DDS EXECUTIVE BRIEFS
An Update on CT DDS Initiatives

December 14, 2010 Issue 35

Nursing Scholar Program

One of the major challenges facing private and public agencies that support individuals with intellectual disabilities has been the ability to recruit and retain professional registered nurses. In response to this issue, the Department of Developmental Services (DDS) has initiated a creative strategy to establish a direct conduit from student nurse to graduate nurse employment within the DDS system. The Department of Developmental Services and the University of Connecticut School of Nursing have established a tuition and loan forgiveness program for UCONN nursing students who are selected as DDS Nursing Scholars and make the commitment to work in nursing positions in the private and public sectors for specified durations.

Two students have been selected as Nursing Scholars and are graduating in December 2010 and have made the commitment to work at least one year in the DDS system. The expectation is they will be ready to assume a nursing position in early January 2011 after receipt of their RN licensure. They will participate in the DDS nursing orientation program and will need a nursing resource person in the agency where they are employed. If you are interested in providing an employment opportunity for one of these graduate nurses, please contact Dory McGrath at 860-418-6083 for more information.

Trained Non-Licensed Personnel

The regulations concerning Administration of Medications were amended to include trained non-licensed personnel. The amendments implement a change in statute to provide a level of quality assurance and protection from any assertion that staff are practicing nursing. Trained non-licensed personnel is defined as any person who (1) is a department-funded, paid employee; (2) is hired by a consumer, the family or guardian of a consumer, or a provider to provide individual and family support services; (3) has successfully completed training required by the department, and (4) has been approved to administer medication to consumers in their own home, family home or specialized day services. Trained non-licensed personnel will be administering medication primarily to consumers who reside with their families. The intent of this regulatory change was to recognize the role parents or other family members have in the oversight and supervision of staff in their homes that dispense medications in lieu of the family member. In some instances, consumers residing in their own homes with direct oversight by their family can utilize trained non-licensed personnel for medication administration. These situations will be reviewed on a case by case basis by the Department of Developmental Services (DDS) Medication Administration Unit. This change is not intended to impact the current requirement for certification for provider staff who are hired to provide support to individuals living on their own and receiving Individualized Home Supports. The trained non-licensed personnel will receive specific information and oversight on the administration of an individual's medication(s) from the family on an ongoing basis. The Case Manager will be the liaison between the family and the DDS Medication Administration Unit in requesting information concerning the trained status of staff hired by the family.

DDS will offer training for medication administration at various times and locations throughout the state. The length of the DDS course for trained non-licensed staff will be 12 hours and covered over two days. Curriculum includes instruction in medical terminology, drug classification, safe techniques of medication administration and demonstration of skills related to medication administration. Information specific to the consumer's medication(s) such as dosage, route, frequency, side effects, and interactions would be supplied by the family. Training for trained non-licensed staff is expected to begin in early 2011.

Advance Planning Document Update

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Overview

With permission from The Office of Policy and Management (OPM), DDS has begun the development of an Advance Planning Document (APD) for submission to the Centers for Medicaid and Medicare Services (CMS). Within the current DDS IT system architecture, this APD will outline development and/or modification of various DDS application modules and application interfaces resulting in an overall integrated data system to manage information critically associated with DDS's operation of its two current and one planned HCBS Waivers. The APD project will also be referred to as the *DDS Application Integration Project* (AIP).

The State of CT, through the approved DDS APD, will be eligible to receive up to 90% Federal reimbursement for IT development (equipment and personnel) costs associated with this project, 75% Federal reimbursement for ongoing IT maintenance and 50% Federal reimbursement for administration of the department's modernized IT system.

The APD process is lengthy and requires submission of both a Planning APD (PAPD) and an Implementation APD (IAPD). In the APD, DDS must describe the desired overall integrated IT system, the various application modules to be included, the underlying technical architecture they will operate within, the integration points among the various application modules, the interface with DDS private providers, consumers and their families, and other external data bases such as DSS. Associated costs for this project must be included in both the PAPD and IAPD. If the department's PAPD and IAPD are approved by CMS, DDS will move forward to secure OPM approval to develop an RFP to secure the services of a Technical Vendor to implement the proposed comprehensive DDS IT solution.

Status

DDS has brought Beth McArthur back as a retiree to assist with this project until the end of December 2010. Tim Deschenes-Desmond is the department's lead staff on the project. The department is hiring a technical project manager with APD experience to continue to support the project through its completion. The APD application process is expected to take about a year. Rough time line estimates are for IAPD submission to CMS in July 2011, followed by Technical Vendor RFP development and approval, selection process and contract negotiation to be completed by December 2011. Application development is estimated to begin no earlier than January 2012 and continue for approximately two years based on the scope of applications to be developed or modified and available resources. The department has established an APD Steering Committee to oversee the project and will be working with various user groups and the provider community to obtain their input and address their needs in the design of the Application Integration Project. As we get closer to detailing the features of individual application modules in the IAPD phase, we will be seeking input from various business users. Watch for further communications on our progress. For more information contact tim.deschenes-desmond@ct.gov or beth.mcarthur@ct.gov.

Transfer Policy and Procedure

On October 1, 2010, the DDS reissued the transfer policy and procedure. Both conform to Section 17a-210 (b) through (e) of the Connecticut General Statutes and identify the circumstances in which the transfer policy and the procedure must be implemented. Under all circumstances, the department must be notified of the proposed transfer of any individual from a residential facility that is operated, licensed, or funded by the DDS to another such program.

Important elements of the policy and procedure:

- Articulate the due process rights of individuals and their parent, guardian, or legal representative when a transfer is proposed.
- Applicable to any individual who is a consumer of the Department of Developmental Services (DDS) and who resides in a residential facility that is operated, licensed, or funded by DDS.
- Not applicable to an individual transferring from one residential unit to another within the training school or regional center, to a transfer initiated by the planning and support team with the involvement of the individual and guardian, to a transfer initiated by the individual or guardian using portability, or to the admission of an individual to a health care or other facility that is not operated, licensed or funded by DDS.
- Define an emergency transfer as the immediate transfer of an individual from any residential facility to another such program when necessary to avoid a serious and immediate threat to the physical or mental health of such individual or others residing in the residential facility.
- State that in cases other than because of an emergency, written notification from the DDS of the proposed transfer must be sent to the individual and the individual's parent, guardian, conservator, or other legal representative at least 10 days prior to the proposed transfer.
- Outline the due process rights of the individual and the individual's parent, guardian, conservator, or other legal representative to object to a proposed transfer.
- Emphasize that the transfer process requires the qualified provider and DDS to work together to assure that the transfer hearing rights of individuals, when applicable, are observed.

This policy and procedure apply to all qualified providers who support individuals in residential facilities that are operated, licensed or funded by the DDS. If you have any questions, please contact James P. Welsh, Director of DDS Legal and Government Affairs, at 860-418-6059, or your local Regional Director.

The following are the links to the policy, procedure and attachments on the DDS website at www.ct.gov/dds . Please note that Attachment B has been corrected to contain the signature line.

http://www.ct.gov/dds/lib/dds/dds_manual/if_hrc/transfers/ifpo002_transfer_policy.pdf
http://www.ct.gov/dds/lib/dds/dds_manual/if_hrc/transfers/ifpo002pr001_transfer_procedure.pdf

Waiver Assurances

The Centers for Medicare and Medicaid Services (CMS) considers an approved Home and Community Based Services (HCBS) waiver a contract between the state and the federal government. As part of that contract CMS requires that each waiver contain a Quality Improvement Strategy to ensure compliance with the Federal Assurances (Bold) and sub-assurances (Bulleted) listed below.

Level of Care—Persons enrolled in the waiver have needs consistent with an institutional level of care.

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Service Plans—Participants have a service plan that is appropriate to their need and they receive the services/supports specified in the plan.

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provider of waiver services or through other means.
- The state monitors service plan development in accordance with its policies and procedures.
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
- Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Qualified Providers—Waiver service providers are qualified to deliver services/supports.

- The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Health and Welfare—Participants health and welfare are safeguarded and monitored.

- The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

Financial Accountability—Claims for waiver services paid according to state payment methodologies.

- State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Administrative Authority—The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.

- The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Continuous Quality Improvement (CQI) is the foundation of a HCBS QI strategy. It drives the CMS' partnership with states by improving the lives of waiver participants. CQI in waiver programs consists of Design, Discovery, Remediation and Improvement.

States must design a Quality Improvement Strategy that includes Performance Measures for each of the sub-assurances. The Performance Measures must be measurable and stated as a metric. CMS expects states to strive for 100% compliance on each of the Performance Measures. In the discovery portion of the Continuous Quality Improvement cycle states must either review each individual enrolled in the waiver or review a statistically significant sample of waiver participants (for each of the DDS waivers the sample size is approximately 400 randomly selected individuals). When review of the available data shows less than 100% compliance for a Performance Measure CMS requires remediation of each of the instances where the requirement is not met. For example, if the data shows that 300 individuals on the IFS waiver did not have an IP developed within one year of the previous plan we must ensure that new plans were developed for those individuals and indicate what the timeframes for plan development were (within 30 days, 60 days, etc.). In addition to proving remediation at the individual level we must develop a plan for improvement to prevent future occurrences of late plan development. The overall Quality Improvement Strategy must include the following:

- Process to trend and analyze discovery and remediation information.
- Process to prioritize and implement system design changes.
- Process to monitor and analyze the results of system design changes.

DDS is using data from a variety of sources including Quality Service Review (QSR), eCAMRIS, Waiver applications, abuse and neglect investigations, mortality reviews, and billing reports to measure compliance with the sub-assurances.

CMS conducts an audit of each waiver approximately two years prior to its expiration. The DDS IFS waiver will be audited this spring and the Comprehensive waiver will be audited in the fall. Review of existing data related to the federal assurances and sub-assurances shows a number of areas where remediation and improvement strategies are necessary. The areas with the lowest percentage of compliance are timely development of the individual plan, lack of assessments and individual plans at the program site, and lack of documentation regarding required staff trainings. In order to demonstrate compliance with the federal assurances and sub-assurances agencies must ensure that assessments, individual plans, and required documentation are available at the program site and that program staff have had required trainings and are knowledgeable about each individual's risk areas and program goals.

The department has formed a statewide committee comprised of regional and central office staff that will review data related to the Performance Measures in the waivers and makes recommendations for systems improvements. Thus far, review of the data has resulted in revision of the interpretive guidelines for the QSR indicators and development of a number of resources for case managers related to completion of the IP document and conducting Quality Service Reviews.

Update Individual Plan (IP) Training Tool

Focusing on IP Improvement

Attached you will find two links for an IP Training Document. This is not a new IP form. This document is a training tool for DDS Case Managers and Private Provider staffs that currently complete the IP. DDS continues to review this training tool with case managers, quality monitors and resource managers.

We ask you to use this tool for IP refresher training with your staff in an effort to improve the quality of the IP. We know this tool alone will not improve the contents of the IP. Over the next month we will also be posting a power point presentation with audio.

The attached training tool replaces the power point that was on the DDS website.

For those providers that use the College of Direct Supports there is a person center planning section that we encourage your agencies to use in training staff.

http://www.ct.gov/dds/cwp/view.asp?a=2042&q=391144 Link to DDS page with IP Training Documents in PDF and Word
http://www.ct.gov/dds/lib/dds/family/ip_training_document.pdf Link to PDF document.

If you have any questions about the New Training tool please contact siobhan.morgan@ct.gov.

Record Retention

There has been some confusion regarding record retention requirements. Section 17-313b-14 requires organizations to maintain business records and records pertaining to the provision of service for 10 years. This provision ensures that records are available to DDS and DSS. The current Purchase of Service Contract follows the regulations and requires records to be maintained for 10 years. The rate setting regulations where the requirement is delineated are not being revised at this time. When revisions to those regulations are initiated this area will be reviewed to for a possible reduction in the number of years.

For funded services not subject to the regulations or the contract, the requirement is six years as stated in the waiver manual.