DBHDD Statewide Meeting of Providers of Developmental Disability Services

Frank W. Berry, Commissioner

State Offices South at Tift College

March 15, 2013

We are only as good as our network of providers.

1. We want you to be successful.

2. We need you to be successful.

3. Our clients need "US" to be successful.

The U.S. Department of Justice has recently expressed deep concern about the state's compliance with the quality of community placements for individuals with developmental disabilities.

Always Prepared!

At any time, expect a visit from:

- **The US Department of Justice**
- **The State of Georgia**
- **A Family**

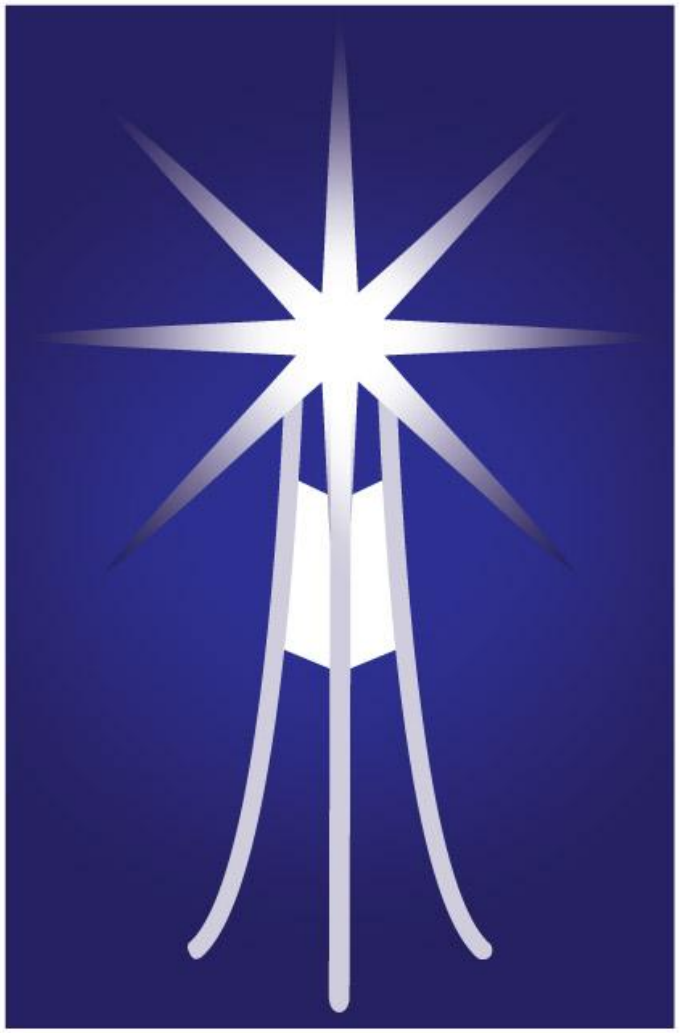
Today

DBHDD leadership will define...

Quality

Accountability

Partnerships



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Department of Behavioral Health & Developmental Disabilities

ADA Settlement Agreement

Pamela Schuble, LCSW
Director, Settlement Coordination

March 15, 2013

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2010 ADA Settlement Agreement - Scope

- Five Year Agreement – signed in October of 2010.
- Provides Community supports and crisis services for
  - Persons with developmental disabilities (DD) who would otherwise be served in ICF/MR facilities
  - Persons with serious and persistent mental illness (SPMI) who would be served in State Hospitals without community services
- Quality management

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Mental Illness Target Population

- The target population for community services is 9,000 individuals with Severe and Persistent Mental Illness (SPMI)
  - who are currently being served in the State Hospitals
  - who are frequently readmitted to the State Hospitals
  - who are frequently seen in Emergency Rooms
  - who are chronically homeless, and/or
  - who are being released from jails or prisons

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Intellectual Disabilities Population

- The Agreement calls for:
  - The cessation of admissions of individuals to State Hospitals July 1, 2011
  - Movement of individuals from State Hospitals to the community with appropriate community supports
  - Additional waivers for individuals in the community
  - Additional Family support money
  - Crisis services – Mobile Crisis Teams and Respite

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Settlement Agreement Services

	1-Jul-11		1-Jul-12		1-Jul-13		1-Jul-14	1-Jul-15
Mental Illness Provisions	Target	Compliance	Target (cumulative)	Compliance	Target	Compliance	Target	Target
35 Community Hospital Beds	35	Yes						
Crisis Line (no date)	1	Yes						
ACT Teams	18	Yes	20	Yes	22	Yes		
Intensive Case Management Teams	1	Yes	2	Yes	3	Yes	8	14
Supported Housing Beds	100	Yes	500	Yes	800	703	1400	2000
Bridge Funding (yearly)	90	Yes	360	Yes	270		540	540
Supported Employment	70	Yes	170	Yes	440	Yes	500	550
Community Support Teams			2	Yes	4	Yes	8	
Case Management Services			5	Yes	15	Yes	25	45
Crisis Stabilization Units			1	Yes	2	Yes	3	
Peer Support Services			235		535	Yes	835	
Crisis Service Centers					1		3	6
Mobile Crisis Services (counties)					91		126	159
Crisis Apartments					6	3	12	18
Target Population List								9000
Developmental Disabilities								
Cease all TIC admissions to State Hospitals	0	Yes						
Move persons from SH to community	150	Yes	300	Yes	450	22	600	750
Family Supports (yearly)	400	Yes	450	Yes	500	204	500	500
Community Waivers			100	Yes	200	Yes	300	400
Mobile Crisis Teams			6	Yes				
Crisis Respite Homes			5	Yes	9	Yes		
Education - Program Created for Judges and Law					Program	Yes		
Quality Management Audit of Waiver Services					X	Yes		
Assess Compliance					Annually	Yes	Annually	Annually
Quality Management System			X	Yes				
Reporting				Semi-Annual		2/1/2013		

Updated 10/23/2012

Independent Reviewer

- Elizabeth Jones, Washington DC
- No authority of the court
- Issues annual report of compliance to the Court
- Must confer with parties before filing reports or budget with the court

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Monitoring of the Agreement

- Specifically tailored to the particular program or activity
- Engagement of experts/consultants
- Shared with DBHDD throughout the process
- Opportunities for correction as necessary

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Monitoring of the Agreement

- Are services individualized according to the individuals' strengths and needs?
- Are there appropriate supports for the placement?
- Community integration?

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Monitoring of the Transitioned Individuals from State Hospitals to the Community

- 150 Waivers per Year for Transitions
- Subpopulation identified by statistician at VA Commonwealth – 48
- RN Consultants perform unanounced in-home visits
- Accepted screening instrument vetted with DBHDD
- Situations where health and safety issues are identified are brought forward to DBHDD immediately

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Monitoring of the Transitioned Individuals from State Hospitals to the Community

- Elizabeth Jones and DBHDD Follow up
- Visits to every Region
- Follow up to previous year's visits by nurse consultants particularly to individuals with previously identified issues
- In FY '13, visits to individuals placed this year to prevent problems and proactively deal with placement issues

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Monitoring of the Transitioned Individuals from State Hospitals to the Community

- Limited understanding of the individuals in their care
  - Medical issues – lack of informed consent for psychotropic medications, lack of follow up with medical providers or about medical issues, i.e. neurological, gastro-instestinal.
  - Behavioral issues – lack of understanding of behavior support plans and very limited use
  - Lack of follow through with ISP or daily activities – individuals who have no community activities, have lost access to community programs because of behavior, never leave the house

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Home

- Everyone strives for and deserves a permanent home
- Placed in your care, these individuals are now in their own homes
- Do you and your staff know them, understand them, care for them like you would members of your family?
- Do you advocate for them like you would a family member?
- Does your staff have the skills, interest and ability to provide these individuals the level of care and commitment that you would like to see?

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Quality Transition Outcomes

Charles Li, MD MHSA
Assistant Commissioner
Division of Developmental Disabilities

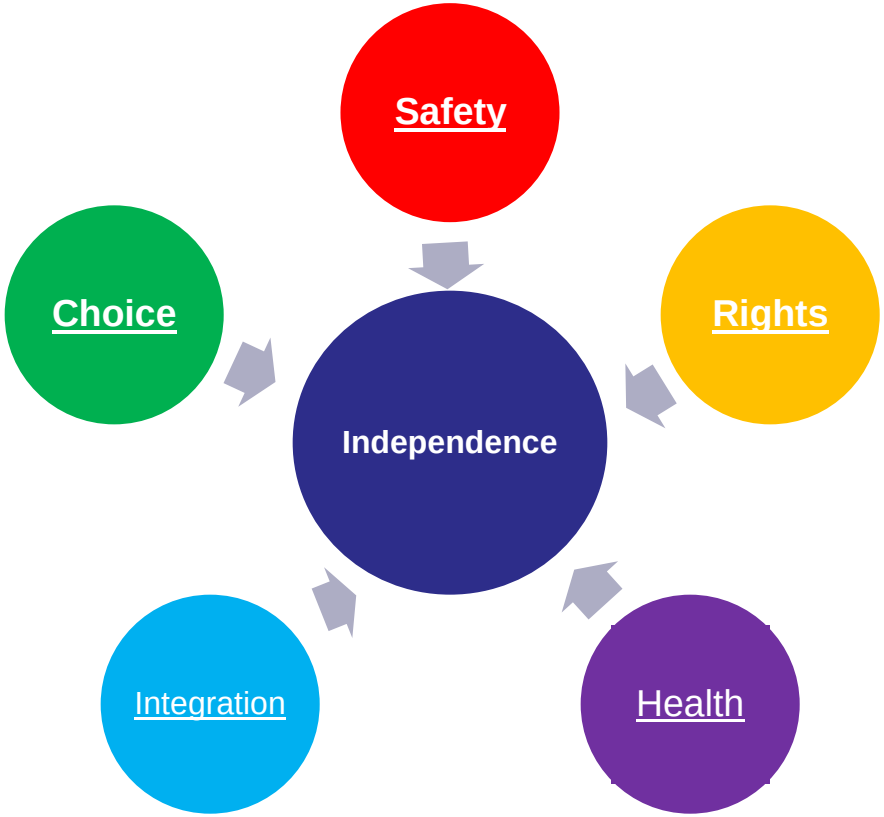
March 15, 2013

DBHDD Vision & Goal

Vision - **Every person who participates in our services leads a satisfying, independent life with dignity and respect.**

Goal - **The goal is for all transitioned individuals to receive adequate services and supports in community and to achieve independence, integration, and meaningful life.**

Five Key Words



Quality Domain 1 – Safety and Security

This domain measures whether the individual's services are provided in a safe, secure and comfortable environment. It looks at how staff are screened prior to hiring, trained in incident management policies and if providers have processes for resolving safety concerns and responding to incidents. This area also measures whether providers have a complaint resolution system that works as well as a mechanism for correcting issues found by investigations so that these things do not occur again.

Quality Domain 2 – Rights, Respect and Dignity

This domain looks at whether the individual is treated with respect and dignity, if rights are protected and if inappropriate restrictions are prohibited. It also looks at whether the person has access to his or her personal funds and is allowed to do the things that he or she wants to do, as appropriate.

Quality Domain 3 – Health

This domain measures whether the individual achieves or maintains the best possible health by getting the appropriate assessments and health care services. It looks at whether providers help individuals receive necessary health care, if medications are given correctly, and if individuals are provided nutritious meals that follow any specially prescribed diets.

Quality Domain 4 – Choice and Decision Making

This domain looks at whether the individual and family are involved in making decisions about the individual's services, if the individual's plan includes his or her choices and if the provider supports the individual to make good decisions. It also measures the provider's method of getting feedback concerning satisfaction with services and how the provider uses that information to change services.

Quality Domain 5 – Community Integration

This domain looks at whether the individual participates in integrative, community activities, has transportation, and participate in inclusive work activities. It also looks if the individual has opportunities for meaningful relationships and if the provider has activities and opportunities that support the individual to have important relationships and be a valued member of his or her community.

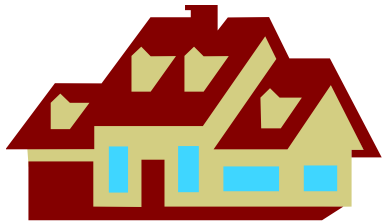
Quality Domain 6 – Individual Planning & Implementation

This domain measures whether a individual's Individual Support Plan covers his or her needs, preferences and decisions. It looks at how the individual and family participate in developing the plan, whether the right assessments have been used to develop the plan, and if the plan includes supports and services that meet the individual's needs. This domain also looks at whether the plan is used to obtain services and if staff know about the plan and how to use it to work with the individual. Finally, it looks at how the plan is monitored to make sure it is implemented to help the individual.

Specific Issues - Housing

DD providers are expected to offer each individual choices of housing in the most integrated setting. Specifically, the providers should:

- Assess the individual's strength, skills, and life goal to find housing that will assist the individual to achieve independence.
- Provide informed choice that allows the individual and/or family members to make an intelligent and individualized decision about housing options that are most likely to lead a successful life in community.
- Avoid offering one option, which is not a true choice.
- Set goals/objectives in Individual Service Plan to encourage, train, and assist individuals to move from congregated settings into independent living.



Specific Issues – Safe & Home-like Environment

The living environment should be safe and meet sanitation standards. There should be no condition in the environment that could negatively affect individuals' health and safety. It is not acceptable to arrange the living environment like an institution. Individuals should make their own decisions on how to arrange the environment based on personal preference and choices.

Specific Issues – Medical & Behavior Support

Individuals' medical and behavior support service needs are fully assessed and provided, including physician care, nursing service, dental, behavior support plan, and medication administration. Individuals have routine physical examine and have access to specialists as well as emergency care. Providers are expected to:

- Show evidence that medical and behavior support needs are met by retaining services with local clinicians.
- Have trained staff on medical and behavior support plan for each individual.
- Have ability to decrease/avoid negative interactions with law enforcement.
- Have ability to decrease utilization of emergency services.

Specific Issues – Employee Competency

Employees of the providers are expected to be trained adequately to support the individuals. They should know the individuals' life goals and objectives, the major medical and behavior issues, the behavior support plan, and Individual Service Plan.

Quality Assurance Monitoring and Provider Supports

Sara Case, Director

Office of Developmental Disability Programs

Division of Developmental Disabilities

March 15, 2013

DBHDD Expectation

*Each individual that you support receives **QUALITY** services necessary to have a meaningful life in a safe environment.*

WHO?

Any individual who has transitioned from a State hospital **since**
July 1, 2010

WHAT?

Do You Know???

- What is **IMPORTANT FOR** each individual you support?
- What is **IMPORTANT TO** each individual you support?

Environment

- Is the individual's environment clean?
- Are food and/or supplies adequate?
- Does the individual appear well kempt?
- Is the environment free of any safety issues?
- Does the environment meet the individual's needs?

Health and Safety

- Emergency room visit
- Unexpected medical hospitalization
- Critical incident
- Activation of Georgia Crisis Response System
- Police Involvement
- Use of Restraints
- Rights Restriction

Documentation

- Medication Administration Record (MAR)
- Individual Support Plan (ISP)
- Supporting Documentation for ISP
- Informed Consent (psychotropic medication)
- Behavior Support Plan BSP
- Supporting Documentation for BSP

Critical Healthcare

- Fluid intake
- Food Intake
- Seizures
- Weight fluctuations
- Positioning
  (per protocol/documented clinical need)
- Bowel movements
  (per protocol/documented clinical need)

Staff General Knowledge

- How does the individual communicate their wants, needs, choices, pain, distress, hunger, etc?
- What does the individual do during the day?
- What does the individual WANT to do on any given day (dreams, hopes)?
- What does the individual do with their time?
- Do staff know what to do when the individual has a significant medical concern?

Staff Knowledge of the Behavior Support Plan

- Do staff know the ABCs of behavior?
  - **A**ntecedents to behaviors
  - **B**ehaviors to increase/decrease
  - **C**onsequences for behaviors
- Do staff know how to record behavioral data?
- Do staff know how to manage a significant behavioral crisis?

Individual's Satisfaction

- Do you like where you live? Have you met your neighbors?
- Do you like the people that support you (the way they speak to you, help you, etc?)
- Do you participate/attend any clubs, groups, organizations, Church activities or events in your neighborhood or community?
- Do you have transportation to get to where you want to go?
- Do you get to choose what you do during the day? On weekends?
- What do you do for fun/entertainment?
- What makes you happy? Sad?

WHERE?

Transition Monitoring will occur in any and all environments in which the individual is supported.

WHEN?

Transition Monitoring may occur at any time…

Announced
OR
Unannounced

HOW?

Transition Monitoring is Conducted By:

- Regional Staff
- Support Coordination Staff
- Central Office Staff

Identified areas of concern are followed up by regional staff…

Regional Follow-Up

Michael Link, Director
Office of Regional Operations
March 15, 2013

Regional Monitoring

- Regional Offices have begun and will continue monitoring of individual transitioned from a state – hospital to community-based providers.
- Reviews may be conducted by Support Coordination (SC) agencies.
- Findings of SC may be reported to a Regional Office.
- The Regional Office must follow-up if issues necessitate follow-up.

Accountability

- Providers not meeting proficiency in providing quality care are subject to have a decrease or a halt in referrals from the Regional Office.

- Proficiency is determined by the metrics of the provider monitoring tool.

Health and Safety Risks

- Providers who are found to have health and safety risks will:
  - Cause an immediate halt in referrals
  - May be subject to having any individual in their care moved to another provider

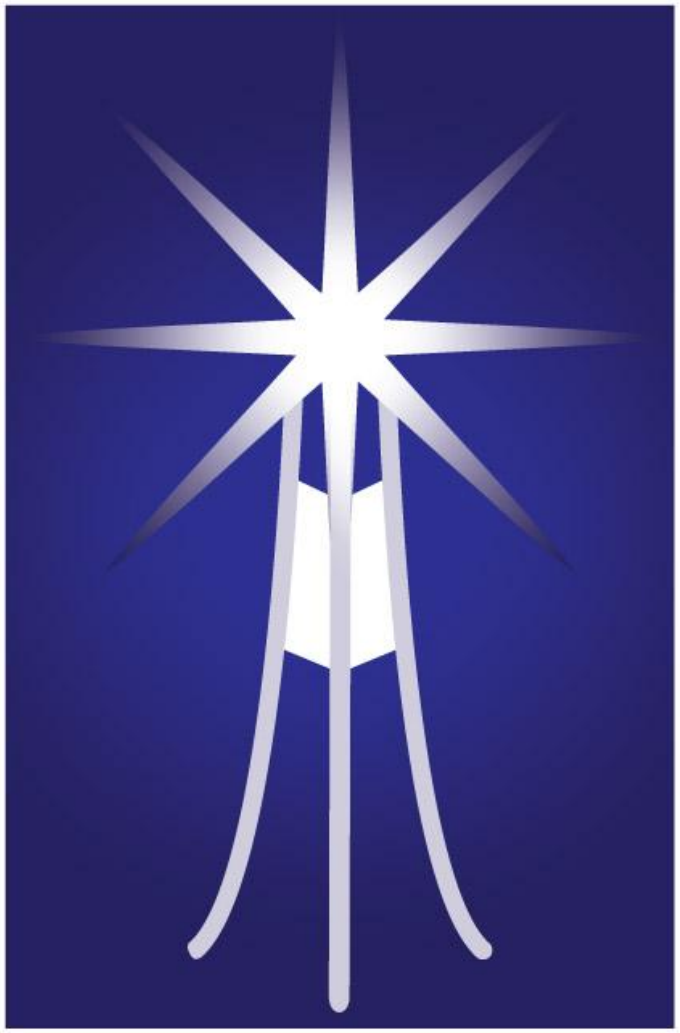
Demonstration of Quality

- Providers who cannot demonstrate a level of quality service are at risk of losing their contract ability with DBHDD.

- DBHDD is not under any obligation to sign contracts with vendors who it may have contracted with in the previous year.

Moving Forward

- Regional Offices will address questions submitted on note cards at future regional DD provider meetings.
- Providers should be proactive in meeting and establishing relationships with their regional offices.
- Regional offices in turn will make efforts to be accessible and available to discuss quality of care issues.



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