Understanding PROMISE

- **Another Great DSAMH Production**

PROMISE Agenda

- What is PROMISE and why?
- The ADA and the Olmstead Act
- Goals of PROMISE?
- How is PROMISE expected to work?
- How does one qualify?
- How is success determined?

PROMISE

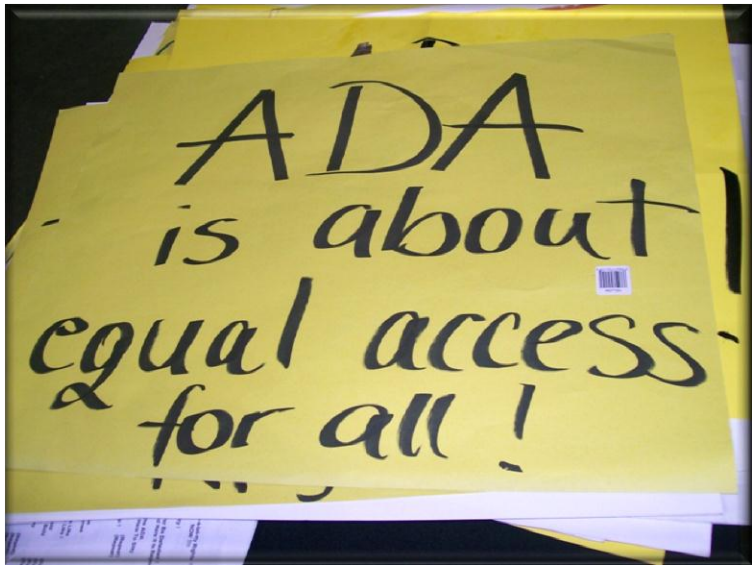
*What does **PROMISE** stand for?*

Promoting Optimal Mental Health for Individuals through Supports and Empowerment

OVERVIEW OF THE AMERICANS WITH DISABILITIES ACT (ADA)

Signed in 1990, the ADA bans discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities.

Source US Department of Labor



OVERVIEW: THE OLMSTEAD DECISION

In 1999, the Supreme Court held that under the Americans with Disabilities Act people with mental disabilities have the right to live in the community rather than in institutions if, "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the individual, and the placement can be reasonably accommodated."

ADA.gov

Why PROMISE?

- **On July 15, 2011, The United States Justice Department and the State of Delaware agreed that people living with Severe and Persistent Mental Illnesses should not be kept in institutions and should live in the least restrictive environment.**

Delaware.gov DSAMH website

Why PROMISE?

Therefore, the State of Delaware and CMS (the Centers for Medicare and Medicaid Services) have entered into a partnership that leverages State funding for services for this target population's transition and support in the community as per the DOJ settlement.

THE GOALS OF PROMISE VIA THE DOJ SETTLEMENT AGREEMENT

- ☑Creating a community crisis system- DONE!
- ☑Creating statewide access to assertive community treatment teams (ACT), intensive case management teams (ICM), and specially trained care management teams to serve the needs of the individual in the community as expected via the DOJ settlement: – DONE!
- ☑Provision of housing vouchers and subsidies;- DONE! (however, DSAMH does not fund the service, DSAMH only monitor's it. PROMISE is not a housing program) and
- ☑Development of supported employment, rehabilitation services, substance use disorder treatment, educational services, and family and peer support services: - DONE!

Delaware.gov DSAMH website

Eligibility Is determined by the DSAMH Eligibility and Enrollment Unit where qualifying individuals need to be:

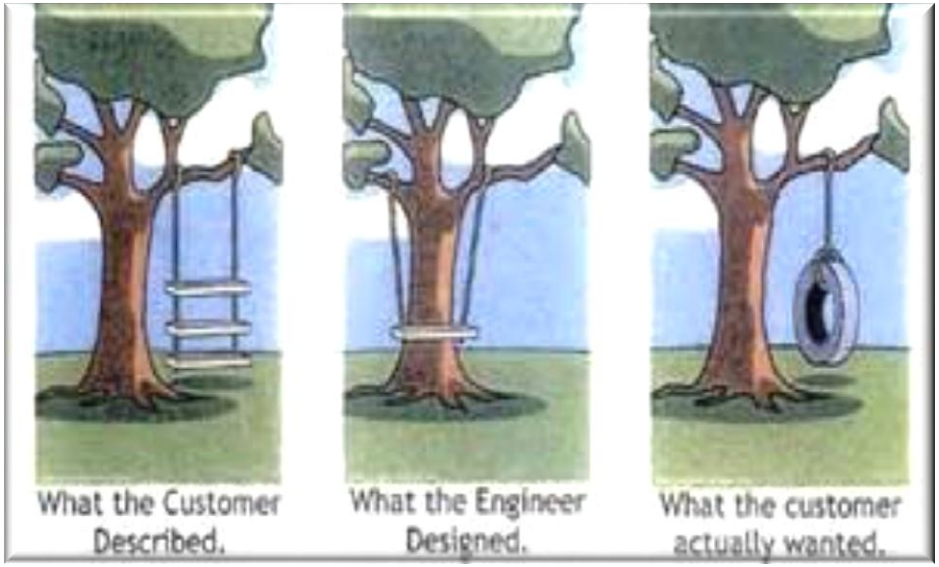
- Over the age of 18 year;
- Have a qualifying Behavioral Health diagnosis;
- Meet needs-based criteria: either a **moderate** or **severe** functioning level on the Delaware-specific *American Society for Addiction Medicine* assessment tool that evaluates both mental health and Substance Use Disorder (SUD) conditions. It is the gatekeeper to determine who needs and qualifies for a PROMISE service(s).

MEDICAID AND MCO'S

Also as part of the DOJ settlement Qualifying Medicaid MCO recipients in an ACT team can also participate in the PROMISE program.

The PROMISE program is based on the 1115 Demonstration Amendment waiver, which allows for the provision of the wide range of services (that we will discuss later) and functions as the mechanism that will allow those services for qualifying beneficiaries to bill Medicaid.

WHAT ABOUT PEOPLE ALREADY RECEIVING SERVICES?



The PROMISE program might be able to enhance and/or offer new and unique services specially tailored for the needs of the individual currently receiving services.

THE PROCESS- AN IMAGINARY WALK TO GET PROMISE SERVICES

- ✓ **Person arrives (possibility in crisis)**
- ✓ **Hospital provides a psychiatric evaluation/psychosocial assessment, and is stabilized in the hospital**
- ✓ **If the person is eligible for Medicaid and is living with SPMI, the person might be eligible to participate in the PROMISE program**
- ✓ **The individual or representative calls the Eligibility and Enrollment Unit (EEU)**
- ✓ **The EEU requests the psychiatric and psychosocial evaluations and conducts a brief screen for the individual; then preliminarily approves and refers person to the appropriate assessment center**
- ✓ **The assessment center reads the packet and contacts the Care manager (CM).**
- ✓ **The CM obtains copies of psychosocial and psychiatric evaluation and begin to work with the person and their natural supports to promote their self-directed recovery plan.**
- ✓ **CM makes recommendations based on the person's wants and needs to the EEU and fiscal for approval and assigning to a provider**

CARE MANAGERS…

All PROMISE beneficiaries will receive DSAMH care management.

DSAMH PROMISE CARE MANAGERS

Are responsible for:

1.The ongoing monitoring of the provision of services included in the beneficiary's Recovery Plan and/or beneficiary's health and welfare.

2. Initiating the process to evaluate and/or reevaluate the beneficiary's level of care/needs-based eligibility and/or development of Recovery Plans.

CARE MANAGERS…

3. Work with the beneficiary to identify barriers to individual goals, include services, natural supports and community resources across episodes of care ensuring.

4. Will ensure that the four functions of care management occur:

    1. Assessment
    2. Recovery Plan development
    3. Facilitating access
    4. Referral to needed services and monitoring of services.

HOW PROMISE WORKS PART I

The PROMISE (DSAMH) Care Manager (C.M.)

1. The **PROMISE** C.M. Authorizes the PROMISE programs and monitors it's Services for the person

The Person

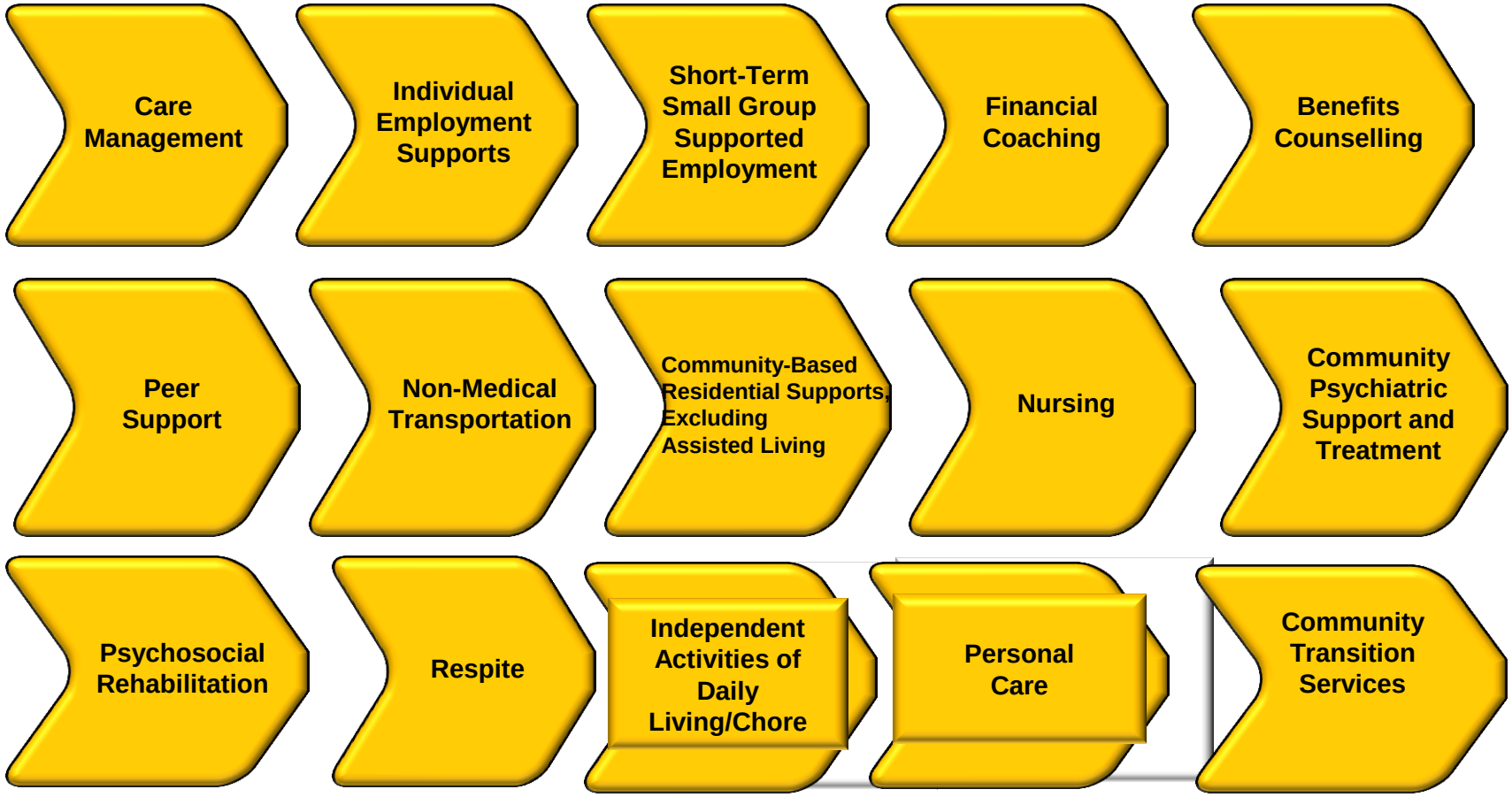
2. The **PROMISE** C.M. works with the Provider's the Person and their chosen people and natural supports to create his/her pre-planning inventory that will result in their -Person - Directed Recovery Plan.

3. The **PROMISE** care manager will also monitor the services chosen by the person so s/he can successfully live in the community

PROMISE — SERVICES AND SUPPORTS

***PROMISE* will offer individually-tailored, community-based, and recovery-oriented services to help people live independently in the community. Participants will choose services based on their unique –medically necessary and approved needs.**

PROMISE is not a one size fit all program:



PROMISE — SERVICES AND SUPPORTS (CONT'D)

Care Management

Assists beneficiaries in accessing PROMISE services.

Provides for the ongoing monitoring of the services included in the beneficiary's Recovery Plan and the person's health and welfare.

For Medicaid beneficiaries the CM will inform the MCO about the Promise recipients care plan

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Individual Employment Supports

One-on-one supports to obtain and maintain an individual job in competitive minimum wage or customized employment, or self-employment in an integrated work setting as part of the general workforce.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Short-Term Small Group Supported Employment

Short-term services and training activities provided in regular business, industry, and community settings for groups of two to four workers with disabilities.

Provides support to gain skills to enable transition to integrated,- in-line with the preferences of the group to eventually gain competitive employment.

Emphasizes the importance of a rapid job search for a competitive job and provides work experiences to develop strengths and skills.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Financial Coaching

Builds upon the success of the $tand By Me program in Delaware.

Provides a personal financial coach and a toolkit to navigate the challenges leading to personal financial security.

Goal is to increase clients' understanding and ability to manage their finances to increase their future financial stability and economic opportunities.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Benefits Counseling

Benefits counseling provides work incentive counseling services to *PROMISE* participants seeking to improve their economic self-sufficiency and maintain access to necessary healthcare and other benefits.

Will assist individuals to understand the work incentives and support programs available and the impact of work activity on those benefits.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

A peer/recovery coach uses lived experience with a mental illness or substance use disorder SUD to assist and support beneficiaries in their recovery journey.

Beneficiary-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms, while enabling the use of natural resources and the enhancement of recovery-oriented attitudes, such as hope, self-advocacy, and community living skills.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Enables qualifying participants to access employment services, activities, and resources and is offered in addition to medical transportation under the State Plan,

Available only when the beneficiary has no other transportation options available.

Non-Medical Transportation

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Community-Based Residential Supports, Excluding Assisted Living

Provide supportive - health-related residential services in State licensed settings.

Residential services are needed, per the Recovery Plan, to enable the beneficiary to remain integrated, healthy, and safe in the community.

Include personal care and supportive services (homemaker, chore, attendant services, and meal preparation).

Include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable beneficiary supervision needs to ensure safety.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Nursing

Services necessary, per the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure the health, welfare, and safety of the person.

To be utilized in the beneficiary's home and community rather than in a provider-owned setting.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Community Psychiatric Support and Treatment

Goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the beneficiary's Recovery Plan.

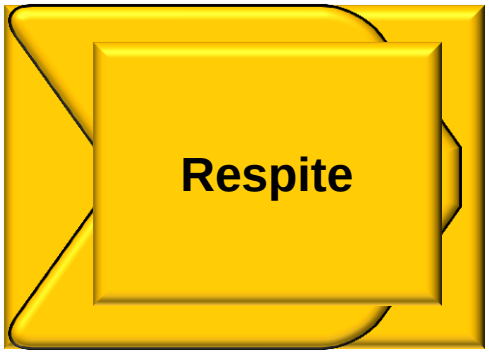
Assists the person to identify strategies or treatment options associated with his/her mental health and/or SUD needs, with the goal of minimizing the negative effects of symptoms or emotional disturbances or associated environmental stressors; which interfere with the beneficiary's daily living, financial management, housing, academic, and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Psychosocial Rehabilitation

- **Restores the beneficiary to fullest possible integration as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.**
- **Face-to-face intervention with the beneficiary present.**
- **Restoration, rehabilitation, and support with the development of daily living skills to improve self management of negative effects of psychiatric or emotional symptoms that interfere with a person's daily living.**
- **Supports development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.**

PROMISE — SERVICES AND SUPPORTS (CONT'D)



Provided to beneficiaries unable to care for themselves and is furnished on a short-term basis because of the absence, or need for relief, those persons who normally provide supportive care.

May be provided in an emergency to prevent hospitalization.

Provides planned or emergency short-term relief to a beneficiary's unpaid caregiver or principle caregiver who is unavailable to provide support.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Services are delivered to beneficiaries that reside in a private home and are necessary, per the POC, to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.

Independent Activities of Daily Living/Chore

Consists of general household tasks such as meal preparation, cleaning, laundry, and other routine household care or heavy household chore services such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy furniture in order to provide safe access and egress; removing ice, snow, and/or leaves; and yard maintenance.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Personal Care

Assistance with activities of daily living (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating, and assisting with mobility).

Primarily provides hands-on care to beneficiaries that reside in a private home and that are necessary, per the Recovery Plan, to enable the beneficiary to integrate more fully into the community and ensure health, welfare, safety.

PROMISE — SERVICES AND SUPPORTS (CONT'D)

Non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement where the person has a lease or is in a private residence.

Necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits;
- essential household furnishings and moving expense;
- set-up fees or deposits for utility or service access;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning;
- moving expenses;
- necessary home accessibility adaptations; and,
- activities to assess need, arrange for and procure needed resources.

PROMISE — PERSON-CENTERED PLANNING

There is no one size fits all service plan.

Individuals in *PROMISE* will have the key voice, with support as needed, in directing planning and service delivery, and will indicate who they want to be involved.

The person-centered planning process itself will:

- Be timely and occur at times and locations of convenience to the individual;
- Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants;
- Offer choices to the individual regarding the services and supports they receive and from whom; and
- Include a method for the individual to request updates to the plan.

Success will be measured against individual goals for recovery related to independent living and working in the community.

Measuring Promise's Success

Is Accomplished by the individual

- The individual determines if he or she is achieving their goals. They inform their care manager if they are succeeding in increasing their social integration, and self-determination in all of their life domains such as: community living, employment, education, recreation, health care, and relationship building…PROMISE.

Member Rights and Protections

- Another Great DSAMH Production

GOAL

To identify and provide a clear understanding of Members Rights and Protections

OBJECTIONS:

To identify DSAMH mission statement and its dedication to protect consumer rights and to protect against abuses.

Define some common abuses and the importance of protection against exploitation

Provide an overview of the ADA and its protections of this special population

PREVENTING ABUSE AND NEGLECT DEFINITIONS:

Neglect: **failing to provide a needed care: attention, food, clothing, supervision etc…**

Physical Abuse: **intentional physical act by a staff or other which causes or may cause physical injury to a person.**

Psychological Abuse: **Acts other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean a person.**

Sexual Abuse: **any acts or attempted acts such as rapes, incest, sexual molestation, exploitation, or sexual harassment and inappropriate or unwanted touching.**

Verbal Abuse: **Verbalizations, which inflict or may inflict emotional harm, invoke fear and/or humiliation, intimidation and degrading or demeaning a person.**

Financial Exploitation: **is the illegal or improper use of another individual's resources for personal profit or gain**

VERBAL ABUSE

The use of oral, written or gestured language that willfully includes disparaging and offensive terms to individuals served (or their families), within hearing distance, regardless of their age, ability to comprehend, or disability.

Examples- but are not limited to: threats of harm; saying things to frighten an individual, etc.

SEXUAL ABUSE

Includes, but is not limited to: sexual harassment, sexual coercion, or sexual assault such as rape, sexual molestation, sexual exploitation or sexual harassment or inappropriate or unwanted touching of an individual by another.

PHYSICAL ABUSE

Includes, but is not limited to, hitting, slapping, pinching and kicking.

It also includes controlling behavior through corporal punishment.

PSYCHOLOGICAL ABUSE

Includes but is not limited to: humiliation, threats of punishment or deprivation and harassment.

It may inflict emotional harm, invoke fear or intimidation, degrade or demean an individual.

Psychological abuse may be inflicted in various ways that may or may not be verbal such as intimidating looks, gestures and expressions.

EMOTIONAL ABUSE:

Includes but is not limited to

Ridiculing or demeaning an individual;

Making derogatory remarks about an individual or toward an individual;

Cursing directed towards an individual;

Threatening to inflict physical or emotional harm on an individual; and

Ignoring an individual who is in need of help, regardless of reason.

FINANCIAL EXPLOITATION

The act of depriving, defrauding or otherwise obtaining the personal property or financial rights of a person by taking advantage of his/her disability or impairment. This includes but is not limited to:

Theft of an individual's money or property;

Use of individual money or property without the permission of the individual or guardian;

Acceptance by staff money or property regardless of permission;

Mishandling of individual money or property;

Providing favors in exchange for individual money, work, or sexual favors.

INVOLUNTARY SECLUSION

Is defined as separation of an individual from other individuals or from her/his room or confinement to her/his room (with or without roommates) against the individual's will, or the will of the individual's guardian

MISTREATMENT

Includes but is not limited to:

(a) The inappropriate use or careless monitoring of medications;

(b) The inappropriate use of isolation (i.e., seclusion) where the Individual is told he or she needs to stay in one place and not join his or her peers in a community setting;

(c) The inappropriate use of chemical restraints on a individual where the use of medication is believed to be used to restrict the individual's movement;

Neglect

Includes but not limited to:

- **Lack of attention to the physical needs of a individual including but not limited to toileting, bathing, meals, and safety;**
- **Failure to report individual health problems or changes in health problems or changes in health condition to an immediate supervisor;**
- **Failure to carry out a prescribed treatment plan for an individual.**

Examples include, but are not limited to:

NEGLECT CONTINUED…

Putting a Individual at risk by allowing him or her choices inconsistent with safety concerns;

Failure to maintain 1:1 or 2:1 observation or special precautions on a Individual for whom such precautions have been ordered;

NEGLECT CONTINUED…

Any act that may cause a delay in treatment or a delay in referring a Individual for emergency services;

Inadequate program supervision resulting in Individual-Individual or Individual-staff altercations and;

Failure to follow policy with regard to safety procedures such as face to face visual observations, continuous monitoring, intermediate monitoring, etc. for that Individual.

RESTRAINT:

- **Types of Restraint: Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.**

ACCORDING TO THE 2014 ACT STANDARDS: ACT TEAMS SHALL BE KNOWLEDGEABLE ABOUT AND FAMILIAR WITH INDIVIDUAL RIGHTS INCLUDING THE CLIENTS' RIGHTS TO:

29.1.1 Confidentiality

29.1.2 Informed consent to medication and treatment

29.1.3 Treatment with respect and dignity

29.1.4 Prompt, adequate, and appropriate treatment

29.1.5 Treatment which is under the least restrictive conditions and which promotes individuals' meaningful community integration and opportunities to live like ordinary Delawareans;

29.1.6 Nondiscrimination;

29.1.7 Control of own money;

29.1.8 Voice or file grievances or complaints.

WHAT, AND WHY?

The Americans with Disabilities Act is a federal regulation enacted by Congress in 1990 and signed into law that same year on July 26th, by President George H.W. Bush.

WHY?

The ADA is a law that protects people living with disabilities from certain types of discrimination.

It provides similar protections as the Civil Rights Act of 1964, which protects against unfair treatment based on race, religion, sex and national origin.

1 out of 5 Americans have a disability

Brault, 2008

More on rights…

About Psychiatric Disabilities…

Examples: depression, anxiety disorder, bipolar disorder,
Schizophrenia

Approximately 5 – 10% of the U.S. population has a mental illness

Many myths about this disability but the reality is…

- **Most mental illnesses are treatable.**
- **Psychiatric disabilities are the result of a brain disorder- not of a poor character or a "weak" personality.**
- **Don't assume people with psychiatric disabilities are violent**

National Alliance on Mental Illness (NAMI), 2008

PTSD, DEPRESSION AND TBI

"SIGNATURE DISABILITIES" OFF VETERANS OF WARS IN AFGHANISTAN AND IRAQ

PTSD:

- About 20 % of recently returned veterans screened positive for depression or PTSD (RAND, 2008)
- Rate of PTSD among returning service members was 6 % diagnosed, with an additional 27% estimated to be undiagnosed (Erbes, Westermeyer, Engdahl & Johnson, 2007)

TBI:

- 19% of soldiers received a probable TBI, with more subtle (and more difficult to diagnose) blast-related injuries being the most common (RAND, 2008)

Many veterans have more than one disability - 30% of returning veterans screened positive for PTSD, TBI and/or major depression

(RAND, 2008)

Psychiatric Disabilities
Some key points…

- **Don’t confuse mental illness with intellectual disabilities**
- **People with psychiatric disabilities are generally no more violent than the rest of the population**
- **Don’t assume that people with psychiatric disabilities can’t make decisions or handle any stress**

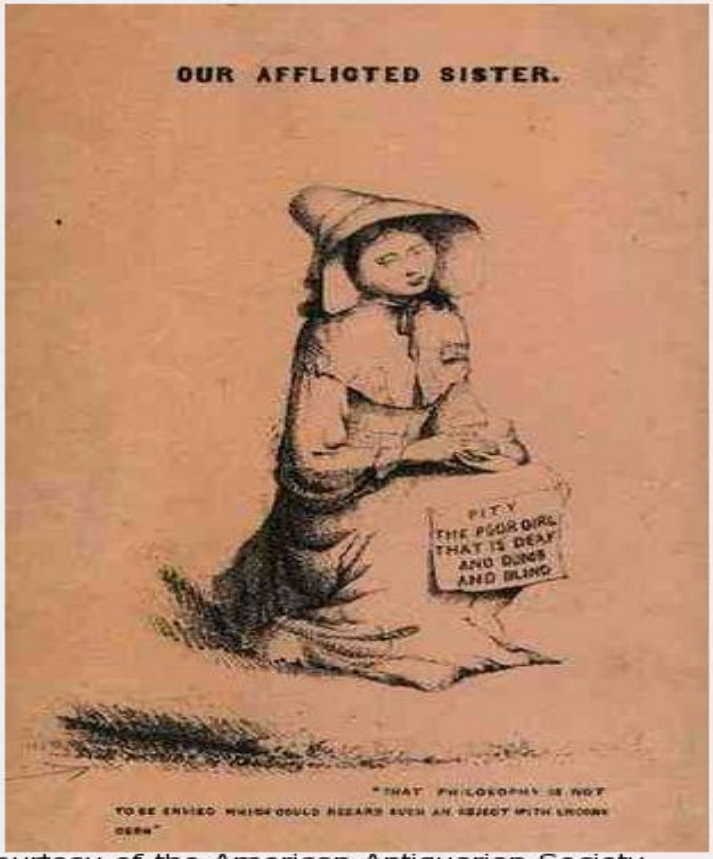
ACTIVITY

Think of a word to describe disability. What is the first word or phrase that comes to your mind?

Feel free to either write it down or just think of it. Remember it; we'll come back to it later!

Moral View: Disability means God is Displeased

People who were not "perfect" in body were thought to be "flawed" in the eyes of God



Courtesy of the American Antiquarian Society

Medical Model: Disability must be Cured

- Based on Science/Medicine
- Views disability as a genetic defect that must be fixed
- People with disabilities viewed as tragic, helpless, pitiful

The Eugenics Movement

OBJECTS OF CHARITY

CIVIL RIGHTS/MINORITY MODEL

Deinstitutionalization

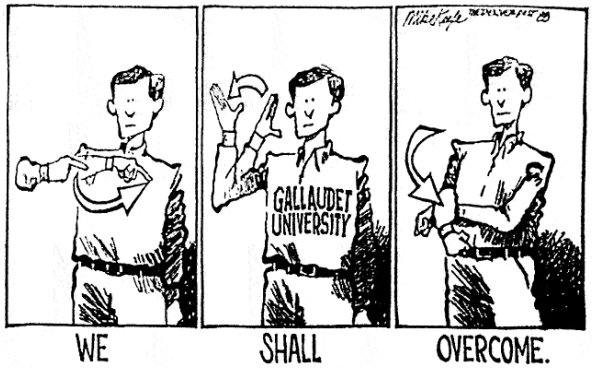
Independent Living Movement

Disability Identity groups formed by people with disabilities

SOCIAL CONSTRUCTION MODEL

Role of society in addressing barriers to integration

Active and equal participants in the communities in which you live and work



CONSUMER RIGHTS COMPLETED

The Bill Of Rights: The government may not deprive citizens of “life, liberty, or property” without due process of law...

People living with Severe and Persistent Mental Illness (SPMI) in today’s society must be afforded the same rights and protections as all other Americans!

CONCLUSION

In providing the protections of the natural human rights of those we support and serve, we are in-effect protecting our own rights and liberties.

It is only through this time honored and worthy event that we will truly maintain our humanity.

The False Claims Act

(31 U.S.C. §§ 3729–3733, **also called the "Lincoln Law") is a federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal Government's primary tool in combating fraud against the Government.**

FCA HISTORY:

The False Claims Act was enacted in 1863 by a Congress concerned that suppliers were defrauding the Army. The FCA provided that any person who knowingly submitted false claims to the government was liable for double the government's damages plus a penalty of $2,000 for each false claim.

In 1986, there were significant changes to the FCA, including increasing damages from double damages to triple damages and raising the penalties from $2,000 to a range of $5,000 to $10,000.

Read more about the FCA here: https://www.taf.org/false-claims-act-story

WHAT'S NEW & WHY NOW?

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Delaware and the Centers for Medicare and Medicaid Services (CMS) have entered a partnership to create and implement the new PROMISE program.

Center for Medicare and Medicaid Services

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Under CMS, there are stringent billing duties for both the State and it's contractors.

AN OVERVIEW OF THE FCA

In terms of billing the government, fraud can be defined as:

Billing for services not provided, not -covered and/or for higher reimbursement rates than the contract permitted

http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf

IF FRAUD HAS OCCURRED, CMS AND OTHER FEDERAL ENTITIES CAN:

Recoup funds falsely claimed

Institute fines, penalties and possibly prosecute person(s) determined to be involved in the fraudulent practice

DOCUMENTATION

- ✓ All staff must be properly trained and credentialed to conduct treatment/services
- ✓ All documents and benefactor information must remain confidential
- ✓ All documentation must be properly signed, completed and submitted within established timelines
- ✓ Benefactors must be active partners (within their capacities) in the Recovery Planning process
- ✓ Services must individualized to the benefactors recovery plan and properly documented

ALL PAPERWORK NOT ELECTRONICALLY TRANSMITTED MUST:

Be legible and written in black or blue ink.

Properly dated listing each benefactor contact

When necessary include the benefactor's signature

Be well written including all agency specific and contractually related information in proper order and detail

Handled according to HIPAA (Health Insurance Portability and Accountability) standards to protect the PHI (Personal Health Information) of the benefactors at all time.

All billing must be completed and submitted within contractual guidelines

GROUP SCENARIO

As a team leader you trust your staff and count on their integrity and performance.

Prior to your staff meeting you can't help but overhear the group talking about the "short-cuts" they use to save time "especially" on Fridays. Some of the more unique confessions were:

- **Routine copy and pasting of previous notes**
- **Date changing**
- **And "magically appearing" signatures from severe/profound or uncooperative PROMISE recipients resistance or unable to sign "without" assistance.**

What if anything would you do? Why?

IN REVIEW: CORNELL UNIVERSITY LAW DEFINES THE FCA AS:

31 U.S. Code § 3729 - False claims- any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 [1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

See this and more at:

http://www.law.cornell.edu/uscode/text/31/3729

FIN

HCBS BASICS AND ASSURANCES

DSAMH PROMISE'S PROGRAM

WAIVER BASICS

Medicaid is a joint federal/state funding program that pays for most long term care provided to low income, older persons and persons with disabilities providing access and support for qualifying people to live in the community.

WAIVER BASICS

Congress established the Home and Community Based Services (HCBS) waiver as an alternative to care provided in institutions.

The waiver allows states to use Medicaid funding to provide services and supports to persons living in their homes or in other community-based settings, such as group homes, adult foster homes or assisted living facilities.

Persons are eligible to receive HCBS waiver services if they meet federal qualification criteria and if the cost of their home or community-based care does not exceed limits established by a state.

WAIVER BASICS CONTINUED

A state must apply to the Centers for Medicare & Medicaid Services (CMS) through an HCBS waiver application for permission to operate the waiver.

States can be flexible in how they design their HCBS waiver with respect to:

1. **Target population**

2. **Number of people to be served**

3. **Services provided**

WAIVER BASICS CONTINUED

Self-direction: promotes individual choice and control over the delivery of HCBS waiver services.

Self-direction means that the participant can make decisions over some or all of her/his HCBS waiver services and accepts the responsibility for taking a direct role in managing them.

The participant decides who provides services and how they are delivered, Example: with support, recruit, hire, and supervise people who furnish daily supports.

4. Geographic areas served

BACKGROUND CONTINUED

Every application must address how a state intends to meet CMS requirements known as the HCBS waiver assurances.

The assurances were put into place by Congress to address the unique challenges of assuring the *quality* of services delivered to vulnerable persons living in their community.

A state's HCBS waiver application must include the following:

WAIVER BACKGROUND CONTINUED

Waiver Design: The population and geographic area to be served, the mix of services offered, the quality standards, provider qualifications, policies and payment methods.

Performance Measures: The standards a state will use to evaluate the waiver and how it's reaching CMS' assurances.

Discovery Methods: The data a state collects to measure how well it is meeting each performance measure; the method and frequency of data collection and analysis; and the person or entity responsible for using the data for decision-making.

Remediation: How a state will take action when individual problems are found.

System improvement: Method to prevent similar problems from happening to others or to make the HCBS waiver more effective and efficient.

BACKGROUND CONTINUED

The first time a state submits an HCBS waiver application, CMS approves the program for three years; when a state submits a renewal application, CMS approves it for five years.

After its HCBS waiver is approved, a state must submit evidence to CMS documenting that the HCBS waiver program is operating as approved and is in compliance with each of the six assurances.

BACKGROUND CONTINUED

HCBS waivers are person centered. They invite people to play active roles in deciding the services they want to receive and when. This can make a big difference in quality of life. But delivering services in home and community settings raises new challenges to assure the quality of these programs.

THE 4 HBCS CHALLENGES

1. There is no one on site to monitor care and services at all times.
2. Participants rely on many people for their care and safety.
3. Participants may be vulnerable and unable to seek help.
4. People may be afraid of losing their services if they report problems.

So what are the assurances and how do they relate?

FEDERAL HCBS WAIVER ASSURANCES

The six assurances, and the subject of this training, are:

1. Level of Care: Participants enrolled in the HCBS waiver meet the level of care criteria consistent with those residing in institutions.

2. Service Plan: A person's needs and preferences are assessed and reflected in a person-centered service plan.

3. Qualified Providers: Agencies and workers providing services are qualified.

4. Health and Welfare: Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen.

FEDERAL HCBS WAIVER ASSURANCES

5. Financial Accountability: A state Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on a per person or aggregate basis (as determined by the state).

6. Administrative Authority: A state Medicaid Agency is fully accountable for HCBS waiver design, operations and performance.

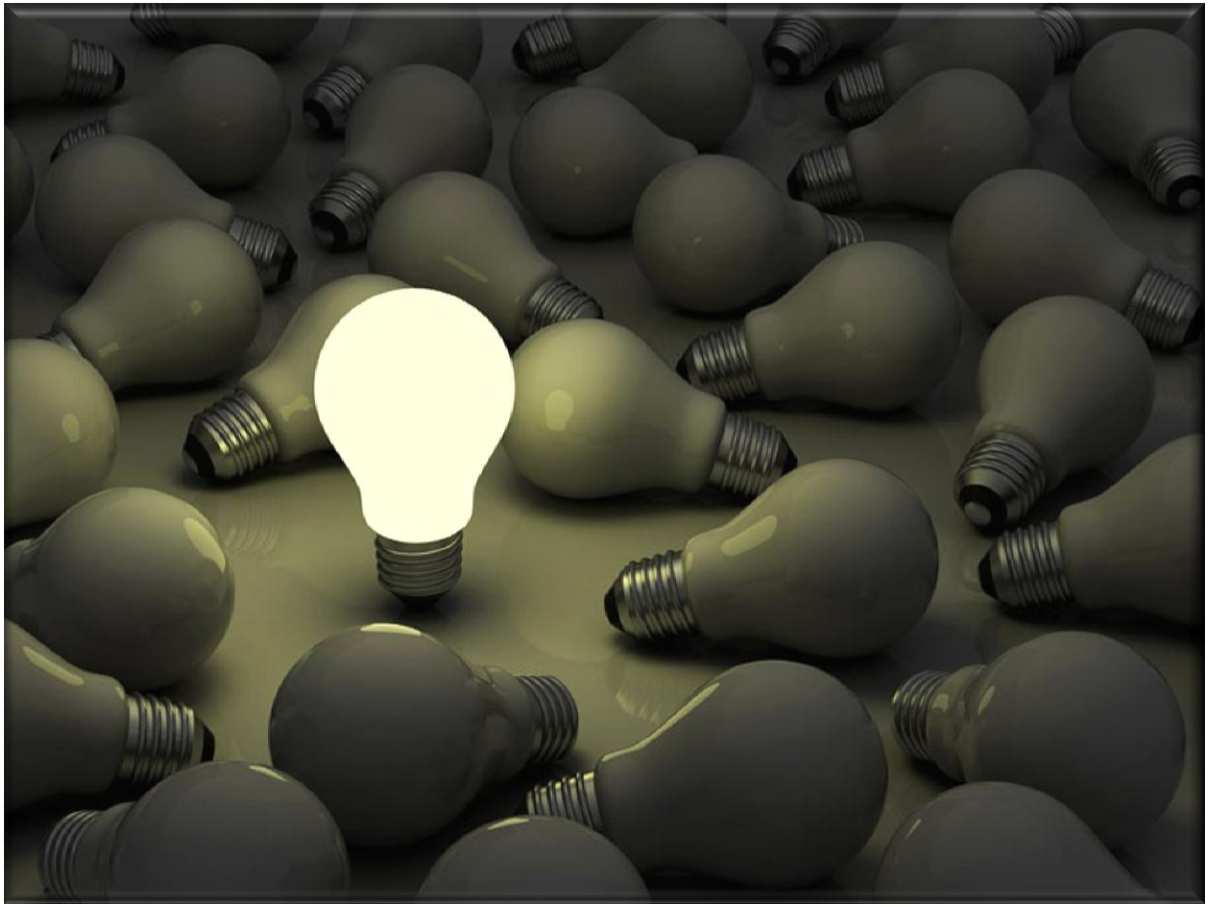
QUESTION

You have a PROMISE recipient who says one thing in the presences of the PROMISE care manager, but lives entirely differently in the community.

What responsibility do you have as a provider to support this individual?

THE APPEALS PROCESS

Sometimes things aren’t an ideal fit.



ADVERSE ACTIONS

Adverse Actions: include but are not limited to:

- **The person is determined to be ineligible for the program s/he is requesting or receiving**
- **The person is denied the service**
- **The person receives a reduction in the quantity of service unit's requested or previously received.**
- **The person's case is closed.**

WHEN THE PLAN DOESN’T FIT…

Services under the PROMISE program are directed by the person and centered on their needs.

Unfortunately, not all services or personnel can live up to the hopes and desires one might have.

To remedy those circumstances the appeals process has been created.

IN THE APPEALS PROCESS- BENEFICIARIES HAVE THE RIGHT…

To express dissatisfaction about the quality of care of the services they receive and to appeal the decisions about their PROMISE eligibility and the services they've requested in their recovery plan…

THE APPEAL PROCESS

Beneficiaries not satisfied with the quality of services can contact the Care manager and express the concern(s)

DISSATISFACTION WITH THE CONTINUITY OF SERVICE?

The Care manager will speak to the beneficiary about the service and attempt to find a resolution.

Group Question:

- What if the beneficiary doesn't like the service provided by the Care manager?

If the problem is with the Care manager, the beneficiary must contact the Consumer Affairs office with their concerns.

An internal complaint log will be started and reviewed by the Consumer Affairs office.

THE APPEALS PROCESS: IF THE PERSON HAS NOT RECEIVED THEIR REQUESTED SERVICES:

The EEU (Eligibility and Enrollment Unit) will send the person a NOA or "Notice Of Action."

This notice is designed to explain the state fair hearing process, as well as to provide information detailing how to file an appeal.

THE APPEALS PROCESS: IF THE PERSON HAS NOT RECEIVED THEIR REQUESTED SERVICES:

The State fair hearing process, evaluates the provided information, and determines if the appeal is or is not valid.

Participants can sit in on the decision hearing.

NOA FORMS INCLUDE SOME OF THE FOLLOWING INFORMATION:

- DSAMH Enrollment and Eligibility Unit (EEU) compliance expectations with DE regulations
- The person's name and ID number
- The Care Manager's name, address and phone number
- The PROMISE services requested detailing initial eligibility, determination, and eligibility redetermination..
- Affected waivered services re: Recovery Plan updates
- Description of the action taken: denial, limited authorization, suspension or termination
- The reason for the action and the effective date with a citation of the rule or policy causing the action

NOA FORMS INCLUDE :

A customer rights and responsibilities form that contains information explaining the appeals process and information on legal resources such as Community Legal Aid.

Community Legal Service

IN THE EVENT THE PERSON DOES NOT AGREE WITH THE DECISION,

The Medicaid beneficiary/guardian may appeal the State hearing decision following the instructions on the NOA letter.

REVIEW

Adverse Actions refers to a qualified PROMISE recipient who believes service(s) or the quality of such, is not being provided as per his/her Self-directed recovery plan.

- **The person is to direct the concern to the attention of his care manager.**
- **If the care manager is the problem, she or he will be replaced (conflict-free)**
- **The person can complain and ask for redress of the issues via the Consumer Affairs Office.**
- **If the person does not agree with the outcome she/he can request an NOA or Notice of Action to appeal the decision.**
- **The State hearing officer will hear and decide over the issue.**
- **The PROMISE recipient if unhappy, can appeal the hearing officers decision.**

Conflict Resolution

GOAL

To Provide An Overview Of What Conflict Is And To Teach Methods To Effectively Resolve Its Challenges

GROUP QUESTION

What Is Conflict?

- It can be defined as an opposition to something. Such as a disagreement between two people, genders, culture, nations etc...
- **It can also be defined as:**

a mental struggle resulting from incompatible or opposing needs, drives, wishes, or external demands

Do You Agree With This Statement?

CONFLICT OFTEN ARISES OUT OF THE COLLISION OF PASSIONATE BELIEFS AND UNMET EXPECTATIONS…

CONFLICT IS ALSO..

- An opportunity for positive change/growth.
- A learning opportunity.
- A chance to use one’s Emotional Intelligence
- (E.I. - the ability to manage one’s emotions and to make the best possible use of them in any situation)

WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF CONFLICT?

Advantages

Clarity-get your point across

Get Your Way

Heard/Understood

Control/Power/Influence/Fear

Respect/Empowerment

Recognition

You Could Be The Winner!

Disadvantages

Hurt Feelings/Resentment

Effects Reputation

Promotes Gossip/Rumors

People Remember The Worst Behaviors

Reduces Communication, People Shut down

People Won’t Like You Anymore

GROUP ACTIVITY

You have 5 minutes to think about and talk to your group about a conflict causing event. It could be your experience or that of a friend or family member.

What was the outcome?

Elect a person with the most interesting experience to tell the room.

Please remember to keep the story BRIEF…

CONFLICT

Conflict is natural, normal and when reflected upon with Emotional Intelligence, extremely helpful for personal growth.

WHAT MAKES PEOPLE DESIRE CONFLICT?

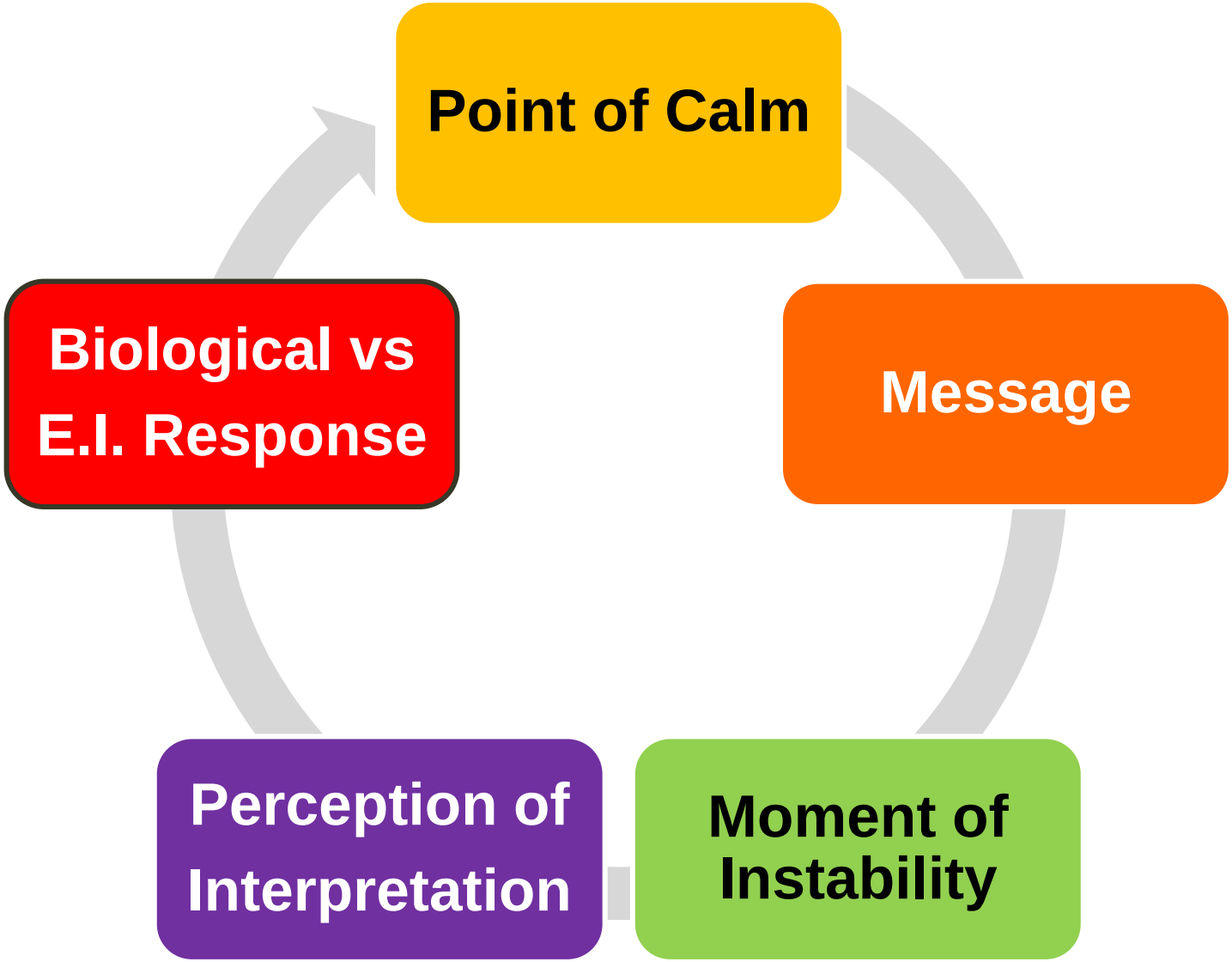
Think about 2 or 3 people with whom you find it difficult to communicate or tolerate…

- What behaviors do they have that cause problems for you?
- How do you respond to the behavior? (Action Plan)
- What would your rate the result of your efforts thus far?

ASK YOURSELF HOW DID THESE PEOPLE LEARN HOW TO PUSH <u>YOUR</u> BUTTONS?

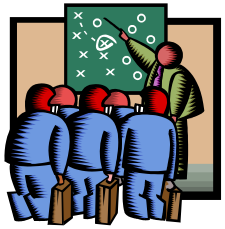
Answer: They Simply Watched How *<u>You</u>* Responded To Their Behavior - And They've Been Controlling Your Responses Ever Since!

THE CYCLE OF CONFLICT CAN START AND END INSIDE YOU!



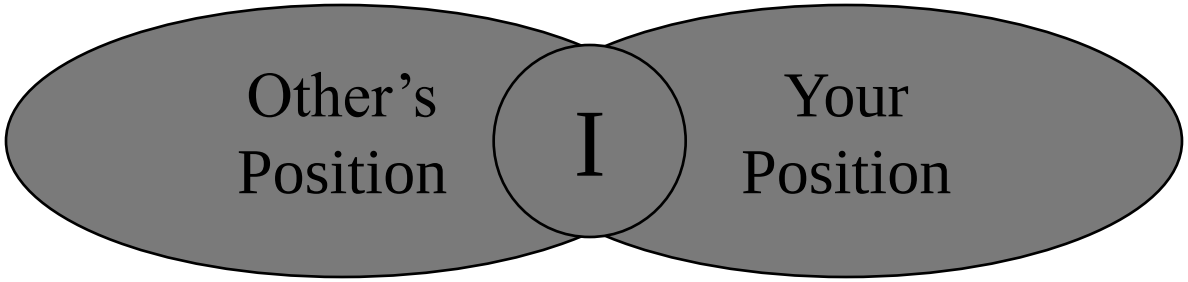
Methods Of Resolving Conflict

But there is another….



COMMUNICATION IN CONFLICT RESOLUTION

- Seek first to understand.
- Identify the intersection.



- Seek to be understood.
- Mutually generate options and resolutions.

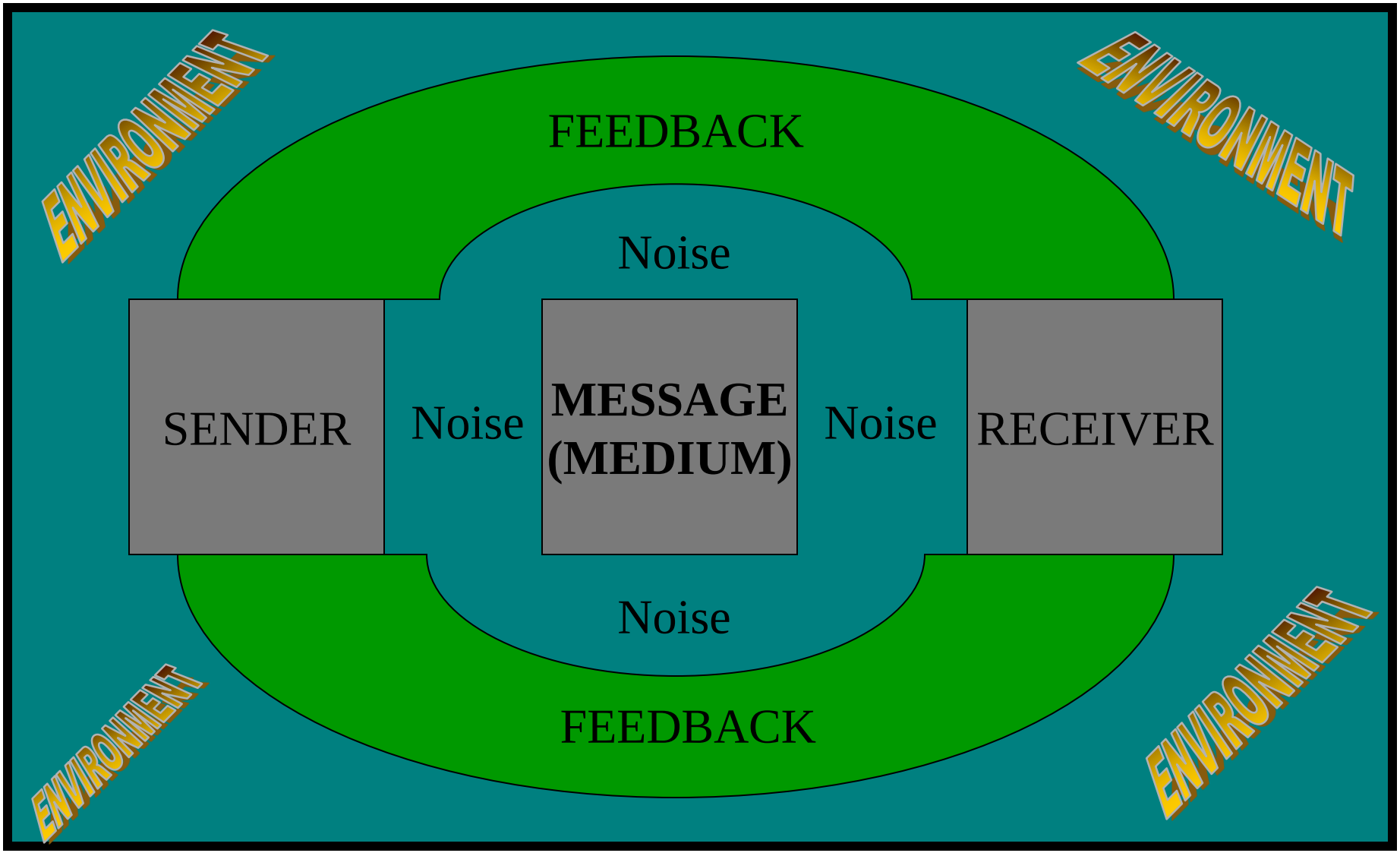
The Key To Internal Conflict:
Ask Yourself
"Am I Taking This Too Personally?"- Why?

CONFLICT RESOLUTION DEFINITION

Conflict resolution is a process to assist parties in communicating their issues and exploring solutions.

“In the duality of the human mind, one might recognize that true conflict resolution is based on honest self-re-evaluation and the willingness to provide oneself with kindness and acceptance”

COMMUNICATION MODEL



EFFECTIVE COMMUNICATIONS

Active Listening

Open – ended questions

Rephrase

Reflect

Summarize

Non-judgmental

Check body language

Use “I” Statements

The Iceberg of Conflict

SEARCH FOR THE HIDDEN MEANING

Find your third voice and search for the following:

- **Issues** – What is the true conflict?
- **Personalities** – Are differences between your personalities contributing to the conflict?
- **Interests** – What do you really want?, What does getting what you want have to do with the conflict?

OVERVIEW

Recovery and Resiliency

Understand the Definition of Recovery in the Recovery Model

Understand Recovery From an Individual or Family Members Perspective

Peer Support Services and Growing Resiliency

Effective Peer Support

RECOVERY

Recovery Working Definition by SAMHSA:

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

RECOVERY

Recovery for an individual:

- HOPE is the cornerstone of recovery
- Is different for each person and is self directed
- Involves different wants, needs, desires, diagnoses, experiences, and other factors
- Is about supporting him/her in finding meaning and purpose in their life

Recovery isn't about being cured of an illness, although some consumers report that, it involves improving the quality of one's life.

PARADIGM SHIFT

FROM	TO
❑ Focused on symptoms, illness, deficiency. ❑Provider directed- client roles in pursuit of treatment goals. ❑Motivation for change is punitive. ❑Medication compliance is paramount. ❑Responsibility for treatment and progress rests on provider. ❑Services are embedded in Mental Health System	❑Focused on strengths, goals, where we are going, ❑Partnership based on valued roles, empowerment, ❑Motivation for change based on individuals' goals, ❑Medication is based on informed choice and individual values, ❑Individual supported to assume responsibility for self monitored behavior, ❑Emphasis on the use of natural community resources

FIVE STAGES IN THE RECOVERY PROCESS

Impact of Illness	The person is overwhelmed and confused by disabling power of the illness**.** **The task is to decrease the emotional distress by reducing the symptoms.**
Life is Limited	The person has given into the disabling power of the illness and is not ready/ able to make a change. **The task is to instill hope, a sense of possibility, and to rebuild a positive self-image**.
Change is Possible	The person is beginning to question the disabling power of the illness and believes that his/her life can be different. **The task is to empower the person to participate in his/her recovery by taking small steps.**
Commitment to Change	The person is challenging the disabling power of the illness and is willing to explore what it will take to make changes. **The task is to help the person identify his/her strengths and needs inn terms of skill, resources and supports.**
Actions for Change	The person is moving beyond the disabling power of the illness and is willing to take the responsibility for his/her actions. **The task is to help the person use his/her strengths and to get the necessary skills, resources and supports**.

THE PATHWAY TO RECOVERY INCLUDES:

Hope

Individualized & Person- Centered

Self-Direction

Empowerment

Non-Linear

Strengths-Based

Peer Support

Respect

Responsibility

Holistic

THE IMPORTANCE OF PEER SPECIALISTS

Peer Specialists Can Assist Consumers By:

Identifying the stage of recovery they are in

Offering HOPE and optimism, sharing their recovery story, being grounded in their own recovery

Improve social networking

Improve quality of life

Promote Wellness

Improve Coping Skills

Support acceptance of illness/situation

Reduce Concerns

Increase satisfaction with health status

No one relates to an individual with a disorder better that someone who has gone through it themselves

Build RESILIENCE

REVIEW QUESTION

Based on this curriculum the most effective way to help a person through the recovery process is to ensure:

- ✓ **The person takes their medications it is paramount to care**
- ✓ **People focus on the symptoms, illness, the individuals deficiencies**
- ✓ **The provider directs the person in pursuit of his/her treatment goals.**
- ✓ **Poorly motivated individual's failing to change such be treated punitively.**
- ✓ **The responsibility for treatment and progress rests on provider.**
- ✓ **All services are embedded in Mental Health System**

True or False?

Cultural Competency: A Service Improvement Tool

- For Substance Abuse Treatment Services Healthcare Professionals

Who am I?

- First Impressions about me
- Did your impression of me change? Why
- What helped form those impressions?

ICE BREAKER

Name

Where are you from

What you do

Why you do it

WHY ARE WE HERE?

Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground.

National Institutes of Health

WHY ARE WE HERE?

Delaware Health & Social Services (DHSS) promotes an environment of mutual respect for all people so that everyone, both employees and clients/customers, has the ability to achieve his or her very best. This is predicated on the belief that each individual has value. DHSS celebrates and promotes the value of diversity in an effort to build trust, harmony and understanding among all who are employed by or come in contact with the Department and its programs.

DHSS Beliefs and Principles

WHY ARE WE HERE

Our mission is to promote health and recovery by ensuring that Delawareans have access to quality prevention and treatment for mental health, substance use, and gambling conditions

Our Vision: Always the Right Time, Always the Right Place, To Get the Right Service

DSAMH Mission and Vision

WHY

By becoming aware of others and the points of separation and contention, I am forced to look at myself.

Only then can you see how the differences become barriers to service.

Only then can solutions be found

DELAWARE HAS A DIVERSE POPULATION

Total Population 925,749

- **New Castle** 549,684
- **Kent** 169,416
- **Sussex** 206,649

Female 51.6%

Age

- **Under 18** 22%
- **Over 64** 15.9%
- **Between 18- 64** 62.1%

- **White** 68.9%
- **Blk Af/Am** 21.4%
- **Am/Ind/Na/Am** 0.5%
- **Asian** 3.2%
- **Na/Hi Pac/Is** Z
- **2 or More** 2.7%
- **Hispanic** 8.2%

DSAMH ADULT ADMISSIONS FY 10

Total	7,496
• Female	31%
• Male	69%
Age	
• 18-20	9.61%
• 21-24	17.10%
• 25-34	36.67%
• 35-44	17.72%
• 45-54	13.90%
• 55-64	3.99%
• 65+	0.72%

- Race
  - White 72.75%
  - Blk Af/Am 22.9%
  - Am/Ind Na/Am 2.12%
  - Asian Pac/Is 0.40%
  - 2 or More 0.97%
  - Hispanic 4.72%
  - Unknown 1.47%

100% of your clients have at least 1 disability

"Drug addiction is an impairment under the ADA."

Disability

HONORING AND RESPECTING CULTURAL DIFFERENCES WITHIN COMMUNITIES.

There is a high degree of diversity within any given community. This diversity may not be readily apparent to individuals and organizations that seek to provide services to these communities.

National Center for Cultural Competence

You Do Not Know What You Do Not Know

Defense Equal Opportunity Management Institute

TWO UNIVERSAL TRAITS

The need or overriding desire to understand the world that we find ourselves in.

***Cogito, ergo sum* or "I think, therefore I am"**
Descartes, Rene´. *Meditations*.

WHAT IS THE PROBLEM?

We know how to interact with people who are like ourselves

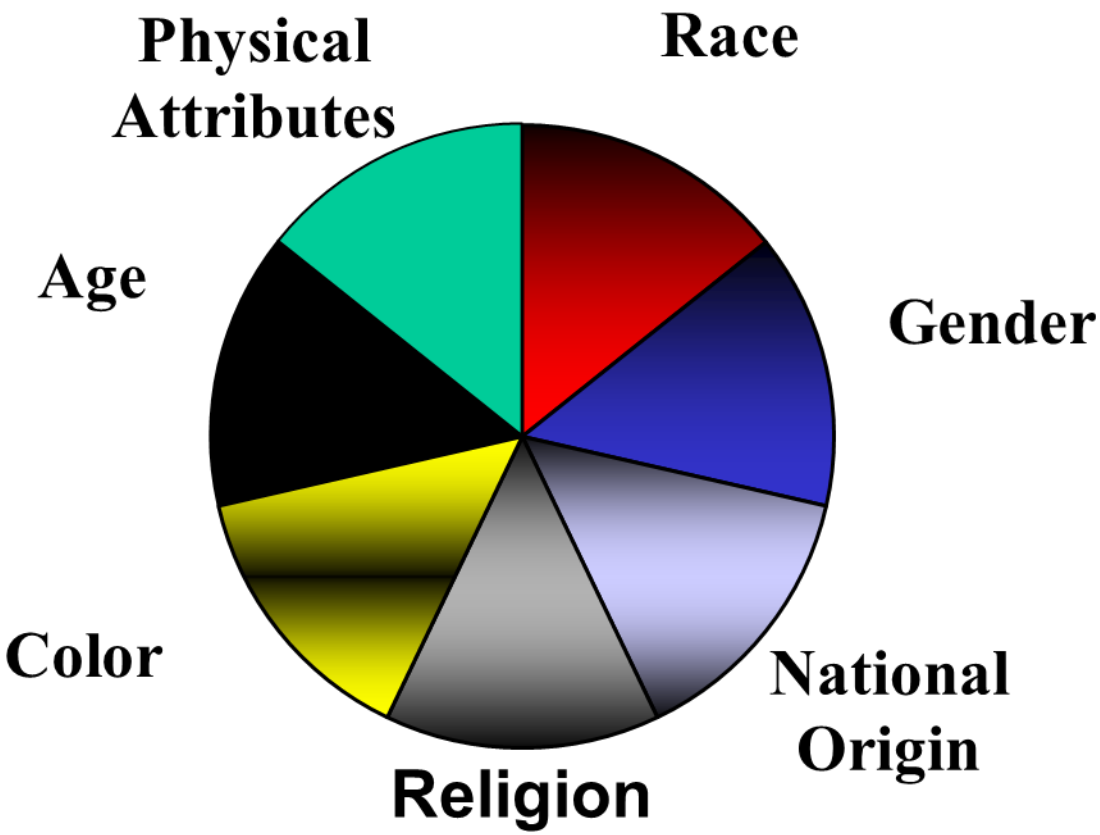
- **Norms**
- **Beliefs**
- **Commonality**

WHAT IS CULTURE? GROUP ACTIVITY

Defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics

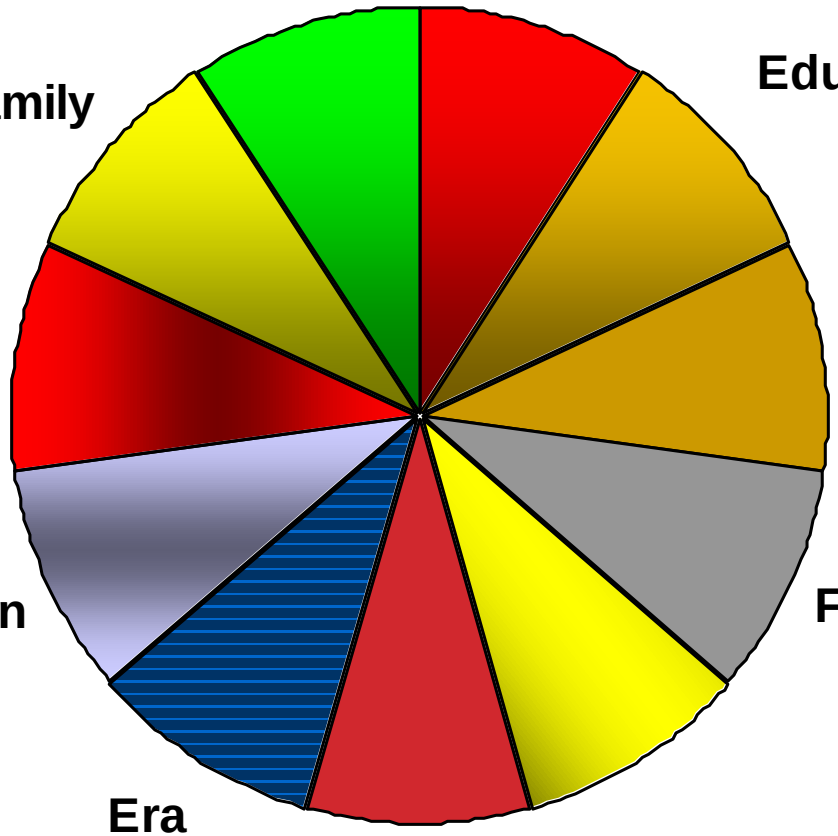
- **U.S. Department of Health & Human Services**

PHYSICAL POINTS OF DIFFERENCE (PPD)



Source: Diversity the Art of Useful Disagreement

CULTURAL POINTS OF DIFFERENCE (CPD)



Source: Diversity the Art of Useful Disagreement

BUILDING BRIDGES

Takes:
Physical Interaction
Education
Willingness
Communication
Recognition of Similarities

Source: Universality Diversity and the Maintenance of Self-Identity

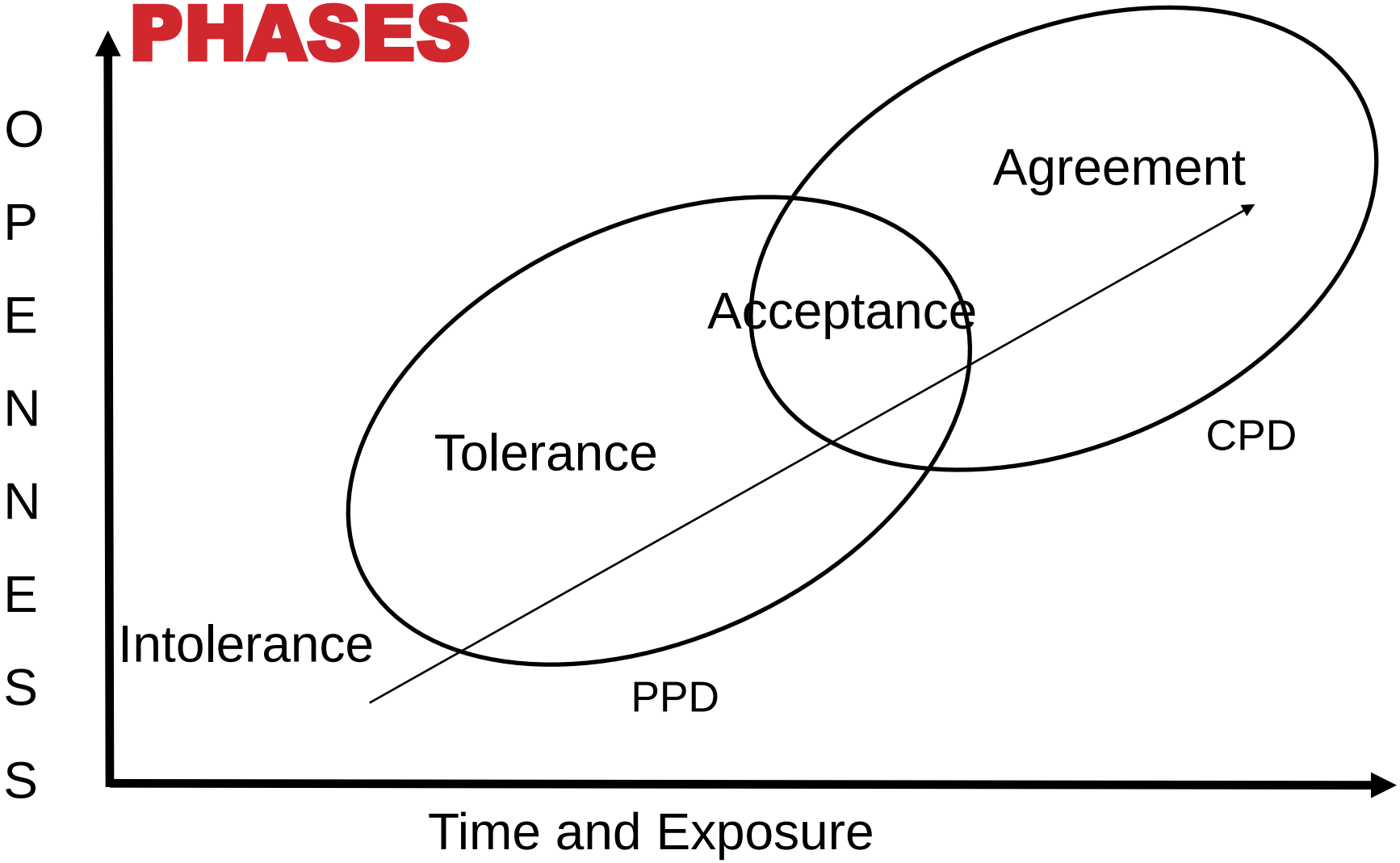
FOUR PHASES OF UNDERSTANDING

Intolerance → Tolerance → Acceptance → Agreement

←

Source: Diversity the Art of Useful Disagreement

THE RELATIONSHIP BETWEEN THE LEVELS AND THE PHASES



Source: Diversity the Art of Useful Disagreement

CULTURAL COMPETENCIES ARE NOT

Political Correctness

Color Blindness

Patronizing

COMMUNICATION

Including people from diverse backgrounds with a diverse way of looking at the world, also means they will have a diverse way of communicating to that world.

Next to our physical appearance, how we communicate is the biggest barrier to an effective diverse workforce.

STEPS

Cultural Awareness

- **Step One: Recognize and Acknowledge the Difference**
- **Step Two: Recognize potential points of contention**
- **Step Three: Recognize your value judgments**
- **Step Four: Develop a plan of action**

BENEFITS TO PATIENT/CONSUMER

More likely to continue to access services

Recognize DSAMH commitment to deliver services in a manner that respects and incorporates their cultural perspectives

Patients/consumers may be motivated to seek care sooner

Patients/consumers may be able to communicate their health care needs more effectively and better understand their diagnoses and treatment.

Patients/consumers who benefit from this approach may also encourage others within their community

National Center for Cultural Competence

WHAT IS THE PROBLEM?

We know how to interact with people who <u>are</u> like ourselves

- **Norms**
- **Beliefs**
- **Commonality**

Question: can you provide the best possible service to a person that is totally <u>unlike</u> you?

SEEK TO UNDERSTAND

Acknowledge and tend to an individual's multiple memberships. Identify their connections to others, e.g. individuals, family members, and community resources.

Above all, avoid making inaccurate generalizations on the basis of appearance, language, abilities, or family name. The goals are to understand the cultural influences impacting this person or family, recognize the inherent strengths and resources, and utilize them in engagement and planning.

PRIORITIES

What is this person’s language of comfort?

Has the person been notified verbally and in writing of their right to an interpreter?

Is an interpreter needed? If so, how will this happen?

Are consent forms in the person’s language?

What is the person’s literacy level? How will you ensure understanding?

IN CLOSING

It is all about the client

Your are providing an important service

You are the key to effective communication

PERSON CENTERED PLANNING

A person's needs and preferences are assessed and reflected in a person-centered service plan.

- **Service planning is one of the most critical aspects of the PROMISE program. It is through this process that the needs, goals, and preferences of participants are expressed.**
- **Risks and other needs are also identified and addressed.**

PERSON CENTERED PLANNING

- **Care managers play a key role in assuring that participants actively engage in the planning process, have the information they need to make decisions, and understand the choices available to them.**

PERSON CENTERED PLANNING

Requirements of PROMISE program assurance:

- **The State has established policies and procedures for how service plans are to be developed.**

- **In the PROMISE program the Care manager will coordinate and monitor the beneficiaries service delivery, and how the recovery plan and its services are updated when necessary.**

PERSON CENTERED PLANNING

The following are key components of this assurance.

The ASAM Assessment:

- **Every PROMISE participant must have an assessment of his/her needs, goals, preferences and health and safety risk factors.**
- **Delaware uses the Delaware-specific *American Society for Addiction Medicine* assessment tool that evaluates both mental health and Substance Use Disorder (SUD) conditions to determine if the person is eligible for PROMISE services.**
- **Additional assessments are used by the PROMISE care managers to identify the persons needs and the appropriate services.**

PERSON CENTERED PLANNING

The following are key components of this assurance.

The Assessment:

The ASAM tool assesses the person's general health, emotional and behavioral health, cognitive ability, ability to understand and communicate with others, and ability to perform activities of daily living (e.g., ability to bathe, walk, eat).

The use of the ASAM standard form improves the reliability, consistency and accuracy of the data that is collected.

PERSON CENTERED PLANNING

Service Planning:

Every PROMISE participant must have a written Self Directed - Recovery plan. The service plan must address all of the participant's assessed needs and personal goals, including health and safety risk factors.

PERSON CENTERED PLANNING

Service Planning:

Health and Safety Risk Factors are often categorized into

1) health risks (e.g. chronic conditions such as diabetes),

2) behavioral risks (e.g. poor decision-making about safety and health issues as a result of brain injury or cognitive limitation; violent or criminal behavior; substance abuse etc…

3) risks to personal safety (e.g. abuse or exploitation).

PERSON CENTERED PLANNING

Service Planning:

The service plan must reflect the full range of a participant's needs and include both Medicaid and non-Medicaid services as well as informal/natural supports.

PERSON CENTERED PLANNING

Service Delivery:

Services must be delivered in accordance with the Person's Recovery plan.

Services must be authorized through the service plan in order for them to be paid for.

PERSON CENTERED PLANNING

Choice:

Participants in the PROMISE program are encouraged to choose from 15 (medically necessary) community based services, designed to enhance their ability to function independently in the community.

PERSON CENTERED PLANNING

Choice:

With the help of the care manger, the participant chooses the members of their team that will help them to select the services that will best support them in the community.

These people might be members of their family, the community, providers, and other natural supports.

THE PLAN

The plan is developed around the person, as to not make the person fit a plan. It is built on their needs, wishes, hopes and dreams which is believed to make living in the community likely to be successful.

THE PLAN

The person is encouraged to make informed decisions; and the team helps to take responsibility to do whatever is necessary to assist the person in making fully informed decisions

During the meeting roles and expectations are expressed to enhance team and relationship building and to solidify effective communications

RULES ON THE MEETING

The Care managers ensures:

- **The meeting stays focused on the individual, not the team**
- **That the game plan is to work towards the person's preferred lifestyle through goals…**
- **The Care manager must keep the financial impact of services in mind as s/he helps to guide the beneficiary to the medically necessary services they need.**

AFTER THE MEETING

The Care managers reviews the documentation

Continues to communicate with all team members to assess progress and bring the team together to revise the plan as needed

Ensures the provider provides the service and maintains documentation on such services

Regularly review and revise the plan by following the same procedures previously mentioned.

Division of Substance Abuse and Mental Health

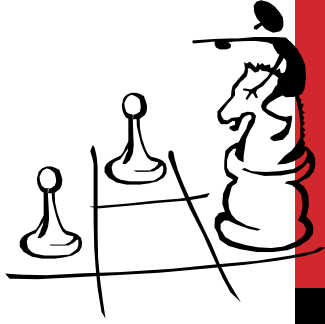
DELAWARE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH INCIDENT REPORTING

UNDERSTANDING GENERAL AND CRITICAL INCIDENT REPORTING

GOAL

The goal of this presentation is to provide a clear understanding of the expectations and standardization of the DSAMH General and Critical Incident Reporting Process.

OBJECTIVES



Explain the purpose of the training

Discuss important definitions

Illustrate the Adult registry expectations

Clarify the reporting procedures

Evaluate forms

PURPOSE…

Clarify the difference between General and Critical Incidents Reporting

Provide a clear understanding of the expectations and standardization of the reporting process for the State of Delaware.

Purpose…

Incident report training assures that individual safety, health, welfare and treatment services are delivered in a Individual-driven and respectful manner.

PURPOSE…

DSAMH desires that all state employees and providers understand the expectations of this training -

And comply with the standards discussed in this setting in compliance with DHSS Policy Memorandum 46, referenced throughout this body.

This is also a part of the CMS PROMISE training assurances.

DEFINITIONS

Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish (42 CFR 488.301). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Other examples of types are abuse are...

***Neglect*: failing to provide a needed care: attention, food, clothing, supervision etc…**

***Physical Abuse*: intentional physical act by a staff or other which causes or may cause physical injury to a person.**

***Psychological Abuse*: Acts other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean a person.**

***Sexual Abuse*: any acts or attempted acts such as rapes, incest, sexual molestation, exploitation, or sexual harassment and inappropriate or unwanted touching.**

***Verbal Abuse*: Verbalizations, which inflict or may inflict emotional harm, invoke fear and/or humiliation, intimidation and degrading or demeaning a person.**

***Financial Exploitation*: is the illegal or improper use of another individual's resources for personal profit or gain**

ABUSE REGISTRY AND CRIMINAL HISTORY/BACKGROUND INVESTIGATIONS

Abuse Registry: An official listing of individuals who have been convicted of abuse, neglect, exploitation or found through a civil/administrative procedure to have committed abuse, neglect or exploitation against a person.

ABUSE REGISTRY AND CRIMINAL HISTORY/BACKGROUND INVESTIGATIONS

Criminal History or Background Investigation: The screening of potential employees for a history of abuse, neglect or mistreatment of persons in accordance with established state law and federal law (42 CFR 483.13).

GENERAL INCIDENTS

General incidents, which include any event which causes or could cause injury which has serious impact on a PROMISE beneficiary or others that occurs while a PROMISE beneficiary is receiving covered behavioral health services.

Please include all hospitalization and medication errors in the general incidents.

CRITICAL INCIDENTS

<u>Critical incidents</u>, which are defined by Delaware law (Title 16, Section 1131-1134 for reporting and investigation of abuse allegations requiring immediate reporting and investigating) and include abuse, neglect, mistreatment, financial exploitation and significant injury, and

CRITICAL INCIDENTS

Includes but is not limited to…

- ✓Unexpected death of an individual;
- ✓Suspected physical, mental or sexual abuse and/or neglect of a Individual;
- ✓Theft or financial exploitation of a Individual;
- ✓Severe injury sustained by a Individual;
- ✓Medication error involving an Individual and/or suspected medication diversion;
- ✓Inappropriate/unprofessional conduct by a provider involving a Individual;
- ✓Physical abuse with injury(Individual to Individual); physical abuse(staff to Individual);
- ✓Sexual abuse: staff to Individual; non-consensual Individual to Individual; non-consensual other to Individual;
- ✓Emotional Abuse: staff to Individual; Individual to Individual; other to Individual;

CRITICAL INCIDENTS

Includes but is not limited to…

- ✓Neglect;
- ✓Mistreatment;
- ✓Financial exploitation;
- ✓Individual elopement when: whereabouts are unknown and harm occurs; or whereabouts of Individual is unknown; or whereabouts are unknown and police are notified;
- ✓Significant injury when: source is unknown and injury is suspicious or injury requires transfer to medical facility/ ER;
- ✓Contusions/bruises caused by staff to dependent Individual; a burn greater than 1st degree; a serious, unusual or life-threatening injury;
- ✓Fall with significant injury with subsequent transfer to an emergency room or admission to an acute care hospital;

CRITICAL INCIDENTS

Includes but is not limited to…

- ✓Entrapment causing injury or immobility;
- ✓Entrapment requiring assistance of another to release;
- ✓Medication or treatment error or omission which: causes discomfort; jeopardizes health or safety;
- ✓Suicide/attempted suicide;
- ✓Poisoning;
- ✓Housing fire;
- ✓Utility interruption-8 hours or more;
- ✓Structural damage or unsafe conditions;
- ✓Water damage impacting health, safety or comfort.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH (DSAMH):

DSAMH directs the entire state system of services and supports for persons with mental health, substance use, or co-occurring disorders in Delaware.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH (DSAMH):

The DSAMH Director is a designated official DHSS designee under the State Mandatory Individual Abuse Reporting Law and is responsible for ensuring that the standards established under this DSAMH regulation are incorporated in all state and provider managed service systems.

DSAMH CONTRACTED PROVIDERS

All DSAMH contracted providers shall operationalize policies and procedures for screening employees for a history of abuse, neglect, mistreatment as defined by Delaware State law and determines eligibility and fitness for employment.

DSAMH CONTRACTED PROVIDERS

Providers shall have training for employees on protection of individuals' rights, prevention, identification and proper and complete reporting of abuse, neglect, exploitation, mistreatment and misappropriation of property and that staff are aware of circumstances that might lead to such situations.

PROCEDURES

A. Caring For the Physical and Emotional Needs of the Individual:

DSAMH employees and contracted provider agencies, to whom an allegation is reported or who observes or suspects that an Individual has been abused, neglected, mistreated, financially exploited or significantly injured is required to <u>first</u> ensure that the physical and emotional well-being, safety and needs of the Individual are addressed.

THE REPORTING EMPLOYEE

Regardless of employer , employee shall document his/her observations and include any witnesses to the event.

The employee shall document when the event is alleged to have occurred and the date/time that he/she received the report and the date/time he/she wrote the report.

The reporting employee shall also document the incident in the Individual's medical record progress notes.

A MEDICAL PHYSICIAN

Shall thoroughly examine the individual as soon as possible if any type of physical abuse, neglect or mistreatment is alleged, observed or suspected.

The Physician shall clearly document his or her findings and the treatment prescribed on the *Allegation of Abuse, Neglect, Mistreatment, Financial Exploitation and Significant Injury Report* and in the Individual's progress notes.

HEALTH AND SAFETY

If a medical physician is not available, and the Individual is in distress or needs medical care, the Individual shall be sent, with staff, to the closest Emergency Department.

PROVIDING FOR THE SAFETY AND CARE OF THE INDIVIDUAL

If the possibility exists that there is physical evidence of the incident all staff must preserve the area where the incident occurred and assure the area is secured.

The state or provider staff on site at that location shall be responsible for securing the scene and notifying the local police.

PROVIDING FOR THE SAFETY AND CARE OF THE INDIVIDUAL

In the event of the observation of physical evidence of a crime the state or provider staff shall be responsible for calling the police.

This evidence should be collected by the Police or designated personnel.

PROVIDING FOR THE SAFETY AND CARE OF THE INDIVIDUAL

The state or provider agency senior staff, shall be responsible for taking immediate action to ensure the Individual(s) safety and care.

This shall include the right to temporarily reassign or remove staff from the immediate worksite during other than regular hours.

STAFF (STATE OR CONTRACTED PROVIDERS)

Whomever becomes aware of a serious critical incident, is mandated to immediately report this incident through:

Immediately completing and sending of an *Allegation of Abuse, Neglect, Mistreatment, Financial Exploitation and Significant Injury Report* to the risk management department at 302-255-2934

STAFF (STATE OR CONTRACTED PROVIDERS)

Who become aware of a serious critical incident is mandated to immediately report this incident through:

Immediately contact risk management via telephone to inform of the event and complete a written critical incident report within twenty-four hours (24 hours)of knowledge of any and all critical incidents.

ALL STATE AND PROVIDER PROFESSIONAL AND LICENSED STAFF

Shall have a responsibility to notify the appropriate supervisor if abuse, neglect, mistreatment, financial exploitation or a significant injury is alleged to have occurred.

ALL STATE AND PROVIDER PROFESSIONAL AND LICENSED STAFF

Although the reporting staff shall convey the information to their supervisor, these staff shall be required to confirm that appropriate reporting has occurred by:

- ✓**Verifying with the appropriate supervisory staff that the appropriate notifications outside of the unit have occurred.**
- ✓**Informing his/her own immediate supervisor of the event.**
- ✓**Documenting the incident in the Individual's progress note.**

PROCESS FLOW AND TIMEFRAMES FOR ADDRESSING AND SUBMITTING INCIDENT AND DEATH REPORTS AND DOCUMENTATION.

All Division of Substance Abuse and Mental Health (DSAMH) staff and contracted providers who provide services to Individuals on a regular, or intermittent basis, who have witnessed an event, who has been the recipient of a verbal or written report, or who has reason to suspect that an Individual has been abused, neglected, mistreated, or financially exploited is required and shall report such an incident immediately.

PROCESS FLOW AND TIMEFRAMES FOR ADDRESSING AND SUBMITTING INCIDENT AND DEATH REPORTS AND DOCUMENTATION.

All critical incident reports shall be reported to DSAMH within twenty-four (24hours) hours of knowledge of any and all critical incidents.

THE FOLLOWING IS THE STEP-BY-STEP PROCESS FOR INCIDENT REPORTING WHEN SENDING TO DSAMH.

When a Provider first witnesses or becomes aware of a critical incident or death it must be reported to DSAMH's Quality Assurance (QA) and Risk Management Unit immediately (See telephone number and E-mail address at top of form)

The Incident Reporting Form must be submitted within 24 hours of reporting the incident to the DSAMH QA and Risk Management Unit.

When applicable, a Risk Manager will contact the PROMISE CARE Manager to ensure that he or she is involved in the case.

The DSAMH Risk Manager will follow-up with the providers to ensure the client's safety and care with 24 hours, when applicable.

THE FOLLOWING IS THE STEP-BY-STEP PROCESS FOR INCIDENT REPORTING WHEN SENDING TO DSAMH.

After the submission of the Incident report, the DSAMH Director of Quality Assurance and Risk Management Unit may assign an investigator. The determination is indicated on the incident reporting form located at the bottom.

A Risk Manager may be assigned to investigate based upon the type of incident. When applicable the Division of Long Term Care will be notified The Division of Long Term Care Residential Protection (DLTCP).

When applicable, the PROMISE Care Manager will work with the risk manager investigator within 24 hours of receiving the Incident Report.

THE RISK MANAGER SHALL SUMMARIZE THE INFORMATION GATHERED DURING THE PRELIMINARY INQUIRY. THIS INCLUDES, BUT NOT LIMITED, TO THE FOLLOWING:

Requesting documentation

Conducting interviews with consumers

Conducting interviews with Provider staff, etc.

At the conclusion of the Preliminary inquiry a report will be created and sent to the DSAMH Medical Director, Division Director, and Director of Community Behavioral Services.

Final reports will be sent to the DSAMH Incident and Mortality Reporting Committee (IMR).

The committee will make the determination regarding substantiating an incident and make recommendations.

Providers will receive written notification of the outcome of incidents reported that require any further follow-up or investigation with ten (10) business days after the conclusion of the investigation.

ADDITIONAL REPORTING FOR RESIDENTIAL FACILITIES:

Will be required to submit an Incident/Death reporting form as stated

Must also submit a PM 46 form

Additional Reporting for Deaths:

All DSAMH contracted providers or DSAMH state agency staff are mandated to report all Individual deaths regardless of the circumstances or time of death, whether anticipated or unanticipated. This notification shall occur within twenty-four hours (24 hours) of knowledge of the death. In addition to reporting the Critical Incident on the designated incident form, Staff and/or Provider shall complete a DHSS Death Notification Form (Only for Group Homes as in PM-65).

ADDITIONAL REPORTING FOR RESIDENTIAL FACILITIES:

Will be required to submit an Incident/Death reporting form as stated

All Providers will be required to complete the Death Review Form with-in three business days

When applicable, the provider will need to follow DHSS PM-65 (Only applies to Group Homes and DPC). This policy is the Departments Death reporting policy that must be completed.

A Root Cause Analysis (RCA) may also be requested.

FIN