

STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

**PROVIDER ORIENTATION
OVERVIEW**

AGENDA

9am – 10:30 am (90 minutes)

Self Determination (75 min) PAGE 3

- Mission
- Pledge
- Vision
- Self-Determination, Self-Direction, Self-Advocacy
- Employment, WIOA and Transitional Services

Person Centered Planning: Designing Your Life (15 min) PAGE 46

- Individual Plan
- Individual Progress Review (6 Month Review)

Break (10 min)

Community Companion Homes (CCH) (10 min) PAGE 54

Quality of My Life (15 min) PAGE 58

- DDS Quality Service Review

Planning & Resource Allocation Team (15 min) PAGE 72

- LON
- Utilization Resource Review
- Notice Of Opportunity
- How do supports get paid for?

Individual Budgets (25 min) PAGE 78

- Rates
- Fiscal Intermediary
- Documentation and Billing
- Vendor Authorization

Purchase of Service (POS) Contracts (20 min) PAGE 84

- POS Contracts
- Medicaid ID Numbers
- Documentation and Billing
- Financial Reporting: Annual Report/Operational Plan
- Role of Provider Specialist

10:40am – 12:05 am (85 minutes)

Lunch (1 Hour)

Review Processes (30 min) PAGE 97

- Incident Reports/Critical Incidents/255M
- PRC Procedure
- PRC Data & Behavior Plans
- Forensic Review
- HRC

Abuse & Neglect (20 min) PAGE 117

- Reporting
- Investigation
- Definition
- Prevention

Resource Administration – (20 min) PAGE 127

- COOP
- Provider Profiles
- Performance and Fiscal Reviews
- Web Page Review
- Portability
- Transition to LON Based Rates

Break (10 min)

Quality Improvement (15 min) PAGE 137

- Continuous Improvement Plans
- Enhanced Contract Monitoring

Health and Wellness (20 min) PAGE 140

- Medication Administration Certification
- DNR
- Nursing Policies/Procedures/Directives
- Nursing Meetings

Regional Contacts / Provider Orientation Training / Leadership Forum Meeting Schedule (5 min) PAGE 146

Questions/Evaluation (30 min)

1:05 pm – 2:15 pm (70 minutes)

2:25 pm – 3:35 pm (70 minutes)



SELF - DETERMINATION

**A Focus on Self
Determination, Self
Advocacy & Employment**

Mission



The Mission of the Department of Developmental Services is to partner with the individuals we support and their families, to support lifelong planning and to join with others to create and promote meaningful opportunities for individuals to fully participate as valued members of their communities.

Respectful Language

The Respectful Language policy requires the use of “people first” language when referring to individuals who receive supports and services from DDS. Person-first language is a way of referring to special needs that emphasizes the individual rather than the diagnosis. The intent is to emphasize the things we all have in common rather than differences, and to allow the many things that are special about individuals to shine through. In addition, the policy replaces the term “mental retardation” with “intellectual disability” unless clinically or legally necessary.



**WE ARE PEOPLE.
CALL ME BY MY NAME.**

Please stop using these words.



Disability Awareness/People First Language Pledge

I PLEDGE:

- To advocate and accept my responsibility to be respectful to the individuals I work with and for.
- To RESPECT and treat all individuals equally.
- To Call each person by their name and refer to them as “INDIVIDUALS” and stop using the word “CLIENT”.
- To Support self-advocacy and stand up for individuals’ human rights.
- To be an advocate for “No More R Word” in my work place and everywhere I go.
- To Assist and make sure that each person that I work with can make their own choices, be part of a community of their choice, and feel accepted to be themselves.
- I will use People First Language, which means seeing THE person NOT the disability, using words and terms that are easier for people to understand.
- To be an ambassador for Self Advocates, Speak up for People First Language, and Be the voice for change that makes peoples’ lives happen!

Vision

All citizens supported by the Department of Developmental Services are valued contributors to their communities as family members, friends, neighbors, students, employees, volunteers, members of civic and religious associations, voters and advocates.

These Individuals...

- Live, learn, work and enjoy community life in places where they can use their personal strengths, talents and passions.
- Have safe, meaningful and empowering relationships.
- Have families who feel supported from the earliest years and throughout their lifetimes.
- Have lifelong opportunities and the assistance to learn things that matter to them.
- Make informed choices and take responsibility for their lives and experience the dignity of risk.
- Earn money to facilitate personal choices.
- Know their rights and responsibilities and pursue opportunities to live the life they choose.



Vision Ideas and Discussion

Share ideas and examples of how to “make life happen” based on the Vision Statements.



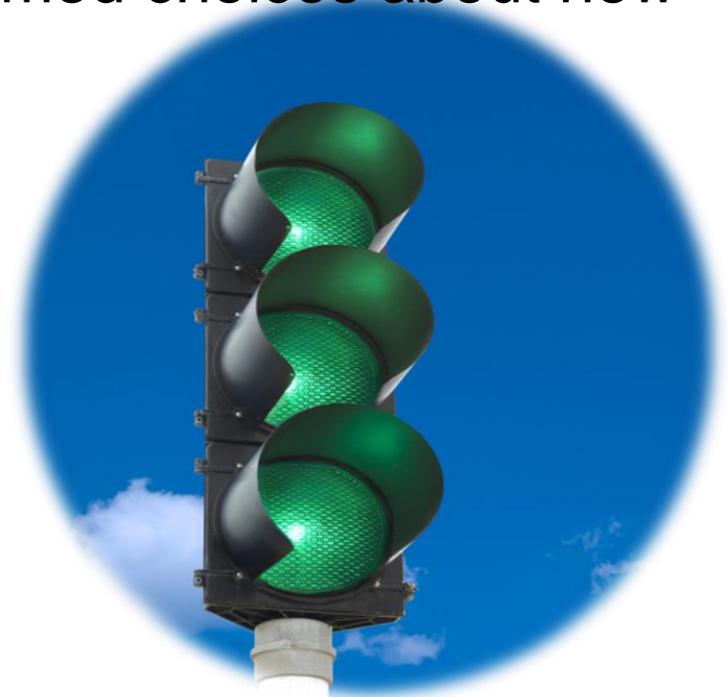


**Supporting
People to Live
their Vision !**

What is Self Determination?

Self Determination is a value that is expressed when individuals learn about basic rights; use this knowledge to broaden their experiences; and use these new experiences to make informed choices about new ways of living and being.

Self Determination means taking greater responsibility and control of one's life.



Self Determination

People living self determined lives have:

- ❖ Freedom to decide how to live their lives.
- ❖ Support they need to live full self determined lives.
- ❖ Authority over their resources and supports.
- ❖ Responsibility for their decisions and actions.

Self Determination is based upon a foundation that encourages and supports: Respect, Dignity, & Dreaming...Whatever It Takes!



What is Self Direction?

Self Direction is a service delivery model that individuals can use to become more self-determined and to have greater control and authority in their lives. The self-direction model affords the individual the ability to hire and manage employees to provide specific services, goods or equipment.

Self Direction is a path one can choose to become more self determined.



Evolution of Supports & Services



**1970's
Mainstreaming**



**1980's
INCLUSION**



**1990's
Self Determination**

Present- Self Determination



Empowering People

- Support people to MAKE LIFE HAPPEN!
- Live a Self Determined Life!

How Do You Help Support People to Make Life Happen?

- Empower the person to Speak Up and Speak Out!
- Support the person to make their own informed decisions.
- Being flexible and open to support the individual's unique needs.
- Support the person by making accommodations they need.
- Help the person be able to say: “The more I learn to do on my own, the more independent I can be! I am self determined!”

DDS is working to Promote Self Determined Lives

- Self Direction
- Person Centered Plans (Individual Plans)
- Self Advocacy Groups
- Employment
- Healthy Relationships
- Community of Practice
- National Core Indicators (NCI)
- Portability

Self Advocacy & Self Determination

- Self Advocacy and Self Determination go hand in hand.
- You can not be self determined and have a quality of life with out using self advocacy skills.
- Learning to be a good self advocate is important.



Self Advocate Coordinators (SAC) at Work

- Who are the DDS Self Advocate Coordinators (SACS)?
 - Legislature Supported
 - A Voice of the People



South Region SAC's

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Self Advocate Coordinators at Work

What do Self Advocate Coordinators (SACs) Do?

- Promote Self Advocacy -Spread the Word!
- Promote Consumer involvement
- Develop leaders
- Support Regional and State activities



SELF ADVOCACY BUILDING THE VOICES



Empowering Others to Speak Up!

- ❖ **Developing and Expanding Self Advocate (SA) Groups**
- ❖ **Working with all of the CT Private Providers**
- ❖ **Increasing the number of Self Advocacy Groups and the number of Individuals attending Self Advocacy Groups.**
- ❖ **Working with Private Providers to have advocates on their boards and an advocacy group within their agency.**
- ❖ **Parents with ID/DD SA Groups – with their children**
- ❖ **SA Groups for individuals in Public supports**
- ❖ **Southbury Training School (STS), Regional Centers/Group Homes**

SELF ADVOCACY BUILDING THE VOICES



Empowering Others to Speak Up!

Being an IP Buddy to support individual advocacy

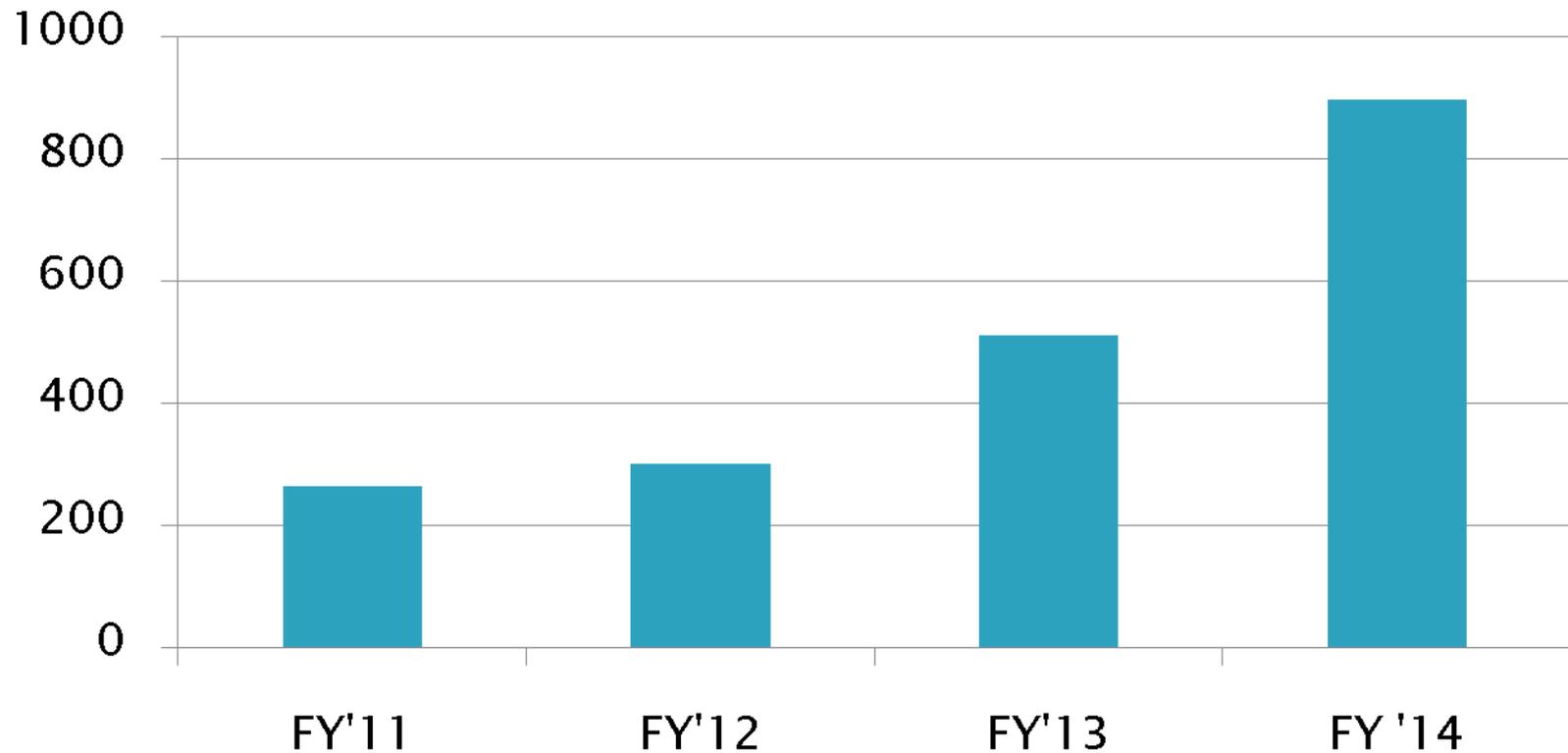
Developing Self Advocate Volunteers to help Spread the Word!

CT Cross Disability Alliance

NCIs – Interviewing and sharing SA Information

GROWING SELF ADVOCACY STATEWIDE

Self Advocates



PROMOTE SELF ADVOCACY SPREAD THE WORD!

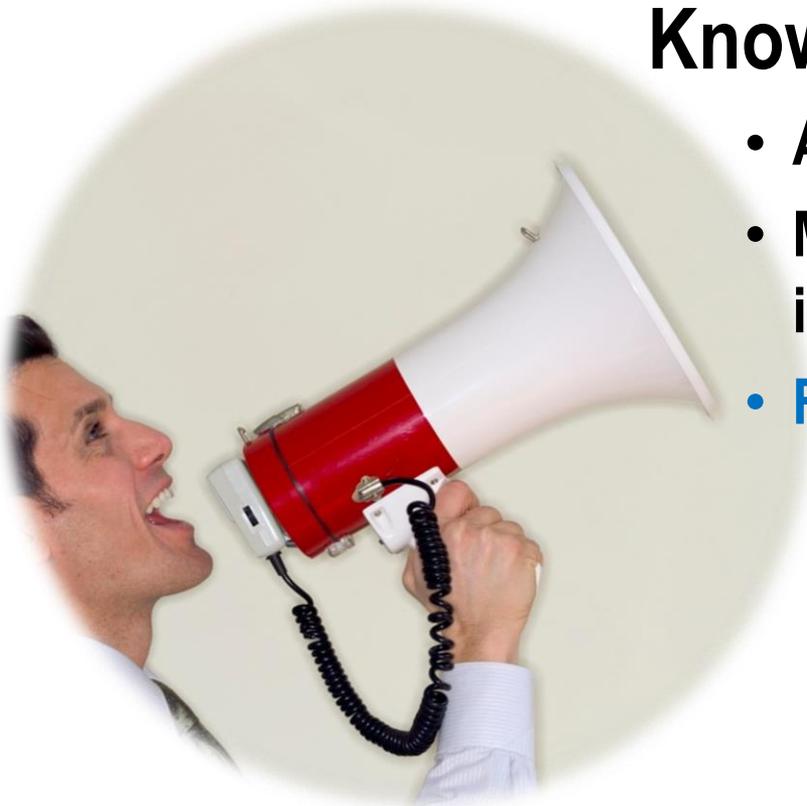
Knowledge is Power!

- All SACs have a Focus Area
- Meets with the Commissioner to discuss issues that are important
- **FAB** Topics – Shared with the SA Groups

Fun

Activities

Brain Power



Employment



What is Employment?



- ① Real work: Work that would otherwise be performed by someone without a disability.
- ② Real wages: Getting paid the same hourly rate as a person without a disability for doing the same job.

“REAL WORK FOR REAL PAY”





CT's Employment First Initiative

- Employment is the first priority option to be explored in the service planning.
- All future graduates and those with Level of Need (LON) levels 1, 2, and 3 must have an employment goal which leads to individual supported or competitive employment.
- All other individuals and their teams should consider individual supported or competitive employment options.
- Annual Individual Plans should help people to secure employment and help people to pursue advancement in their chosen careers.
- Employment is an ongoing path – it does not have an ending.

A Return on Disability

“A Return on Disability”

<http://youtu.be/CRHnlyJI0dg>

“Rising Tide Car Wash”

<http://www.nbcnews.com/feature/mr-smith-goes-to/car-wash-offers-employment-young-adults-autism-n86151>



The New MISSION & VISION IS OURS TO SHARE!



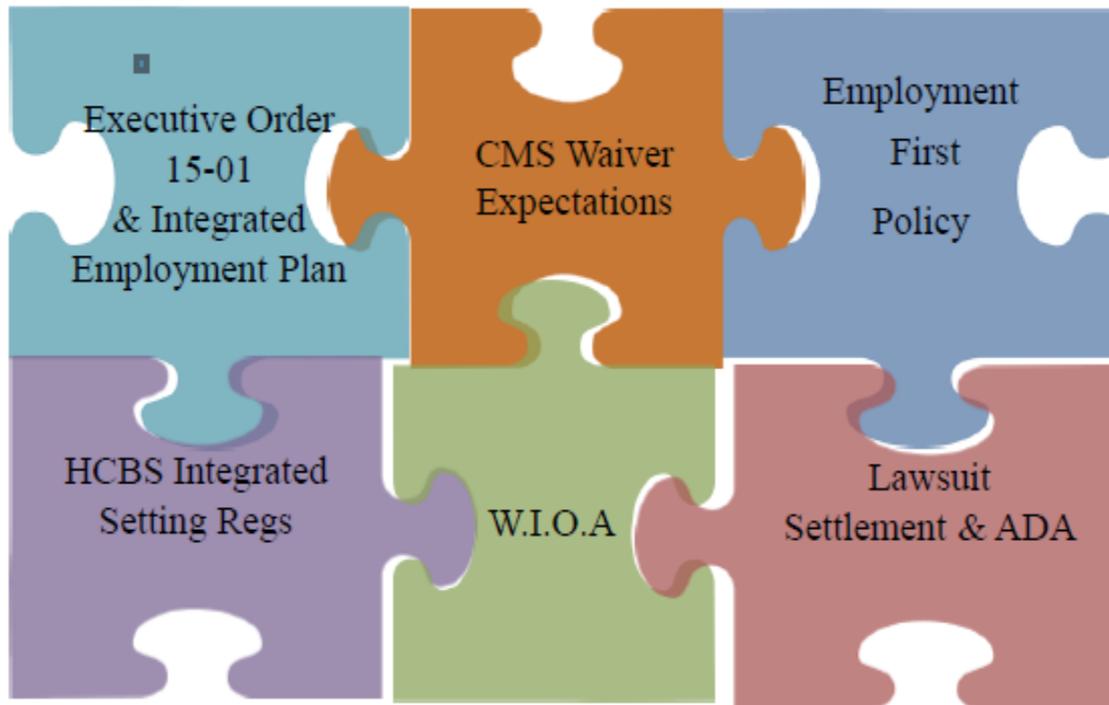
What will you contribute?



Workforce Investment and Opportunities Act (WIOA)



Overview of changes impacting employment and day services



Background

- * WIOA Signed into law on July 22, 2014
- * Effective Dates Vary
 - * Title IV (VR and Supported Employment) became effective upon enactment
 - * Most other sections effective July 1, 2015
 - * Effective for 6 years (through 2020)
- * Implementation began in Connecticut on July 22, 2016

Goal: Competitive Employment

- * Full or part-time work at minimum wage or above
- * Wages and benefits similar to those without disabilities performing same work
- * Fully integrated with co-workers without disabilities
- *Strong focus on youth age 16-24**

Step #1: By July 22, 2016



Grandfather as many grads into existing GSE and other sub-minimum wage services as possible, prior to July 22, 2016

Definition:

(1.) Time limited

(2.) Community-Based

(3.) Supported Vocational Services that focus on:

- * career exploration**
- * skill development**
- * self-advocacy**

(4.) Leads to competitive employment.

Rates:

Follows same
LON Rate structure
as DSO and GSE



Time Limited:

3 Years



Services in the Community: Goal 100%



Where people can spend their time:

- Employment exploration sites
- Adult Education Sites and Post-Secondary Schools
- Workforce Centers
- Libraries
- Health Clubs
- Banks
- Networking Sites

Person Centered Planning: Designing Your Life

INDIVIDUAL PLAN

Is the Person driving the plan?

Are you asking the right questions?

Do you have the necessary assessments?

INDIVIDUAL PROGRESS REVIEW (6 MONTH REVIEWS)

How is life going for you?

What adjustments do we need to make?

Individual Plan (IP)

- CMS dictates that individuals on the HCBS waiver have a comprehensive plan that is developed based on an assessment and reviewed regularly.
- Roadmap for the Individual
 - Document what the person wants out of life
 - Sample questions from Manual
- Team Process
 - Individual and family/guardian
 - People the individual desires to be there
 - Case Manager
 - Provider

Roadmap for Life



The Assessment Process

The Level of Need (LON)

What 15 page tool used by the department to determine support needs in an equitable and consistent manner.

When

- Complete annually within the same month as the previous years LON
- Teams can revisit the LON whenever the individual has a change in condition.
- Case Manager and Team should review the LON if they are going to PRAT.
- Other assessment information should feed the LON .(Nursing reports ADL assessments, Supervision needs)

How

- LON needs to reflect what is typical for the individual.
- Case Manager is the facilitator of the process and enters the information.
- All team members provide input into the LON. Any team member can request to review the LON.
- All risk areas identified in the summary need to be reflected in the PLAN.
- LON composite or Behavioral score (whichever is higher) determines the rate.
- LON Manual is a great resource located on the DDS website.

Individual Plan (IP)



- Completed annually within the calendar month of the previous year's plan.
- All sections of the plan need to be addressed. If an area or question does not apply it should be marked as such.
- The Personal Profile section of the plan is a great place to paint a picture of the individual.
- All waived services need to have an action step identified in the plan
- Action steps need be measureable and identify who is responsible and the timeframe that the support should occur.
- Information contained must be consistent with the LON and other reports.
(example Dietary consistency needs to be listed the same in the nursing report/LON assessment/Dietary guidelines and in the IP)
- All risk areas identified in the LON need mention in the IP
- Address the person's hopes and dreams.

Individual Progress Review (6 Month Reviews)



- **Private Providers (both Residential and Day) are responsible for the completion of a progress review twice annually.**
- **TIMEFRAME:**
 - Completed and forwarded to all team members 2 weeks prior to the IP meeting
 - Completed and forwarded to all team members at the 6 mark identified at the IP meeting
 - Nursing and Behavioral reports are due to the team on a 1/4ly basis.
 - Community Companion Home/Intermediate Care Facility for Individuals with Intellectual Disabilities (CCH/ICF/IID) teams hold 1/4ly meetings and such reports are due at that time.

CONTENT:

- All providers need to utilize the DDS Individual Progress Review form
- 6 month reports need to reflect the individual's progress on all goals identified in the IP for your service.
- The top portion allows you to note changes as they relate to the personal profile section of the plan
- Please make a notation in the comment or recommendation section located on the bottom of the form.
- Provider's collected data from goals is used to compile the progress report.

TOOLS FOR YOUR USE

- Located on the Provider Gateway:
- Under **FORMS** you will find a link to the **Individual Plan Training Document**.
- This is a great resource to insure the IP is completed meeting the waiver requirements.
- Under **RESOURCES**, you will find the **A Guide to Individual Planning** and **Individual Progress Review Directions**.



Roles and Responsibilities

PRIVATE PROVIDERS

- 1) Submit assessments 14 days prior to all team members.
- 2) Provide input to the LON.
- 3) Provide input into the Personal Profile.
- 4) Transcribe the IP within 2weeks (Community Living Arrangement (CLA) Providers only).
- 5) Develop and Implement IP action steps.
- 6) Document Progress on goals.
- 7) Provide 6 month reviews to all team members.

Case Managers

- 1) Schedule IP meeting
- 2) Review all reports and ensure all team members receive a copy.
- 3) Complete LON and share LON and summary with team members.
- 4) Gather personal profile .
- 5) Facilitate meeting.
- 6) Transcribe the plan within 2 weeks for all but Community Living Arrangement (CLA) Providers.
- 7) Review IP for accuracy.
- 8) Distribute plan within 30 days of IP.
- 9) Convene team meetings as needed.
- 10) Update electronic data system.

BREAK

10 MINUTES



coffee break

Community Companion Homes (CCH)

Community Companion Homes (CCH)

- When circumstances make it impractical for an individual to live in their family home, placement in a DDS licensed Community Companion Home (CCH) can be a great choice. The CCH model offers a family setting to people with intellectual disabilities. Families of diverse cultures, backgrounds and composition are sought for the best possible match. Many CCHs are operated by Private Agencies. Agencies receive a monthly Community Companion Home Rate according to the LON Score of the individual(s) in the home.





Provider's Responsibilities

- Advertise, recruit, develop and maintain the license of CCH provider
- Conduct initial and ongoing training for new CCH applicants
- Participate in all meetings and provide the necessary reports as well as assist with the authoring and implementation of residential goals
- Ensure the timely upkeep of benefits
- Ensure all medical appointments are scheduled and kept in designated timeframes
- Provide Nursing and Behavioral Supports
- Ensure the adherence to all Licensing Guidelines/Regulations
- Assist the Licensee with the licensing process through monthly visits to the home
- Assist the Licensee with the Plan of Correction
- Ensure alternative placement for individuals in the event of an emergency

Monthly Monitoring

- Reviewing CCH Books:
 - Medical
 - Journal Entries
 - Incident Reports
 - Behavior Plan and Data as applicable
 - Respite Profile
 - Safety Alerts
 - IP/Periodic Reviews in the home
- Reviewing Home:
 - Test hot water
 - Look for safety issues
 - Verify Licensed Bedroom sleeping conditions
 - Observe interactions between Licensee and Individual(s)
- Reviewing Finances:
 - Review Ledger Sheets
 - Review Checkbook against Ledger
 - Verify Cash on Hand
 - Verify that Benefits/Entitlements are correct
 - Verify that the individual is not over assets for DSS
 - Ensure Inventory List contains all items over \$50



QUALITY OF MY LIFE

DDS Quality Service Review (QSR)

- What is Quality of Life?
 - Yourself
 - How does agency support people to have quality of life?
- The QSR is a tool and process to identify the quality of services and individuals' satisfaction with services and supports.
- National Core Indicators (NCI) are another tool that elicits feedback from the individual on how they experience their supports and services.

Areas for QSR Assessment

There are seven Focus Areas for the QSR and NCI:

1. Planning & Personal Achievement
2. Safety
3. Relationships & Community inclusion
4. Health & Wellness
5. Choice & Control
6. Satisfaction
7. Rights, Respect & Dignity



Data Collection Methods

- **Observation** of the individual where supports are provided
- **Documentation** review of the Individual Plan and other records
- **Safety Checklist** review of the individual's environment and emergency planning
- **Interviews** with the individual receiving services and a support person
- **Application Data** verification of required information
- **Verification** of expected follow-up (Program Review Committee (PRC), Previous QSR findings, Abuse/Neglect Recommendations, etc.)

QSR Components

- **Quality Indicators** are statements indicating specific expectations within focus areas. Example: Indicator D 43 Direct service providers maintain documentation of supports and services provided and progress made.
- **Interpretive Guidelines** for each indicator provide information from policy, procedure, statutes, regulation, directives, and best practice standards. They also provide examples and discussion for reviewers and providers.

Individual Level Indicator Ratings

MET

- The requirements of the indicator are present.

NOT MET - CM

- **DDS Responsible - Case Management as a service**
- The requirements of the indicator are not present.
- Issues identified are the responsibility of the DDS Case Manager; action is required.

NOT MET - DDS

- **DDS Responsible**
- The requirements of the indicator are not present.
- The issues identified are the responsibility of the DDS system; action is required to address the finding.

NOT MET

- **Provider Responsible**
- The requirements of the indicator are not present.
- The issues identified are the responsibility of the Provider; action is required to address the finding.

NOT APPLICABLE

- The indicator does not relate to the individual or service type being reviewed.

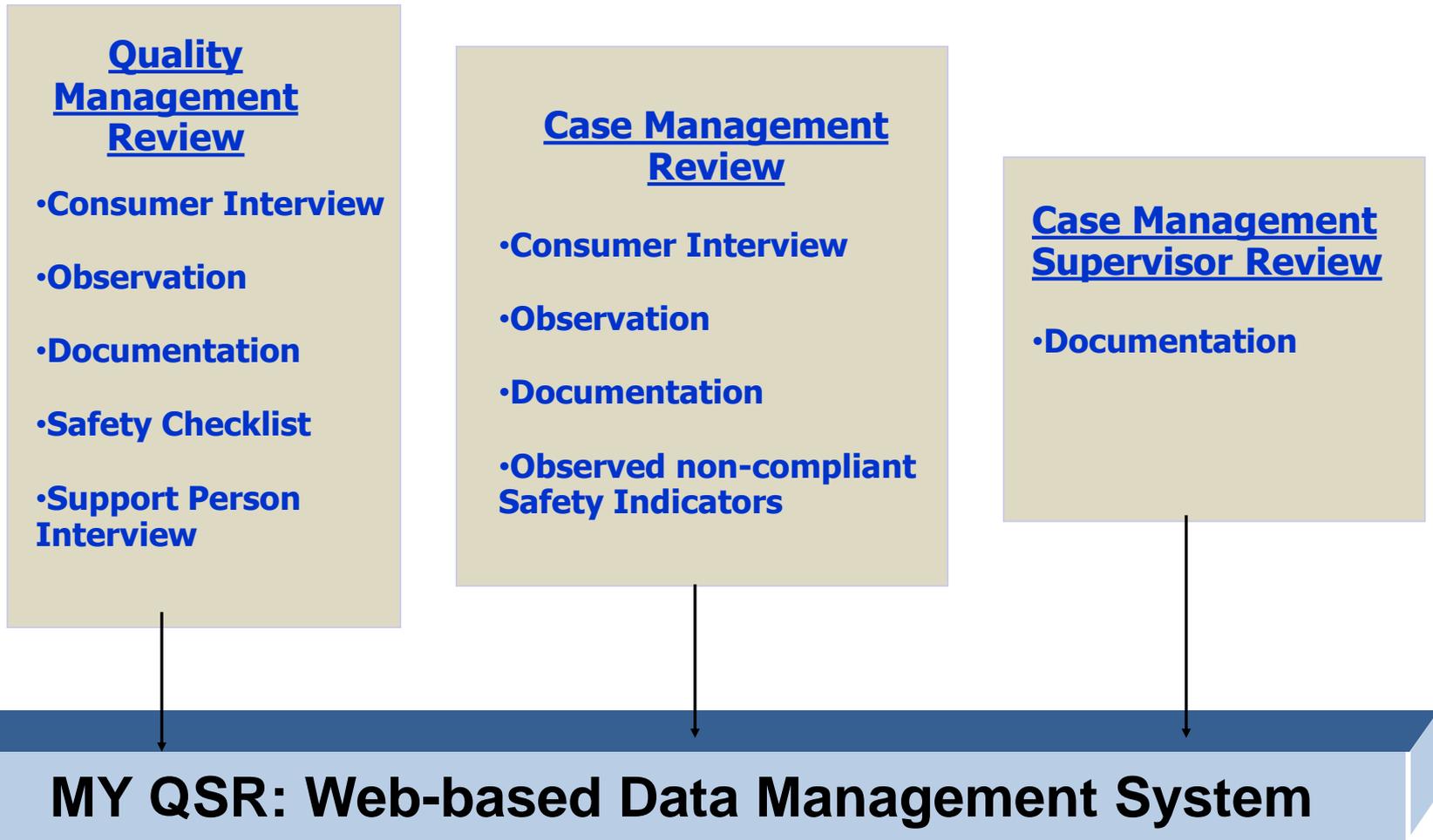
NOT RATED

- The indicator is applicable to the individual or service type, but circumstances have not allowed the reviewer to evaluate the indicator.

QSR Visit Process

- DDS identifies an individual and their service for a review.
- The reviewer will use a review *tool* (set of indicators) that matches their role and the service type being reviewed.
- Review is conducted; visit may be announced or unannounced.
- Review findings are recorded in My QSR.
- Not Met findings must be addressed.
- If written corrective action plans are required, they must be entered into the My QSR and monitored until closed.

One pool of quality indicators are drawn from to make service and role-specific review tools for data collection.



Quality Cycle

- Information gathered may identify areas for improvement or indicate progress is being made, and is used for ongoing quality improvement.
- Findings and quality improvement actions should be used to address both individual and systemic factors.



Integrating the QSR Process

- The QSR process includes provider self-assessment and quality improvement planning activities to evaluate the effectiveness of their own service and quality management systems.
- The QSR process includes DDS using QSR and other data for systemic improvements.

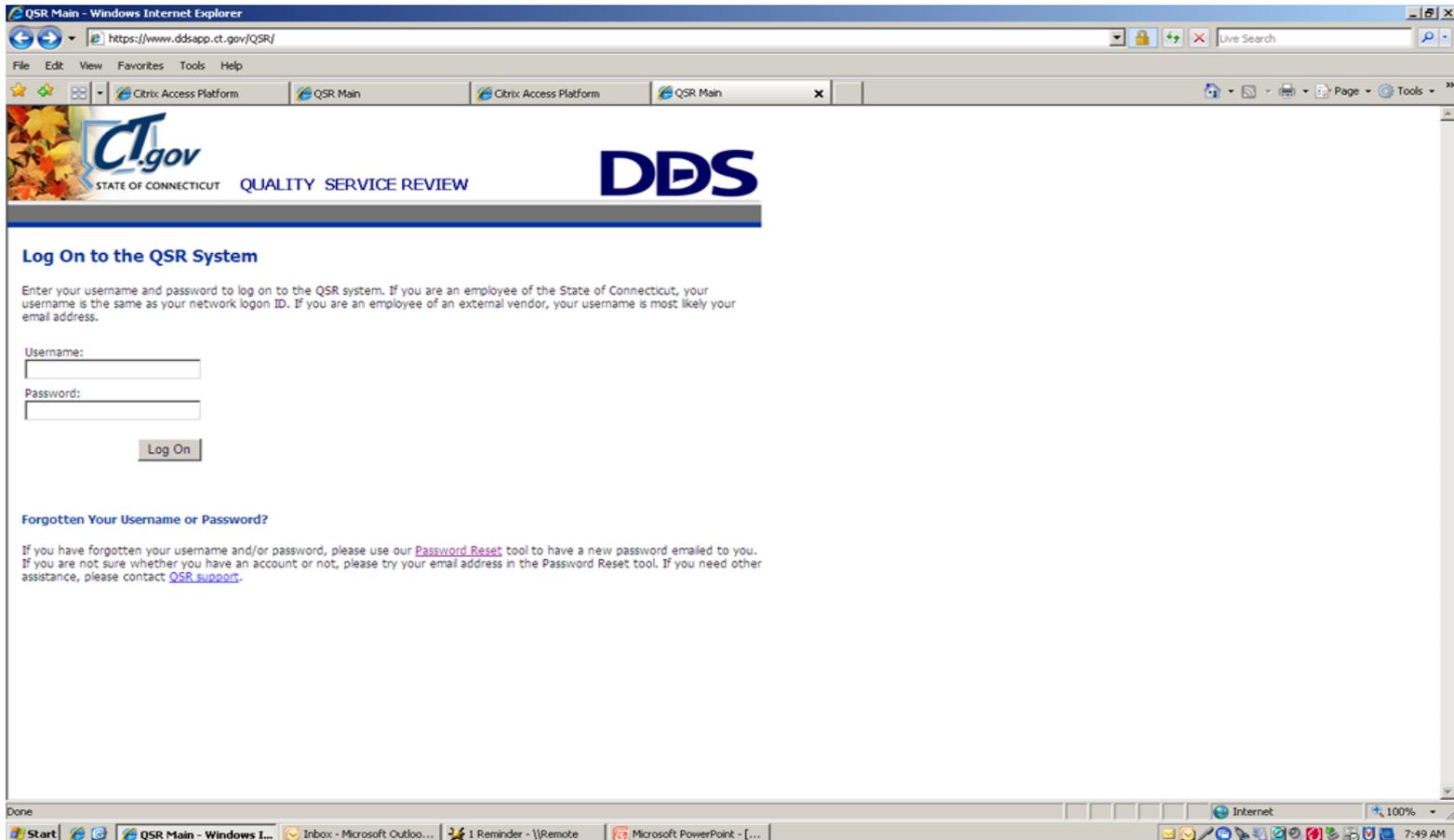
QSR Web-Based Data Application (My QSR)

- Allows quality review data to be recorded by DDS and reported to providers and appropriate DDS personnel.
- Allows required corrective action planning and implementation to be documented and monitored.
- Ensures information is available for use in DDS and Provider quality improvement activities.

DDS QSR Web Address

<https://www.ddsapp.ct.gov/QSR>

Agencies must be assigned in the system by DDS before the logging into this application.



The screenshot shows a Windows Internet Explorer browser window displaying the login page for the DDS QSR system. The address bar shows the URL <https://www.ddsapp.ct.gov/QSR>. The page features the CT.gov logo and the text "STATE OF CONNECTICUT QUALITY SERVICE REVIEW" and "DDS". The main heading is "Log On to the QSR System". Below this, there is a paragraph of instructions: "Enter your username and password to log on to the QSR system. If you are an employee of the State of Connecticut, your username is the same as your network logon ID. If you are an employee of an external vendor, your username is most likely your email address." There are two input fields: "Username:" and "Password:". Below the fields is a "Log On" button. At the bottom, there is a link for "Forgotten Your Username or Password?" with a sub-link for "Password Reset". The Windows taskbar at the bottom shows several open applications: "QSR Main - Windows I...", "Inbox - Microsoft Outloo...", "1 Reminder - \\Remote", and "Microsoft PowerPoint - [...]".

QSR Main - Windows Internet Explorer

https://www.ddsapp.ct.gov/QSR

File Edit View Favorites Tools Help

Citrix Access Platform QSR Main Citrix Access Platform QSR Main

CT.gov STATE OF CONNECTICUT QUALITY SERVICE REVIEW

DDS

Log On to the QSR System

Enter your username and password to log on to the QSR system. If you are an employee of the State of Connecticut, your username is the same as your network logon ID. If you are an employee of an external vendor, your username is most likely your email address.

Username:

Password:

Log On

Forgotten Your Username or Password?

If you have forgotten your username and/or password, please use our [Password Reset](#) tool to have a new password emailed to you. If you are not sure whether you have an account or not, please try your email address in the Password Reset tool. If you need other assistance, please contact [QSR support](#).

Done

Start QSR Main - Windows I... Inbox - Microsoft Outloo... 1 Reminder - \\Remote Microsoft PowerPoint - [...]

Internet 100% 7:49 AM

QSR Requirements

- Providers are responsible for participating in DDS Quality Systems, including establishing and maintaining QSR Web-based interactions.
- Quality Management will provide assistance to providers. Please contact us for initial set-up in the system and for any questions. Once providers establish a designated Vendor Administrator they can establish and manage the accounts of others within their organization.

Reference

Please see the DDS web site: <http://www.ct.gov/dds>

For More Information On...

- Quality Management Services Division
- Supports and Services
- Home & Community Based Services (HCBS) Waivers
- Information for Providers
- Safety Alerts / Advisories/ DDS Safety Campaign
- Health and Clinical Services
- DDS Manual
- Health Standards
- Fire Safety and Emergency Guidelines
- Emergency Management
- Medication Administration
- Announcements, updates, and other information

PLANNING & RESOURCE ALLOCATION TEAM (PRAT)

PLANNING & RESOURCE ALLOCATION TEAM (PRAT)

LON

UTILIZATION RESOURCE REVIEW (URR)

NOTICE OF OPPORTUNITY (NOO)

HOW DO SUPPORTS GET PAID FOR?

PRAT

- Purpose
- Composition of committee
- What needs to come through Planning & Resource Allocation Team (PRAT)?
- How do providers have items/concerns presented at Planning & Resource Allocation Team (PRAT)?
- Allocations based on Level of Need (LON)

Level of Need (LON)

Funding Guidelines

Residential

Day

Utilization Resource Review (URR) Process

- **When** is it required?
 - A URR is done when an individual is above the LON based allocation for home and work/day; has a 1:to:1; or has line-of –site supervision.
- **What** is required?
 - The provider must work with the DDS Case manager to properly prepare the URR package. The provider must provide a descriptor of the specific program, a schedule of what the enhanced staff does specifically with the individual, data (including baseline data and current status; a copy of the behavior program; a titration plan to reduce the enhanced staffing.
- **How** is this decision communicated?
 - URR approval can be granted up to 3 years. If you receive a conditional approval that is time-limited, you must submit the requested information by the date established by the URR committee. Medical URRs may not need to come back through the URR process.
 - Failure to provide substantiating information can lead to removal of funds from a budget/no additional requested funds being added to a budget.

Notice of Opportunity (NOO)

- Notice of Opportunity (NOO) – the start of the referral process
- Format
- Completed by provider – this will help formulate the type/number of referrals you receive – be as specific as possible.
- Responses – you need to respond to the PRAT Manager and Resource Manager regarding your ability/inability to provide services for an individual. You must be specific as to why you can or cannot provide services.
- Referral packets are available on a secure website. Contact Kayon Brown-Palmer at Kayon.Brown-Palmer@ct.gov to get access to the website.

How Do Supports Get Paid For?

- Personal Benefits
 - Husky C
 - Social Security
 - Private insurance
 - Other
- Community Resources
- Individual Budgets (IP 6)
- Purchase of Service Contracts



INDIVIDUAL BUDGETS

RATES

FISCAL INTERMEDIARY

DOCUMENTATION AND BILLING

VENDOR AUTHORIZATION

Rates

- Standardized rates are used to develop the cost of an individual's support package.
- Rates for all home and work/day services are based on LON allocations.
- Group Day services: Day Support Options (DSO), Group Supported Employment (GSE), Prevocational (PVH) do not include transportation in the rates. If transportation is provided, it is billed separately since it is provided separately from the Group Day service.
- Utilize the Case Manager if there are concerns regarding the services or rates that were used in developing an individual's IP.6.
- Residential rate transition began for less than 24 hour supports on 7/1/13.
- Residential rate transition for CLA and CRS began 1/1/2015

Fiscal Intermediary (FI)

Utilize the Fiscal Intermediary for any billing issues. DDS utilizes two Fiscal Intermediaries:

Allied Community Resources

P.O. Box 509, East Windsor, CT 06088-0509

Phone: (860) 627-9500

Toll Free: (866) 275-1358

FAX : (860)627-0330

Sunset Shores of Milford

720 Barnum Ave. Cut-Off, Stratford, CT 06614

Phone: (203) 380-1228

Toll Free: (877) 666-1366

FAX (203) 380-1481

After utilizing the Case Manager and F.I., unresolved issues should be referred to the F.I. Liaison:

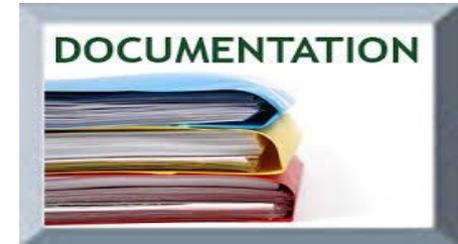
South Region - John Rispoli

North Region – Stacie Silva-Gordon

West Region – John Adams

Documentation & Billing

- Service must be provided in accordance with the consumers Individual Plan.
- For each service provided documentation must include:
 - Goal or Outcome identified in the consumers Individual Plan
 - Date of service
 - Start time and end time of service
 - Signature of staff providing service
 - Daily progress note related to the outcomes in the Individual Plan
- All payments made for services and supports that have been authorized through the IP.6/Individual Budget with a Vendor Service Authorization (VSA), will be made by a Fiscal Intermediary and must be billed 60 days of the service being provided.



Documentation and Billing

- Department of Social Services (DSS) Audits have begun and Centers for Medicare and Medicaid Services (CMS) may also be doing audits.
- ALL DOCUMENTATION FOR BILLINGS MUST BE AVAILABLE FOR REVIEW.
- If documentation is not present to support billing, the DSS auditor will extrapolate a percentage across the entire program.
- Documentation must reflect the service authorized for and be aligned with the individuals IP.

Vendor Authorization

- Providers will receive a Vendor Service Authorization (VSA) indicating authorization to provide individual services and supports. Review authorization upon receipt for accuracy and contact Case Manager should there be a discrepancy.
- **DO NOT BEGIN SERVICES THAT HAVE NOT BEEN AUTHORIZED.**
- VSA will include the following:
 - Service recipient
 - Fiscal Intermediary (F.I.), and billing address
 - DDS Case Manager (C.M.) and phone number
 - Service, Rate, and Unit that have been authorized
 - Annualized funding associated with each service
 - Date of Authorization
 - Authorizer
 - When an agency's total revenue reaches \$200,000 or more vendor services may be converted to a Purchase of Service (POS) contract. (See handout labeled *Similarities and differences in services through individual budgets and POS contract*)



Purchase of Service (POS) Contract

UMBRELLA CONTRACT

DOCUMENTATION AND BILLING

CONTRACT SERVICE AUTHORIZATION

ROLE OF PROVIDER SPECIALIST

Purchase of Service Contracts (Umbrella Contract)

- There is one state wide umbrella contract for home and work/day services per agency.
- The Operations Center is a division of DDS Central Office that oversees statewide contract development.
- Contract reporting requirements can be explained by your Provider Specialist.
- Affidavits and Certificates – www.ct.gov/opm
 - Ethics Affidavit
 - Gift and Campaign Affidavit
 - Consulting Agreement
 - Non-discrimination certificate
 - 7/1/12 above affidavits and certificates will be filed electronically through BizNet
 - Operations Center Provider Specialist can assist with any BizNet issues.
- Home and work/day umbrella contracts have contract service authorizations which identify the individual, rate, service type, and number of hours.

DO NOT BEGIN SERVICES THAT HAVE NOT BEEN AUTHORIZED

Medicaid ID Numbers



- All DDS Providers on contract will be required to maintain an active Medicaid ID Number for all of their non-licensed services
- Providers will also need to maintain an active Medicaid ID Number for each licensed setting they operate (currently Community Living Arrangements and Community Companion Homes)
- Providers will need to re-enroll their Medicaid ID Numbers every three years. You will receive a notice from Hewlett Packard Enterprises notifying you six months before your re-enrollment is due as well as several additional reminders by mail. The letter will contain a tracking number to start the process. Screenshots of the re-enrollment screens are located at CTDSSMAP.com (Provider>Provider Services>Provider Training). Many of the screens will be pre-populated with data already on file
- Failure to re-enroll will result in payments being held

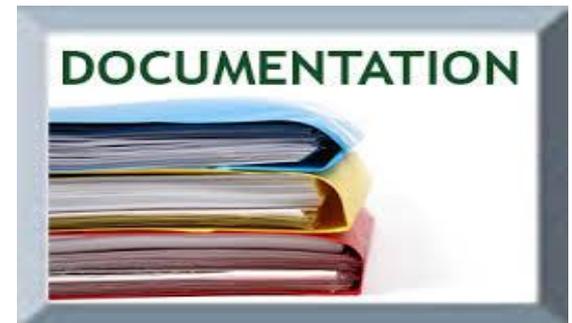


BY MAIL



Documentation & Billing

- Service must be provided in accordance with the consumers Individual Plan.
- For each service provided documentation must include:
 - Goal or Outcome identified in the consumers Individual Plan
 - Date of service
 - Start time and end time of service
 - Signature of staff providing service
 - Daily progress note related to the outcomes in the Individual Plan



Documentation and Billing

- Department of Social Services (DSS) Audits have begun and Centers for Medicare and Medicaid Services (CMS) may also be doing audits.
- Crucial to have ALL DOCUMENTATION for BILLINGS.
- If documentation is not present to support billing the auditor will extrapolate a percentage across the entire program.
- Documentation should reflect the service authorized for and be aligned with the individuals IP.

In case you missed it...

- Do not provide services without a written Contract Service Authorization (CSA).
- In case of emergency, an email from a Regional Director, Assistant Regional Director, Resource Administrator, PRAT Manager or a verbal approval from On-Call Manager until next business day when written approval can be sent will provide temporary authorization until presented at Planning & Resource Allocation Team (PRAT).

- **Providers should review authorizations thoroughly and timely and report concerns/issues to the Regional Resource Manager immediately.**
- Day payments are based on utilization as reported in WebResDay attendance either per day or hourly based on 15 minute units.
- CLA and CRS payments are 1/12 of the service cost if one unit of service is provided during the month as reported in WebResDay attendance. Service authorizations are prorated based on move in date for the 1st month of service.
- IHS, Personal Support and Adult Companion payments are reported hourly, based on 15 minute units.

Payment Reports

- Summary and Detail Reports are provided monthly to contacts listed by agency in the Provider Profile.
- Utilization Reports are also provided on a monthly basis to assist Providers make sure that they are providing services in line with authorizations or can work with region if they feel certain individuals need additional support.

Financial Reporting

Annual Report/Operational Plan

- Operational Plan – is due annually prior to the beginning of the fiscal year and updated when a cost center is added to the contract (software download on Web Page).
- All POS providers doing \$300,000 or more of business statewide
 - Annual Report due **October 15th** (Purchase of Services Contracts only)
 - Annual Report must be completed by Certified Public Accountant.
 - Annual Report – www.myersandstauffer.com for download of report, instructions, & checklist
 - A penalty will be assessed for each day the annual report is late. Extensions should be submitted in writing to the attention of the DDS Commissioner prior to **October 15th**.
 - Financial Statements due **December 31st**
 - State single audit (Non-profits)
 - Audited financial statements (For Profits)
 - Reconciliation forms (Non-profits)
 - 8 month expense report (Attachment D) – due **March 1st**

Financial Reporting

- End of Year Expense Report (Attachment D) – less than \$300,000 – due **September 30th**
- Executive Director Salary Cap - \$101,000
- All agencies must identify an Executive Director or Principle of the Entity.
- Related Party Transactions must be identified in the Annual Report and approved by the DDS Ethics Committee yearly.
- A grid detailing all provider requirements is on the Provider Gateway on the DDS website.

Financial Reporting Non-POS Providers

- Non POS providers who receive revenue under \$100,000 are not required to submit annual financial reports.
- Providers between \$100,000 and \$300,000 submit an end of year expense report and are required to submit a report completed by a Certified Public Accountant detailing the providers compliance with standard DDS Agreed upon Procedures.
- Anyone receiving revenue exceeding \$300,000 is required to submit a single audit in accordance with the State Single Act, an end of year expense report, and audited financial statements.
- A grid detailing all provider requirements is on the Provider Gateway on the DDS website.
- Provider agency is responsible to cover the cost of financial audits.

Role of Provider Specialist

- Collaborate with Regions and Providers to Execute needed Contracts and Amendments
- Tracks and Reviews Financial Reporting Requirements of Contract:
 - Op Plan
 - 8 Month Report
 - End of Year Expense Report or Annual Report
- Participates in providing data for Performance Meetings



LUNCH

1 HOUR



REVIEW PROCESSES

(Processes that ensure individual health and safety)

INCIDENT REPORTS/CRITICAL INCIDENTS/FORM 255M

PROGRAM REVIEW COMMITTEE (PRC) PROCEDURE

PRC DATA & BEHAVIOR PLANS

FORENSIC REVIEW

HUMAN RIGHTS COMMITTEE (HRC)

Incident Reporting/ Critical Incidents/Form 255M

- **Incident reporting**
 - Types of incidents; injury, restraint, unusual incidents, medication errors
 - Forms 255 and 255m
 - Completed forms sent to DDS with 5 days of incident
- **Incident Reporting in own/family home**
 - Form 255OH
 - List of reportable incidents
 - Death - follow Mortality Reporting Policy
 - Abuse or Neglect - Follow Abuse /Neglect policy and procedures
- **Critical Incidents**
 - Review what is reportable – check box at top of page
 - Faxed in immediately – also follow standard report procedure
 - Follow up form faxed in within 5 days
 - Regional Manager on-call should be notified



Program Review Committee (PRC) Applies to Who

PRC Applies to Those Individuals Who:

- 1) Are placed or treated under the direction of the DDS Commissioner, those who live in a **DDS operated, funded, or licensed facility, such as an ICF, CLA, CTH, Day Services or Individualized Home Supports**, regardless of where they live.
- 2) Receive any **HCBS Waiver Services** where paid staff are required to carry out a behavioral intervention that **utilizes an aversive, physical, or other restraint procedure** and/or DDS funded staff who are required to **give a behavior modifying medication**, regardless of where he/she lives.
- 3) Are in the DDS **Voluntary Services Program (VSP)** if they are placed **in an in-state DDS operated, funded and/or licensed facility**.
- 4) Receive ongoing, planned psychiatric supports where **behavior modifying medication is prescribed by a psychiatrist/prescriber** regardless of where the individuals live or whether they receive DDS Waiver Services.

PRC Does **NOT** Apply to Individuals Who:

- 1) Receive DDS Respite Services Only
- 2) Are exempt by Program Review Committee/Human Rights Committee (PRC/HRC), and
- 3) Reside in long-term care facilities licensed, that are funded or overseen by other state agencies.

PRC Exemption

- An individual is his/her own agent (no guardian), takes meds and sees his/her doctor independently, and the Interdisciplinary Team (IDT) agrees with the individual's decision.
- Fill out an Exemption form that includes the IDT team's rationale and signatures. Team will review and make their decision. Letter will then go out to the Case Manager whether it has been approved or disapproved.
- Exemption is for meds only; it never applies for any aversive or restraint procedures.

Aversives/Restraint

- **Aversive Procedure:** A procedure that contains the contingent use of an event or device which may be unpleasant, noxious, or otherwise cause discomfort in order to: (1) alter t/avoid a specific behavior; (2) protect an individual from self harm or injury to others, 3) may include the use of physical isolation, mechanical and physical restraint; 4) may also includes the use of chemical restraints and restrictive procedures, such as escorts response cost, over-correction, restitution, and other similar techniques. Escort techniques, such as, 'guide along,' that apply little or no resistance from the individual, are exempt.
- **Mechanical Restraint:** Any apparatus used to restrict individual movement. This includes 1) any device (e.g. helmets, mitts, and bedrails) used to prevent self-injury; 2) mechanical supports designed by a physical therapist and approved by a physician that are used to achieve proper body position or balance; 3) protective devices that are approved by a physician for specified medical conditions (e.g. helmet used to protect an individual from injury due to a fall caused by a seizure); and 4) mechanical devices that can be removed by the individual at their choosing (e.g., helmets, mitts).
- **Physical Restraint:** Any physical hold used to restrict individual movement or to protect an individual from harming him- or herself or others. Physical interventions that are met with little or no resistance from the individual, such as, 'guide along techniques' or holds used as guidance to teach an individual a skill e.g. hand over hand techniques, are excluded.

Behavioral Treatments (BSP)

Specific

Individualized

Respectful

Typical Program Structure

- **A Behavioral Support Plan Should Include:** 1) Author/Date written or revised; 2) **A Brief Clinical Synopsis**: who the Individual is; history of placements, hospitalizations, incarcerations, substantiated abuse or neglect, medical or psychiatric treatment, and effective behavioral management strategies, and the current situation;
- **Target Behaviors (TBs)**: they need to include both positive (+) and negative (-) TBs; these TBs should be **individual-centered, realistic and measureable**. Avoid an excessive amount of behaviors that are low in frequency and confusing by definition;
- **Proactive Components**: a behavioral strategy should be set within an individual's intellectual abilities in areas of communication, social skills and ADL skill training.
- **Reactive Components**: Specified restraints and aversive procedures (as listed on PRC face sheet and informed consents). Including those for other housemates but affect this consumer;
- **Data Tracking and Data Interpretation**: Include monthly data, in graphics or table chart; Present a **written interpretation of the data by the behaviorist** who authors the Behavioral Support Plan.

Positive Components

- Positive Behavioral Components
- Teaching alternative, positive behaviors and replace maladaptive or aggressive behaviors.
- Communication
- Incompatible behaviors (busy, productive hands; relaxation techniques).
- Remediation for identified skill deficits
- Preparation for more independent, community based living/interaction.

Aversives

- Experienced as negative or punitive by the individual; negative reinforcement.
- Restrictions of personal freedom (door alarms, restriction to house); loss of earned privileges/rewards; invasion of personal space (room/person searches; line of sight supervision).
- Time out (from positive reinforcement)
- Other Traits: specified time, escorted there, staff remain or block exit, directed back to room. The alternative: instruction in voluntary relaxation or quiet time techniques.

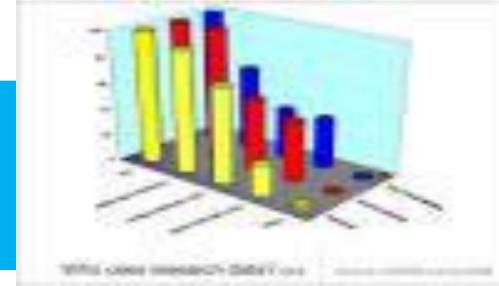
Restraints

- Specify restraint procedures, such as, PMT, SUPPORT, PROACT, CPI, etc.)
- Specify the type of restraints used (should be consistent with what is listed on the PRC face sheet and informed consent and in the BSP), e.g., Lower Figure Four, Supine Floor Control. It does not need informed consent or PRC Review if only “least restrictive PMT” is described.
- Indicate if it is “Planned” procedure as part of the BSP vs. “Emergency” procedure, as it impacts the frequency of PRC review.
- Specify the “Exit” and “Discontinuation” criteria .
- Include “Duration (mechanical/floor control/time out),” and “Frequency” (for all restraints) data

Data

- Mandated by DDS policy;
- Data of monthly average are considered the appropriate data interval, considering the once every 3-year review frequency;
- Data should track the target behaviors listed on the BSP and reflect the symptoms of the psychiatric diagnoses and corresponding psychotropic medications and/or restrictive and aversive procedures.
- Behavioral data must be included in the PRC packet, which is due 2 weeks prior to the scheduled PRC review date. An incomplete packet will not be scheduled for review; a late packet will be scheduled on a future PRC date.

Tables/Graphs



Requirements for Data Presentation:

- 1) Data are presented in the forms of tables and graphics;
- 2) Target behaviors (TBs) must be based on a functional behavioral analysis; they should be measurable, relevant to the person/context, and consistent with the psychiatric diagnoses and day-to-day difficulties the person presents. TBs should have a baseline measure for comparison purpose in order to determine the BSP's efficacy;
- 3) Data should be ***interpreted in a clinical summary***, in the BSP's data section, to address what part of the BSP works and what does not within the measured time period. This should be an integral part of the BSP required for any PRC packet. ***Data without interpretation is incomplete work and frequently reflects an inadequate understanding or application of the BSP in the individual's service.***

Forensic Issues

“Forensic: a term used in the courts of justice” (Black’s Law Dictionary)

Criminal Justice System is comprised of:

- a superior court in each geographic area across the state; each court is presided by a judge, and there are prosecutors or “state’s attorneys” and defense counsels, or “private or public defenders;”
- There are social workers, whereas applicable, work within a Public Defender)Office;
- Various State Agencies, such as, Department of Mental Health & Addiction Services (DMHAS), Department of Children and Families (DCF) and DDS, may be involved; so is the Department of Correction (DOC) if an accused person is not released from the State custody, while his/her legal proceedings are pending;
- After disposition of the case, the DOC, Office of Probation, or Parole Board may be involved with the person depending on the sentence he/she receives.

For DDS, “forensics” or “forensic service” refers to the Department’s ***interactions with the criminal justice system and risk management procedures*** for those who are intellectually disabled yet are or were involved in the court system. **DDS’s forensic system is comprised of:**

- 3 Regional Forensic Liaisons (they are the 3 Regions’ Director of Clinical Services);
- 3 Regional Forensic Committees (West Region Forensic Committee meets on 2nd Thursday afternoon of each month, in Cheshire Regional Center, from 1:00pm to 2:40pm);
- Statewide Forensic Committee (Meet once every other month to reviews significant forensic cases and policy related discussions).

- Conn. Gen. §54-56d (i.e., **Competency to Stand Trial Evaluation and Restoration**): This statute sets out to be the **only legal obligation** that DDS has in criminal court proceedings. DDS has **no other legal obligation** to the Court. The court’s authority over DDS is limited to competency restoration and evaluation of the person, who is, or is perceived as, “intellectually disabled (ID),” regardless he/she is a DDS consumer.
- Connecticut law creates no exceptions or special treatment for an ID defendants. Competency under this statute is limited to whether the defendant is able to understand the proceedings against him or assist in his own defense. The statute presumes competency unless proven otherwise by preponderance of the evidence. **Competency in other areas regarding a plenary guardian or conservator of the person is not relevant for this particular** inquiry. Competency matter may be raised by any party of a court, i.e., the prosecutor, the defense attorney, or the Court itself. A competency examination of a defendant is ordered by a judge.
- An Office of Forensic Evaluation (OFE) team evaluates a defendant, and, if the defendant is found not meeting the competent standards, the OFE must determine whether restoration to competency is substantially probable.

- Once an OFE presents its opinion to court, the Court can make one of several findings. It may include: “Not Competent but Restorable” and order a course of restoration training (usually a 90-day period) with DMHAS, DCF or DDS;
- Or **54-56 (d), sub (m)**, also known as, “Not Competent and Not Restorable,” and release the defendant to be placed under the custody of the Commissioner of DMHAS, DCF or DDS, for the purposes of applying for a civil commitment. In this situation, DDS has that the person in its care and custody from the moment the order is issued and the risk management aspect of the care will be reviewed by the Regional Forensic Committee periodically as part of the DDS service to this individual.
- After the Court places a sub (m) order, DDS must, within a reasonable time, file in the appropriate probate court an application for a petition of **Involuntary Placement**.
- While the Department’s obligation to the Court is limited to the provisions of §54-56d (Competency to Stand Trial), the Department may have some obligation *to the person arrested*, depending on *our legal relationship* to that person.



human rights

Human Rights (HRC)

- Human rights of individuals served by DDS
- Purpose of Human Rights Committee (HRC)
- HRC membership
- What requires review



human rights

Human Rights (HRC)

- HRC process
 - Request review (DDS Manual, I.F. PO.006)
 - Submit packet (content)
 - **Request for Review, consent**, BSP, data, medical notes, 255s, etc.
 - Behavioral -vs- Medical need
 - Scheduling
 - Presentation types
 - Outcomes
 - Timelines
 - Renewals



human rights

Human Rights (HRC)

- Expectations
 - Presenter
 - BSP (person first language, respect for individual's strengths, Positive Behavioral Supports, functional assessment, fading plans, summarized data)
- Implementation prior to HRC review
 - **Full team agreement** that restriction is necessary for the individual's health and safety
 - Does not cover video monitors, restitution, etc.
 - Submit packet immediately
 - Be prepared to present data on effectiveness since implementation
- HRC versus PRC

Final thought ...

“Some values must be **universal**, like **human rights** and the **equal worth of every human being.**”

Bjorn Ulvaeus

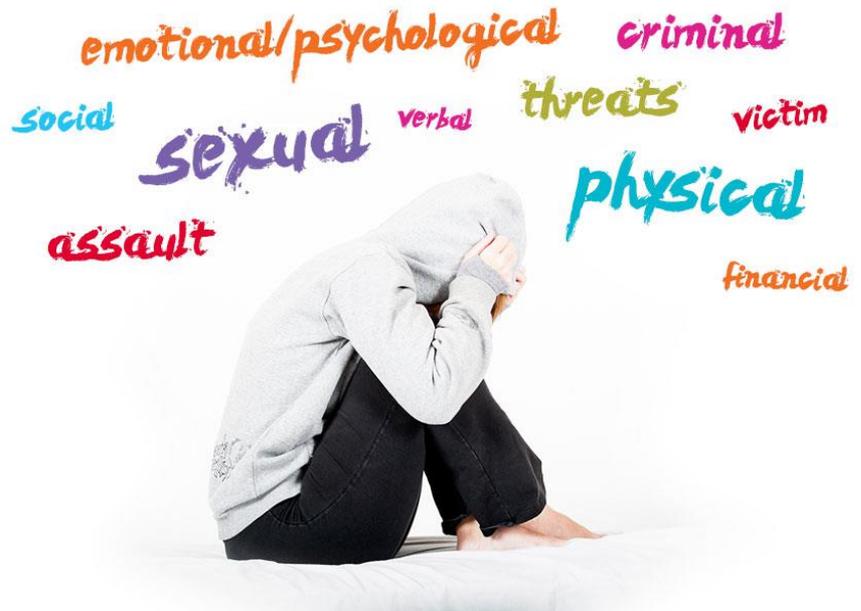


ABUSE and NEGLECT



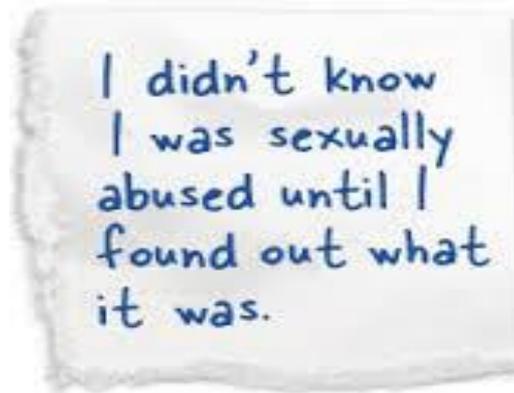
Types of Abuse/Neglect

- Abuse
- Neglect
- Verbal Abuse
- Psychological Abuse
- Financial Exploitation
- Sexual Abuse
- Programmatic Neglect



Definitions

- DDS definitions (hand out)
 - Not universal (police, DDS, DCF, DSS, etc.)
 - Involve caregivers (if alleged perpetrator is not a caregiver, DDS does not have jurisdiction)



Words can
hurt more
than you **think**
they can



If you suspect Abuse/Neglect

- If you witness or suspect abuse or neglect, you **MUST**:

1. Stop it!



Intervene and protect the victim

2. Report it!



Reporting

WHY?

- Mandated reporters (timeline and follow-up (no messages))
 - Agencies cannot filter allegations
 - Reporters must follow up (no messages)

when

- Suspicion threshold (reasonable cause to suspect abuse/neglect)
- Timely reporting

WHO?

- Authorized agencies

Reporting agencies

- Office of Protection & Advocacy for Persons with Disabilities (OPA or P&A)
- Department of Children & Families (DCF)
- Department of Social Services (DSS)
- Department of Developmental Services (DDS)
- Department of Public Health (DPH)
- Police

Age Range:

OPA: 18 - 59

DCF: 17 and under

DSS: 60 and over

Anything OPA doesn't take!

OPA DNTs:

* Verbal

* Psychological

* Financial

Report to A/N Liaison

Official Notification

- Agency responsibilities related to an allegation or investigation
 - Confirm receipt of intake
 - AP off duty
 - Assign and have a DDS Trained investigator complete investigation
 - Make and fulfill recommendations to prevent future instances
 - Do not share copies of investigation
 - Maintain a secure copy in agency file
- Other
 - Injuries of unknown origin
 - Administrative versus abuse/neglect
 - Sleeping on duty, med errors, non-ingested food consistency violations



Investigation

- DDS Investigator training
- Conflict of Interest
- Investigation timelines
- Submitting investigations
- Follow-up



Prevention of Abuse and Neglect

- Leadership
- Expectations/High standards
- Training & Monitoring
- Quality Behavior Support Plans
- Clear documentation
- In-tune with staff
- Consumer needs being met
- Financial checks and balances



A final thought...

Once you lose respect for a person, it is only a matter of time before the abuse/neglect starts.



By watching for respect, we can become part of the solution!

RESOURCE ADMINISTRATION

CONTINUITY OF OPERATIONS PLAN

PROVIDER PROFILES

PERFORMANCE AND FISCAL REVIEWS

WEB PAGE REVIEW

PORTABILITY

TRANSITION TO LON BASED RATES

Continuity of Operations Plan (COOP)

- Continuity of Operations Plan
- Instructions for the Development of the COOP can be found on the DDS Web page on the right under Emergency and Safety Information – Pandemic Flu Planning
- Plans should include the following information (see checklist on DDS Website)
- Emergency Fact Sheets must be on file in each person's residence and day (see form on DDS Website)

Provider Profiles

- Profiles can be found on DDS web page.
- A profile is completed and added to the list when agency/individual becomes a qualified provider.
- You can search for profiles by name or town.
- Currently, every qualified provider is on this listing. There is a separate list for individual practitioners.
- Corrections/Updates - Email the Provider Profile Correction Form to DDS.Provider.Profiles@ct.gov (For example: contact name or email address changes for the agency).

Identified agency contact person(s) will receive all information from DDS and is responsible for inter-agency distribution. An agency can have up to two contact people as well as a CFO contact (CFO is not listed on profile, but stored in a database in order to receive financial reports from DDS).

Performance and Fiscal Reviews

- DDS will hold 2 meetings with providers each year – a Performance/Quality Meeting and a Fiscal Meeting.
- An invitation is sent by e-mail with the date and time of your meeting.
- Fiscal meetings will be held in May & June each year. Meetings will be held in the Prime Region with participation from other regions as appropriate. The focus of these meetings is fiscal issues, participant lists, FI issues , etc.
- Quality Review Meetings are staggered throughout the year with the exception of May, June & July. They are held in the Prime Region with participation from other regions as appropriate.
- The focus of the Quality Review meeting is on a review of QI data and the Continuous Improvement Plan. This meeting will result in a recommendation for agency certification.
- QI data is forwarded to providers prior to the meeting for their review and analysis. They should look at trends and issues and incorporate these into the Continuous Improvement Plan.
- We will discuss the Continuous Improvement Plan in a little more detail later in the program.

Web Page Review

DDS Web Site www.ct.gov/dds

The Provider Gateway link (located on the left side of the page) contains the following:



Web Page Review - Continued

- Provider Gateway – **Topics A-Z – Forms** - Quality Improvement Services
 - Continuous Improvement Plan
 - Agency Self – Assessment
- Provider Gateway **Forms A-Z** and **Resources** should contain all information a provider needs to do business with the State of Connecticut. Contact your Provider Specialist if you have questions.
- On the DDS Website – **Other Resources – Policies & Procedures** – link to DDS Manual

Portability

- If the person isn't happy with supports, they can choose to change them.
- Portability Policy defines the process to be followed when an individual desires/needs a change in support plans which includes a change in provider.
- Procedure applies to all individuals who are funded by DDS
- Agency is given notification that individual is leaving program with date.
- Policy applies to home and work/day supports

"It isn't where you came from, it's where you're going that counts."

[Fitzgerald, Ella](#) Singer (1918-1996)



Transition to Level of Need (LON) Based Rates

- Day Services began a 7 ½ year transition to LON based rates on 1/1/12.
- Providers developed day transition plans in conjunction with the teams and perspective regions to successfully transition by June 30, 2019.
- IHS rate transition began 7/1/13.
- CLA and CRS transition began 1/1/15
- Providers will develop a residential transition plan in conjunction with the teams and perspective regions to successfully transition by June 30, 2022.

BREAK

10 MINUTES



coffee break

QUALITY IMPROVEMENT

Continuous Quality Improvement Plans

Enhanced Monitoring

Continuous Quality Improvement Plans (CQIP)

- This is a document for a provider to use to identify strengths, challenges to providing quality services & supports, and themes/trends that are priorities to be address.
- This information should come from the agency self assessment, data provided at the semi-annual Quality Review, agency own tracking and data.
- This is a dynamic document. It should be continuously changing as goals are met and new ones added. The focus of the goals should be around quality outcomes for the individuals you support.
- Regional staff may make goal recommendations based on data review and/or feedback on performance.
- Web page provides hints to develop an effective Continuous Quality Improvement Plan. You can also find the form and the Self Assessment tool on the DDS Website: Provider Gateway – Resources – Quality Improvement Services
- The provider agency can use any format as long as the following items are included: goal, action, task, person responsible and timeframe.
- Day providers must include an employment goal.

Enhanced Monitoring

- This procedure addresses issues with a provider who is not complying with DDS regulations, policies, procedures etc. and this is having a negative impact on supports and services to consumers.
- An initial meeting is held with the region to outline the issues. The Board of Directors is notified of this meeting and a representative is required to attend.
- In this meeting expected outcomes and timeframes are defined.
- Follow up meetings are held to determine that issue have been addressed and resolved.
- Other actions that may be taken:
 - Suspend new admissions specific program/regional/statewide
 - Suspend expansion
 - Remove as qualified provider
 - Terminate contract

HEALTH AND WELLNESS

MEDICATION ADMINISTRATION CERTIFICATION

DNR

NURSING POLICIES/PROCEDURES/DIRECTIVES

NURSING MEETINGS

Medication Administration

- **Medication Administration** is an R.N. delegated task.
- Med cards require a recertification test every 2 years. Checklist A&B must be done within 90 days prior to the expiration date listed on the Medication card. Annual pass and pour must be done within 4 weeks before or after the staff's anniversary date on their medication card.
- **Contact** - Jackson Pierre-Louis (203-294-5001) the statewide contact at Central Office for courses and curriculum.
- **Revocation Requests** - Send to Regional Health Services Director

End of Life Issues and Information

- **DNR**
 - For all contemplated Do Not Resuscitate (DNR)'s contact Case Manager Or Nurse Consultant – who in turn will notify the Director of Health Services.
- **Death**
 - When a death occurs during regular business hours notify the Case Manager , Nurse Consultant and/or Director of Health Services as soon as possible. Further notifications need to occur based on this notification. When a death occurs after business hours, weekends and holidays – notify the Manager On Call for appropriate region.
- **Mortality Review**
 - When a case is being reviewed all documents will be collected by the Case Manager or Director of Health Services.

Nursing Policies/Procedures/Directives

- **Policy and Procedures**
 - DDS Website, Publications, Manuals, DDS Manuals, I.D. Quality Enhancement, PO.001, PR.001, 002, 003, 005. I.E. Health and Safety, PO.007.
- **Medical Advisories, Health Standards, or Nursing Standards**
 - DDS Website, Supports and Services, Health and Clinical Service – choose either – Medical Advisories and Health Standards or Nursing Standards.
- **RN On Call**
 - CLA and IHS out of family home – must have an on call program in place. RN must be the contact not a manager or LPN.
 - Contact Nurse Consultant with any questions. DDS Web Site under Manuals – Procedure No IE PR 008.
- **Hospitalizations and Psychiatric Hospitalizations**
 - Notify the Case Manager of all hospitalizations and psych hospitalizations.

Private Sector Nursing Meetings

- Held quarterly.
- Contact Regional Nurse Consultant for schedule.

DDS Funding

- Individuals supported by DDS receive funding based on their Level of Need.
- Most individuals independently choose a qualified provider that best meets their needs.
- Sometimes, an individual is unable to find a provider that will meet their needs in an already established setting.
- After the Region has exhausted all available options, DDS will issue a Request for Proposal.

REGIONAL CONTACTS

Provided as separate attachments from this document.

Leadership Forum Meeting Schedule

Provided as a separate attachment from this document.

2016 Provider Orientation Training

- Once a quarter
- Rotates among regions
- Providers must attend a training prior to beginning services/supports
- Schedule for upcoming Provider Orientations:
 - October 28, 2016 North Region
 - January 12, 2017 South Region (snow date to be determined)
 - April 26, 2017 West Region (held in Cheshire)
 - July 14, 2017 North Region
 - October 11, 2017 South Region

QUESTIONS AND EVALUATIONS



PLEASE BE SURE YOU HAVE SIGNED THE
ATTENDANCE SHEET BEFORE LEAVING