;
    b. Practices and activities that reduce stigma; and
    c. Interactions that are respectful, positive and supportive.
7. The organization must have written policies and procedures regarding the visitation rights of individuals, including a requirement that any reasonable restrictions must be based on the seriousness of the individual's mental or physical condition as ordered in writing by the attending physician. Such orders shall state the type and extent of the restriction. The order shall be reviewed for changes as needed and renewed at least annually. Additional orders shall follow the same procedure. The organization must meet the following requirements:
    a. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of his or her visitation rights, including any clinical restriction of such rights, when he or she is informed of his or her other rights under this section;
    b. Inform each individual (or guardian, or parent or custodian of a minor, as applicable) of the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. However, the parent, guardian or custodian of a minor may restrict his or her visitation rights;
    c. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identify, sexual orientation or disability;
    d. Ensure that all visitors enjoy full and equal visitation privileges consistent with the preferences of the individual;
    e. Not restrict visitation by an individual's attorney or personal physician on the basis of the individual's physical or mental condition;
    f. Visitors/guardians are also expected to adhere to any reasonable restrictions as ordered in writing by the attending physician in the area of diet; and
    g. If visitation facilitates/results in problematic behaviors, reasonable restrictions may be ordered and incorporated into the Safety Plan.
8. Access to appropriate services, supports, care and treatment is available regardless of:
    a. Age;
    b. Race, National Origin, Ethnicity;
    c. Gender;
    d. Religion;
    e. Social status;
    f. Physical disability;
    g. Mental disability;
    h. Gender identity; or
    i. Sexual orientation.

B. BEHAVIORAL SUPPORT PRACTICES (CRITICAL)

1. In policies, procedures and practices, the organization outlines and defines the adaptive, supportive, medical protection devices and the restrictive interventions that are implemented or prohibited by the organization and licensure requirements. These devices include but are not limited to:
   a. Use of adaptive supportive devices or medical protective devises (devises which restrain movement but are applied for the protection of accidental injury, required for medical treatment or for corrective/supportive needs):
      i. May be used in any service, support, care and treatment environment;
      ii. Use is defined by a physician's order (order not to exceed twelve calendar months);
      iii. Written order to include rationale and instructions for the use of the device;
      iv. Authorized in the individual service plan (ISP); and
      v. Are used for medical and/or protection against injury and not for treatment of challenging behavior(s).
   b. Time out (also known as withdrawal to a quiet area):
      i. Under no circumstance is egress physically or manually restricted;
      ii. Time out periods must be brief, not to exceed 15 minutes;
      iii. Procedure for time out utilization is incorporated in the behavior support plan; and
      iv. The justification for use and implementation details for time out utilization is documented.
   c. Manual Hold/Restraint(also known as Personal Restraints): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body:
      i. May be used in all community settings except residential settings licensed as Personal Care Homes;
      ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
      iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
      iv. If permitted, Manual/Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and use of personal restraint is documented;
      v. Use of manual/personal restraints must be outlined as an approved intervention in his/her safety plan; and
      vi. If manual/personal restraints are implemented more than three (3) times in a six (6) month period, there must be corresponding procedures to teach the individual skills that will decrease/eliminate the use of personal restraints.
   d. Mechanical Restraint (also known as Physical Restraints): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts. Mechanical/Physical restraints are prohibited in community settings.
   e. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO) is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical control or verbal threats to prevent the individual from leaving. Seclusion is not permitted in developmental disabilities services.

f. **Chemical restraint may never be used under any circumstance.** Chemical restraint is defined as a medication or drug that is:
   i. Not a standard treatment for the individual's medical or psychiatric condition;
   ii. Used to control behavior; and
   iii. Used to restrict the individual's freedom of movement.

   Examples of chemical restraint are the following:
   i. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
   ii. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or agitated.

g. PRN anti-psychotic medications for behavior control are not permitted. See Part II, Section 1; Appendix 1 for list of medications.

2. The approach to developing a positive behavior support plan (including a safety plan) and treatment for individuals demonstrating challenging behaviors should be consistent with the definitions and protocols in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and *Best Practice Standards for Behavioral Support Services* found in the provider manual. Behavior Support activities outlined in the PBSP is guided by an overall emphasis on not only decreasing target behaviors but also concurrently increasing skills in appropriate areas.
3. The PBSP and Safety Plan should be a collaborative effort among each provider providing services for the individual. The providers must work to develop and implement one plan that includes any modification for implementation for each service site and the modification must be addressed and approved prior to finalizing the plan. The final approved PBSP is incorporated by reference into the ISP. A copy of the individual's PBSP must be available at all service sites for implementation.
4. a) A behavior support plan should be developed and implemented for individuals with developmental disabilities who receive psychotropic medications for symptom management of challenging behavior that poses a significant risk to the individual, others, or the environment (e.g., self-injury, physical aggression, property destruction) and is not specifically related to mental illness or epilepsy requiring treatment with psychotropic medications. The behavior support plan must minimally include:
   1) An operationally defined behavior(s) for which the drug is intended to affect;
   2) Measuring target behaviors which shall constitute the basis on which medication adjustments will be made; and
   3) A focus on teaching replacement behaviors in an effort to replace the use of medication with behavioral programming.

   b) A behavior support plan is not required for individuals receiving psychotropic medication to treat mental illness (e.g., schizophrenia, bi-polar disorder) or epilepsy when the record documents that the medication addresses the symptoms of the mental illness or epilepsy.
5. When positive behavior support plan is used to reduce challenging behaviors there must evidence that the following issues have been addressed. The plan is:
   a. Individualized;
   b. Based on a functional assessment;
   c. One that has addressed potential medical causes;
   d. Developed and overseen by a qualified professional (Refer to the *Community Service Standards for All DD Providers* for definitions related to in-field professions);
   e. Inclusive of methods outlined to teach alternative appropriate behaviors that will achieve the same results as the challenging behavior(s);
   f. Inclusive of rationale for the following:

i. Use of identified approaches;
ii. The time of their use;
iii. An assessment of the impact on personal choice of the individual;
iv. The targeted behavior; and
v. How the targeted behavior will be recognized for success.

g. Implemented by trained and competent staff as documented by individual who developed the BSP/Safety Plan and trained the staff.
h. Has monitoring plans for review, analyzing trends, and summarizing the effectiveness of the plan and termination criteria;
i. Consent provided by the individual and his or her legal guardian;
j. Discussed with the individual and family/natural supports (as permitted by the individual); and
k. Developed in accordance with *Best Practice Standards for Behavioral Support Services for Providers of Developmental Disabilities Services* (www.dbhdd.ga.gov).

6. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the BSP and/Safety Plan, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional(s) and may not be in conflict with Federal or State Laws, Rules and Regulations, Clients Rights or Department standards to include but not limited to the document *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and the *Best Practice Standards for Behavioral Support* when developing a behavior support/safety plan.
7. Providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and have an agency's crisis plan, that at a minimum addresses:
   a. Approved interventions to be utilized by staff;
   b. Availability of additional resources to assist in diffusing the crisis;
   c. If the acute crisis presents a substantial risk of imminent harm to self and others, that community based crisis services to include the Georgia Crisis Response System(GCRS) serves as an alternative to emergency room care, calling 911, institutional placement, and/or law enforcement involvement (including incarceration) is implemented;
   d. Protocols to access community-based crisis services to include the Georgia Crisis Response System must be included in agency's policy and procedures with staff trained to implement this protocol; and
   e. Notification process by Direct Support Staff that includes informing the designated on-call management staff and /or Director.
8. All organizations must have the capacity to address individual's behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there should be evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the Individual. Those authoring such plans should minimally meet professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst (Refer to Professional Designations, Section G. for qualifications).
9. If the need for behavior supports is identified, the individual or guardian is given a choice to select the qualified person to develop the BSP and /or Safety plan.

C.I. RESPECTFUL SERVICE ENVIRONMENT (CRITICAL) {To include Host Homes and Day Service Sites}:

1. Services, supports, care or treatment approaches support the individual in:
    a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;
    b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided;
    c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities; and
    d. Inclusion and active community integration is supported and evident in documentation.
2. Services are provided in an appropriate environment that is respectful of individuals supported or served. (For Host Homes and Community Access Services Sites refer to Operational Standards for Host Homes/Life Sharing and Physical Environment NOW/COMP Chapter for Community Access Services). The environment is:
    a. Clean;
    b. Age appropriate;
    c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served);
    d. Individual's rooms are personalized;
    e. Adequately lighted, ventilated, and temperature controlled;
    f. There is sufficient space, equipment and privacy to accommodate;
    g. An area/room for visitation; and
    h. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported.
3. The environment is safe:
    a. All local and state ordinances are addressed:
        i. Copies of inspection reports are available;
        ii. Licenses or certificates are current and available as required by the site or the service;
        iii. An automatic extinguishing system (sprinkler) shall be installed per city/county requirements for residential settings excluding host homes not governed by other federal, state and county rules and regulations, if applicable; and
        iv. Approved smoke alarm shall be installed in all sleeping rooms, hallways and in all normally occupied areas on all levels of the residences per safety code. Smoke alarms especially in the bedrooms shall be tested monthly and practice documented. The facility shall be inspected annually to meet fire safety code and copies of inspection maintained.
    b. Installation of Fire alarm system and inspection of equipment meets safety code.
    c. Fire drills are conducted for individuals and staff:
        i. Once a month at alternative times; including
        ii. Twice a year during sleeping hours if residential services;
        iii. All fire drills shall be documented with staffing involved;
        iv. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
4. When food service is utilized, required certifications related to health, safety and sanitation are available. A three day supply of non-perishable emergency food and water is available for all individuals supported in residences. A residence shall arrange for and serve special diets as prescribed.
5. Policies, plans and procedures are in place that addresses Emergency Evacuation, Relocation, Preparedness and Disaster Response. Supplies needed for emergency

evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.

a. Plans include detailed information regarding evacuating, transporting and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
    i. Medical emergencies;
    ii. Missing persons;
        a) Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
    iii. Natural and man-made disasters;
    iv. Power failures;
    v. Continuity of medical care as required;
    vi. Notifications to families or designees; and
    vii. Continuity of Operation Planning (COOP) to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided. COOP must also include plans for sheltering in place (for more information go to: http://www.georgiadisaster.info/PersonsWithDisabilities/disasterpreparedness.html ; and http://www.fema.gov/about/org/ncp/coop/templates.shtm).
b. Emergency preparedness notice and plans are:
    i. Reviewed annually;
    ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane; and
    iii. Drilled with more frequency if there is a greater potential for the emergency.

6. Residential living support service options:
    a. Are integrated and established within residential neighborhoods;
    b. Are single family dwellings;
    c. Have space for informal gatherings;
    d. Have personal space and privacy for persons supported; and
    e. **Are understood to be the "home" of the person supported or served.**
7. Video cameras **may not be used** in the following instances:
    a. In an individual's personal residence;
    b. In lieu of staff presence; or
    c. In the bedroom of individuals, as it is an invasion of privacy and is strictly prohibited.
8. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place:
    a. Policies and procedures apply to all vehicles used, including:
        i. Those owned or leased by the organization;
        ii. Those owned or lease by subcontractors; and
        iii. Use of personal vehicles of staff.
    b. Policies and procedures include, but are not limited to:
        i. Authenticating licenses of drivers;
        ii. Proof of insurance;
        iii. Routine maintenance;

iv. Requirements for evidence of driver training;
v. Safe transport of persons served;
vi. Requirements for maintaining an attendance log of persons while in vehicles;
vii. Safe use of lift;
viii. Availability of first aid kits;
ix. Fire suppression equipment; and
x. Emergency preparedness.

C II. Infection Control Practices are Evident in Service Settings:

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

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

I. Assessments:

1. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services. Assessments should include, but are not limited to, the following:
   a. The individual's:
      i. Hopes and dreams, or personal life goals;
      ii. Perception of the issue(s) of concern;
      iii. Strengths;
      iv. Needs;
      v. Abilities; and
      vi. Preferences.
   b. Medical history;
   c. A current health status report or examination in cases where:

i. Medications or other ongoing health interventions are required;
ii. Chronic or confounding health factors are present;
iii. Medication prescribed as part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
iv. Allergies or adverse reactions to medications have occurred; or
v. Withdrawal from a substance is an issue.

d. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
e. Social history;
f. Family history;
g. School records (for school age individuals);
h. Collateral history from family or persons significant to the individual, if available:
   i. NOTE: When collateral history is taken, information about the individual **may not be shared** with the person giving the collateral history unless the individual has given specific written consent; and
i. Review of legal concerns including:
   i. Advance directives;
   ii. Legal competence;
   iii. Legal involvement of the courts; and
   iv. Legal status as adjudicated by a court.

2. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
   a. Assessment of trauma or abuse;
   b. Suicide risk assessment;
   c. Functional assessment;
   d. Cognitive assessment;
   e. Behavioral assessments;
   f. Spiritual assessment;
   g. Assessment of independent living skills;
   h. Cultural assessment;
   i. Recreational assessment;
   j. Educational assessment;
   k. Vocational assessment; and
   l. Nutritional assessment.
3. Policies, procedures and practice describe processes or referral of the individual based on ongoing assessment of individual need:
   a. Internally to different programs or staff; or
   b. Externally to services, supports, care and treatment not available within the organization, including but not limited to:
      i. Health care for:
         a) Routine assessment such as annual physical examinations;
         b) Chronic medical issues;
         c) Ongoing psychiatric issues;
         d) Acute and emergent needs:
            1. Medical
            2. Psychiatric
      ii. Diagnostic testing such as psychological testing or labs; and
      iii. Dental services.

II. Individual Service Plan (ISP)

1. An individualized service plan is developed with the guidance of a Support Coordinator or State Services Coordinator, a Planning List Administrator or State Services Coordinator as applicable.
    a. Be driven by the individual and focused on outcomes the individual desires to achieve;
    b. Fully explained to the individual using language/communication he or she can understand and agreed to by individual;
    c. Identify and prioritize the needs of the individual and include a page for signatures of the individual or guardian or other members to indicate who participated in the planning of services. Subsequent addendums must also document individual/guardian's signature; and
    d. Others assisting in the development of the individualized service plan are persons who:
        i. Are significant in the life of the individual;
        ii. Have a historical perspective of the desires of the individual;
        iii. The individual gives consent to have input from family and friends, if desired; and
        iv. Will deliver the specific services, supports, care and treatment identified in the plan:
            a) For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used;
            b) Planning should be facilitated by professional(s) qualified to plan or provide services to persons with this level of complexity; and
            c) Representatives of other agencies outside of DBHDD or providers affecting the daily life of the individual should be present and participating.
    e. A page for signature, title and date by participants (including the individual and professionals) that is attached to the plan, to indicate all participants presence and involvement in the plan that provides services, supports, care and treatment to the individual.
2. Statement of goals or objectives of the individual are:
    a. Each goal/objective is specific to the services provided:
        i. **S**pecific to the desired outcomes;
        ii. **M**easurable for progress;
        iii. **A**chievable skills;
        iv. **R**elevant to service provision;
        v. **R**ealistic to service provision; and
        vi. **T**ime-limited with specified target dates.
    b. The frequency or intensity that the specific service, support, care and treatment will be given or provided;
    c. Identification of staff responsible to deliver or provide the specific service, support, care and treatment;
    d. Clear authorization of the plan:
        i. Refer to definitions of service included in this Provider Manual to determine who must authorize the plan:
            a) Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines.*
        ii. A physician must authorize the plan when it includes medical care and treatment or as required by Georgia Department of Community Health Division of Medical Assistance, part II Policies and Procedures for Comprehensive

Support Waiver Program (COMP) and New Option Waiver Program (NOW). *Protocol for Physician Signature is in waiver manual.*

iii. When more than one physician is involved in individual care, there is evidence that an RN or MD has reviewed all in-field information to assure there are no contradictions or inadvertent contraindications within the care and treatment orders or plan.

3. Documents to be incorporated by reference into an individual service plan include, but are not limited to:
   a. Medical updates as indicated by physician orders or notes;
   b. Addenda as required when a portion of the plan requires reassessment;
   c. A personal crisis plan which directs in advance the individual's desires/wishes/plans/ objectives in the event of a crisis; and
   d. A behavior support plan and/or a safety plan for individuals demonstrating challenging behaviors; and
   e. A BSP and safety plan for individuals who received psychotropic meds for symptom management.
4. Wellness of individuals is facilitated through:
   a. Advocacy;
   b. Individual care practices;
   c. Education;
   d. Sensitivity to issues affecting wellness including, but not limited to:
      i. Gender;
      ii. Culture; and
      iii. Age.
   e. Incorporation of wellness goals within the individual plan.
   f. The intent of the development of the ISP is a process that focuses on the individual's hopes, dreams and visions of a "life well-lived." Information included within this individualized plan should be presented as a single plan that addresses residential and all other paid supports that the individual receives. The Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions. If the individual receives residential services, the residential provider has the primary responsibility in conjunction with the support coordinator or state services coordinator to assure a holistic support plan for all services identified as a need for the individual.
5. There is evidence that the person's data from tracking sheets and learning logs have been reviewed, analyzed for trends, and summarized to determine the progress toward goals **at least quarterly**.
6. Individualized plans or portions of the plan must be reassessed as indicated by the following:
   a. Changing needs, circumstances and responses of the individual, including but not limited to:
      i. Any life change;
      ii. Change in provider;
      iii. Change of address;
      iv. Change in frequency of service; and
      v. Change in medical, behavioral, cognitive or physical status.
   b. As requested by the individual;
   c. As required by re-authorization;
   d. At least annually; and

e. When goals are not being met.

III. Documentation

1. The individual record is a legal document, information in the record should be:
   a. Organized;
   b. Complete;
   c. Current;
   d. Meaningful;
   e. Succinct; and
   f. Essential to:
      i. Provide adequate and accurate services, supports, care and treatment;
      ii. Tell an accurate story of services, supports, care and treatment rendered and the individual's response;
      iii. Protect the individual; their rights; and
      iv. Comply with legal regulation.
   g. Dated, timed, and authenticated with the authors identified by name, credential and by title:
      i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";
      ii. Documentation is to be done each shift or service contact by staff providing the service;
      iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record; and
      iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
   h. Written in black or blue ink;
   i. Red ink may be used to denote allergies or special precautions;
   j. Corrected as legally prescribed by:
      i. Drawing a single line through the error;
      ii. Labeling the change with the word "error";
      iii. Inserting the corrected information; and
      iv. Initialing and dating the correction.
2. At a minimum, the individual's information shall include:
   a. The name of the individual, precautions, allergies (or no known allergies – NKA) and "volume #x of #y" on the front of the record;
      i. Note that the individual's name, allergies and precautions must be flagged on the medication administration record.
   b. Individual's identification and emergency contract information;
   c. Financial information;
   d. Rights, consent and legal information including but not limited to:
      i. Consent for service;
      ii. Release of information documentation;
      iii. Any psychiatric or other advanced directive;
      iv. Legal documentation establishing guardianship;
      v. Evidence that individual rights are reviewed at least one time a year; and
      vi. Evidence that individual responsibilities are reviewed at least one time a year.
   e. Pertinent medical information;
   f. Screening information and assessments, including but not limited to:

i. Functional, psychological and diagnostic assessments.

g. Individual service plan, including:
   i. Identified outcomes or goals (in measurable terms);
   ii. Interventions or activities occurring to achieve the goals;
   iii. The individual's response to the interventions or activities (progress notes, tracking sheets, learning logs or data);
   iv. A projected plan to modify or decrease the intensity of services, supports, care and treatment as goals are achieved; and
   v. Discharge planning is begun at the time of admission that includes specific objectives to be met prior to decreasing the intensity of service or discharge.

h. Discharge summary information provided to the individual and new service provider, if applicable, at the time of discharge includes:
   i. Strengths, needs, preferences and abilities of the individual;
   ii. Services, supports, care and treatment provided;
   iii. Achievements;
   iv. Necessary plans for referral; and
   v. A dictated or hand-written summary of the course of services, supports, care and treatment incorporating the discharge summary information provided to the individual and new service provider, if applicable, must be placed in the record within 30 days of discharge.

i. The organization must have policy, procedures and practices for Discharge/Transfer/ immediate transfer due to medical or behavioral needs of individuals in all cases. Agency employees, subcontractors and their employees and volunteers who abandon an individual are subject to administrative review by the contracting Regional Office(s) representing DBHDD to evaluate increasing new admission capacity further or continuing the relationship with the provider agency.

j. All relocation/discharge of individuals within or outside the agency must have prior approval from the contracting Regional Office representing DBHDD. A copy of the approval must be maintained in the individual record.

k. Progress notes or Learning Logs (for DD individuals) describing progress toward goals, including:
   i. Implementation of interventions specified in the plan;
   ii. The individual's response to the intervention or activity based on data; and
   iii. Date and the beginning and ending time when the service was provided.

l. Event notes documenting:
   i. Issues, situations or events occurring in the life of the individual;
   ii. The individual's response to the issues, situations or events;
   iii. Relationships and interactions with family and friends, if applicable;
   iv. Missed appointments including:
      a) Findings of follow-up; and
      b) Strategies to avoid future missed appointments.

m. Records or reports from previous or other current providers; and

n. Correspondence.

3. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
   a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment; and
   b. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.

4. Community integration and inclusion into the larger natural community is supported and evident. Terms "Integration and Inclusion" mean:
    a. Use of community resources that are available to other citizens;
    b. Providing the opportunity to actively participate in community activities and types of employment as citizens without disabilities;
    c. The organization has community partnerships for capacity building and advocacy activities to achieve this goal of integration;
    d. The organization must provide supports and inclusion activities that shows respect for the individual's dignity, personal preference and cultural differences; and
    e. There is documentation of individualized preferences, person-centered of integration and inclusion in the community;
    f. Building of community relationships (natural/paid/unpaid); and
    g. Supporting individual's choice as measured by the amount of control an individual has over his/her life.
5. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.

IV. Information Management SYSTEM THAT PROTECTS INDIVIDUAL INFORMATION AND IS SECURE, ORGANIZED AND CONFIDENTIAL:

1. The organization has clear policies, procedures and practices that support secure, organized and confidential management of information, to include electronic individual records, if applicable.
2. Maintenance and transfer of both written and spoken information is addressed:
    a. Personal individual information;
    b. Billing information; and
    c. All service related information.
3. The organization has a Confidentiality and HIPAA Privacy Policy that clearly addresses state and federal confidentiality laws and regulations, including but not limited to federal regulations on "Confidentiality of Alcohol and Drug Abuse Patient Records" at 42 C.F.R. Part 2 (as applicable) and state laws at O.C.G.A. §§ 37-3-166 (MH), 37-4-125 (DD) and 37-7-166 (AD) as applicable. The organization has a Notice of Privacy Practices that gives the individual adequate notice of the organization's policies and practices regarding use and disclosure of their Protected Health Information (PHI). The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization should address:
    a. HIPAA Privacy and Security Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
    b. Appointment of the Privacy Officer;
    c. Training to be provided to all staff;
    d. Posting of the Notice of Privacy Practices in a prominent place; and
    e. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record;
    f. Provision of the rights of individuals regarding their PHI as defined in federal and state laws and in HIPAA, including but not limited to:
        i. Right to access to one's own record.
        ii. Right to request an amendment.
        iii. Right to request communications by alternative means.
        iv. Right to request restriction of access by others.
    g. Identification of its Business Associates, and obtaining Business Associate agreements with Business Associates, in compliance with HIPAA requirements.

h. Identification of violations of confidentiality or HIPAA and follow up to include compliance with all requirements of HIPAA at 45 C.F.R. sections 164.400 through 164.414:
    i. Reporting of violations to the Privacy Officer.
    ii. Risk assessment of the violation as required by HIPAA provisions.
    iii. Determination of whether the violation constitutes a "breach" as defined by HIPAA.
    iv. Notifications of breaches to the individual(s) affected, to the Secretary of Health and Human Services, and if necessary to the media, in compliance with HIPAA requirements.
i. Corrective Actions for sanctions of employee(s) as necessary, mitigation of harm to any individual and preventing risks to PHI

4. A record of all disclosures of Protected Health Information (PHI) should be kept in the medical record, so that the organization can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
    a. Date of disclosure;
    b. Name of entity or person who received the Protected Health Information;
    c. A brief description of the Protected Health Information disclosed;
    d. A copy of any written request for disclosure; and
    e. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
5. Authorization for release of information is obtained when Protected Health Information of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of Protected Health Information are followed. Information contained in each release of information must include:
    a. Specific information to be released or obtained;
    b. The purpose for the authorization for release of information;
    c. To whom the information may be released or given;
    d. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and
    e. A statement that authorization may be revoked at any time by the individual, to the extent that the organization has not already acted upon the authorization.
6. Exceptions to use of an authorization for release of information are clear in policy:
    a. Disclosure may be made if required or permitted by law;
    b. Disclosure is authorized as a valid exception to the law;
    c. A valid court order or subpoena are required for mental health or developmental disabilities records;
    d. A valid court order and subpoena are required for alcohol or drug abuse records;
    e. When required to share individual information with the DBHDD or any provider under contract or LOA with the DBHDD for the purpose of meeting your own obligations to the department; or
    f. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release Protected Health Information to the treating physician or psychologist.
7. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
    a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later);

b. Protocols for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement; and
c. Compliance with HIPAA Security Rule provisions to the degree mandated by or appropriate under the Security Rule to protect the security, integrity and availability of records.

8. The organization has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not be limited to:
   a. A complete certified copy of the record to the Department or the provider who will assume service provision, that includes individual's Protected Health Information, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of the individual's continuity of care and treatment;
   b. Unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts; and
   c. The time frames by which transfer of documents and personal belongings will be completed.

9. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individual's records for five years.

D. MANAGEMENT OF INDIVIDUAL'S PERSONAL FUNDS

1. The organization must have written policies, procedures and practices for the management/supervision and safeguarding of funds, possessions, and valuables, of individuals served by the organization. All policies and procedures must be in compliance with DBHDD policy, guidelines of the Social Security Administration associated with the management and protection of the funds of individuals served, and any other federal and state laws or regulations.

   The Management of Funds Policy and Procedures must provide for the following:
   a. A procedure to inventory an individual's possessions and valuables at admission and updated as needed but at a minimum annually.
   b. Individuals have the right to manage their own funds. However, the residential provider organization is responsible for the management/supervision of any individual valuables or funds regardless of the payee status of the provider.
   c. The individual's ability to manage their funds is documented in their Individual Service Plan. Upon admission, each individual's capacity for money management is assessed and documented in Attachment A – Money Management Tool.
   d. When an individual is unable to manage funds, and have no other person in their life to assist, there must be **documented** effort to secure an independent party to manage those valuables and/or funds. The effort to secure an independent party will be documented in the ISP **annually**.
   e. Special care to assure that the funds are not mismanaged or exploited. Procedures define the checks and balances to ensure agency accountability and the ability to demonstrate evidence of working towards the goal of participative management of the funds of the individuals served. Checks and balances to be included in the Policy and Procedures:
      i. Funds may not be pooled or co-mingled in any organizational account or other combined accounts, or with other individual's funds. Collective accounts, as defined, require the permission of the Social Security Administration. The collective account, with a sub-account for each beneficiary, must show that the funds belong to the beneficiaries and not the payee. Documentation in current

record keeping clearly indicates the amount of each beneficiary's share and proper procedures must be followed, that clearly shows the individual's amount for deposits, withdrawals, and interest earned for each beneficiary.

ii. A procedure or set of procedures to assure that at least two people, other than those having authorization to **receive** and **disburse** funds on behalf of any individual, independently **reconcile the bank** and/or account records of any individual served by the organization on a monthly basis.

iii. When providers are selected and become the payee of individuals' checks, they must maintain records of each individual's personal funds and all other records pertaining to personal needs accounts (including bank statements and bank books). Documentation of personal spending is accounted for on the Division of DD approved Personal Spending Account Record (Attachment B), or a payee created document that contains all of the same elements as Attachment B. Only the current month's Personal Spending Account Record must be kept at the individual's place of residence, for immediate inspection, as applicable. All previous month's Personal Spending Account Records may be kept off site at the agency business office, but is to be available to the person served, his or her family, the Support Coordinators, the Regional Office, and any other legally authorized representative for inspection and copying upon request, or within one to two business days of request.

f. Day to Day Living Expenses:

i. The representative payee of individuals served determines and document the current needs of day to day living and use his/her payments to meet those needs (e.g., Day to Day living expenses including housing that is equitably distributed among all individuals supported in the home based on specific residence cost or average cost of similar homes in a geographic area; food where preferences and dietary needs are honored; medical/dental if not covered by Medicare, Medicaid and/or private insurance to the extent that SSI benefits and Social Security are available and Personal items and clothing specified in Social Security Guidelines).

g. Keep written records of at least two years of all payments from the Social Security Administration (SSA), bank statements, and cancelled checks, receipts or cancelled checks for rent, utilities, and major purchases.

h. A strict prohibition, punishable by termination, for any employee, agency or representative of the organization to be listed or designated, either directly or indirectly, as a beneficiary, payee or other member of any funds of the individual, including but not limited to, any insurance, burial or trust benefits.

i. Monitoring and reporting on the use of personal funds are incorporated into the organization's QI program. Individual financial records are subject to audits by the Social Security Office and DBHDD.

j. Copies of each-day-to-day living expense agreement are maintained in the individual's record. Day to Day living expenses agreement must be signed by the CRA provider agency (and Host Home Provider or sub-contractor provided, if applicable) at admission and thereafter annually and submitted to the Division of DD or when there is a change of provider and/or Host Home provider serving the individual.

2. A procedure in accordance with the guidelines listed below to ensure the timely deposit and account of all individual funds (e.g., trust, work-related income, Social Security, disability, benefits, gifts, etc.) in an account in the individual name of each individual receiving any such funds:

a. Funds not needed for ordinary use by the individual on a daily basis shall be deposited in an account insured by agencies of or corporations charted by the state or federal government. The account will be in a form which clearly indicates that the organization has only a fiduciary interest in the funds.
b. Funds received from an individual or on his/her behalf may be deposited in an interest bearing account; provided, however, that any interest earned on such account shall accrue to the individual.
c. To the extent that certain funds are properly due to the organization for services, goods, or donations, said funds must first be deposited to the individual's account and then subsequently disbursed in accordance with these requirements and the written policies of the organization.
d. A requirement that individual funds may only be disbursed upon request or authorization of the individual and/or his/her family, if appropriate, and in the case where the organization serves as the designee to receive and disburse funds on behalf of the individual, members or organizational representatives is needed.

3. Providers are encouraged to utilize persons outside the organization to serve as "representative payee" such as, but not limited to:
   a. Family;
   b. Other person of significance to the individual; and
   c. Other persons in the community not associated with the agency.
4. If individual's funds are not personally managed by the individual, a mechanism is in place for the review of funds by the individual and his or her representative:
   a. At least once a quarter;
   b. To include a review of the bank statement of funds received including date of deposit, fund source), funds spent (date and source with receipt) and balance of funds available;
   c. Documentation of individual review shall be maintained; and
   d. Review and update of other financial assets such as annuity accounts, personal belongings and burial funds.

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

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

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

a) Developmental Disability Professional (DDP) requirements:

DDP services rendered by a provider agency must be provided by a qualified individual DDP, employed by or under professional contract with the provider agency.

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

- Be a Developmental Disability Professional (DDP)
- Have responsibility for overseeing the delivery of waiver and/state services to participants.

The same individual may serve as the agency director, nurse and/or DDP, provided the employee meets the qualification and/or designation of each position. However, the duties of shared roles for each position must be separately delivered and documented. A change in approved and designated DDP must be reported by the agency to the Department of Behavioral Health and Development Disabilities via the DBHDD Provider Network Management Office. Information to be reported must include:

- Updated and current Resume
- Name of individual
- Name of provider agency and contact name of person requesting change of information
- Hours of work, or contract with DDP

The Developmental Disability Professional will deliver their services utilizing a Person-Centered Focus.

b) Each Developmental Disability Professional (DDP) has a specified schedule or contract with sufficient hours per week to meet the duties of the DDP and level of need for individuals receiving services, which includes but are not limited to:

1. Overseeing the services and supports provided to individuals that include:
   a. The agency DDP monitors and/or participates in the implementation and delivery of the Individual Service Plan (ISP).
   b. The agency DDP supervises the delivery of service and ensures that strategies reflect the goals and objectives of the ISP.
   c. The agency DDP monitors the progress toward achievement of goals in the ISP, and makes recommendations for modification to the ISP, as appropriate.
2. Supervising the formulation of the individual's plan for delivery of all waiver services provided to the individual by the provider, on an annual basis subsequent to ISP development and after any ISP addendum that includes, but is not limited to:
   a. Ensuring the implementation strategies reflect the ISP and the needs of the individual.
   b. The agency DDP participates in the development of the ISP.
3. Conducting functional assessments to support formulation of the individual's plan for delivery of all waiver services that include:
   a. The Health Risk Screening Tool;
   b. The Supports Intensity Scale;
   c. Functional Behavioral Analysis, if qualified;

d. And others as needed or required, if qualified.

4. Supervising high intensity services that address health and safety risks for the individuals that include:
   a. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Behavior Support Plan.
   b. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Crisis Plan.
   c. The agency DDP is involved in identifying ongoing supports as needed (medical and/or behavioral) in collaboration with appropriate personnel.

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

c) **Performance Indicators of the responsibilities listed above (1-4) are as follows:**
   a. Active participation in the planning meeting documented in either the meeting minutes/notes and/or progress notes prior to ISP meeting.
   b. Documented contact with the SC prior to the ISP date.
   c. Consulted with, supervised, and provided guidance to direct support staff regarding implementation of the services.
   d. The DDP will complete documentation in any individual's record for any of the above responsibilities. This documentation should include the signature, title/credentials, timed (start and end time of delivery of service) and date.
   e. The DDP will complete, or assure the completion of required agency assessments, included, but not limited to, HRST and SIS, within the given time frame.

For additional details regarding documentation requirements, refer to New Options or Comprehensive (NOW/COMP) Medicaid manual(s) Part II, Chapter 1100.

Hours scheduled and worked must be sufficient to meet the individual needs of each individual served by the provider. The provision of DDP oversight and service provision must be documented in the individual's record. **A DDP is not scheduled to work only on a PRN basis.**

NOTE: DDP direct service provision and oversight for an individual with an approved exceptional rate is in addition to the above requirements and as specified in the letter of approval for the exceptional rate.

d) **Required Trainings for All Developmental Disabilities Professionals**

All Developmental Disabilities Professionals must be trained in all required trainings identified in the Community Service Standards for All DD Providers.

Other required trainings for DDPs in their first year of employment include:

- Individual Service Planning
- Supports Intensity Scale overview
- Health Risk Screening Tool on line training.

The provider agency must also document the participation of each DDP in a minimum of 8 hours per year of additional DBHDD sponsored or other training in the area of developmental disabilities, not listed above or included in the Community Standards for All Providers.

The following professionals qualify to be a Developmental Disability Professional:

i. **Advanced Practice Nurse:** A registered professional nurse licensed in the State of Georgia, who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND who have one year experience in treating persons with intellectual/developmental disabilities in a medical setting or a community based setting for delivery of nursing services.

ii. **Behavior Specialist:** A behavior specialist who has completed a Master's degree in psychology, school psychology, counseling, vocational rehabilitation or a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, therapeutic intervention, counseling, or psychosocial assessment, AND one year of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual disabilities OR developmental disabilities OR completion of a Bachelor's degree in psychology, counseling, OR a related field which included one course in psychometric testing AND two courses in any combination of the following: behavior analysis or modification, counseling, learning theory or psychology of adjustment AND two years of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual/developmental disabilities.

iii. **Board Certified Behavior Analysis (BCBA):** A **BCBA** who has completed a Master's degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analysis Certification Board Exam, AND maintains a prescribed number of continuing education units annually, AND has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.

iv. **Educator:** An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND one year of classroom experience in teaching individuals with intellectual/developmental disabilities.

v. **Human Services Professional:** A human services professional with a bachelor's degree in social work OR a bachelor's degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) AND with specialized training OR one year of experience in providing human services to individuals with intellectual/developmental disabilities.

vi. **Master's or Doctoral Degree Holders:** A person with a Master's or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR

one year of experience in providing services to individuals with intellectual/developmental disabilities.

vii. **Physical or Occupational Therapist:** A physical or occupational therapist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.

viii. **Physician:** A physician licensed in the State of Georgia to practice medicine or osteopathy AND with specialized training in developmental disabilities OR one year of experience in treating individuals with intellectual/developmental disabilities.

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

x. **Psychologist:** A holder of a Doctoral degree from an accredited university or college, AND who is licensed in the State of Georgia AND who has specialized training in developmental disabilities OR one year of experience in evaluating or providing psychological services to individuals with intellectual/developmental disabilities.

xi. **Registered Nurse (Associate Degree or Diploma):** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, AND who has three years of experience, two of which are in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

xii. **Registered Nurse (Bachelor's Degree):** A registered nurse who is authorized by license to practice nursing as a registered professional nurse AND who holds a Bachelor's degree in nursing with one year experience in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.

xiii. **Speech Pathologist or Audiologist:** A speech pathologist or audiologist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship OR one year of experience in treating individuals with intellectual/developmental disabilities.

xiv. **Therapeutic Recreation Specialist:** A therapeutic recreation specialist who graduated from an accredited program AND who has specialized training in developmental disabilities as evidence by college coursework OR practicum/internship experience OR one year experience in providing therapeutic recreational services to individuals with intellectual/developmental disabilities.

G. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. All requests for waivers of these standards must be done in accordance with

Policy #9.102 Requests for Waivers of Standards for Mental Health, Developmental Disabilities and Addictive Diseases, found herein Part VI.

For DD providers utilizing Proxy Caregivers and Health Maintenance Activities:

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities, Chapter 111-8-100 (Go to www. dch.georgia.gov/hfr-laws-regulations). The policies and procedures specified below are applicable to all providers:

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

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

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

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

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

b. Receive training by an attending physician, advanced practice registered nurse, physician assistant, or registered nurse that teaches the proxy caregiver the necessary knowledge and skills to perform the health maintenance activities documented in the individual's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the individual.

c. Demonstrate to the training (i.e., attending physician, advanced practice registered nurse, physician assistant, or registered nurse) the necessary knowledge and skills to perform the health maintenance activities documented in the individual's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the individual.

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

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

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

   c. Provided without the written orders of an attending physician, advanced practice registered nurse, or physician assistant working under a nurse protocol agreement or job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.

   d. Provided without written plan of care as defined above. Provided by individuals who do not meet the requirements specified above.

Appendix I:

Antipsychotic Medications	
Generic	**Trade**
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Serentil
Mesoridazine	Lidone, Moban
Molindone	Zyprexa
Olanzapine	Invega*
Palinperidone	Trilafon
Perphenazine	Orap
Pimozide (for Tourette's)	Seroquel
Quetiapine	Risperdal*
Risperidone	Mellaril

Thioridazine	Navane
Thiothixene	Stelazine
Trifluoperazine	Vesprin
Trifluopromazine	Geodon
Ziprasidone	
Mood Stabilizer Medications	
Generic	**Trade**
Lithium Carbonate	Eskalith or Lithonate
Divalproex Sodium	Depakote
Tiagabine	Bagatril
Levetiracetam	Keppra
Lamotrigine	Lamitcal
Gabapentin	Neurontin
Carbamazepine	Tegretol
Oxcarbazepine	Trileptal
Topiramate	Topomax
Zonisamide	Zonegran
Verapamil	Calan
Clonidine	Catapres
Propranolol	Inderal
Mexiletine	Mexitil
Guanfacine	Tenex

***Also has a sustained release injectable form**