

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

February 21, 2019

The South Carolina Commission on Disabilities and Special Needs met on Thursday, February 21, 2019, at 10:00 a.m. at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION

Present:

Eva Ravenel, Chairman
Gary Lemel – Vice Chairman
Vicki Thompson – Secretary
Sam Broughton, Ph.D.

Absent:

Lorri Unumb

DDSN Administrative Staff

Director Mary Poole; Mr. Pat Maley, Deputy Director; Mr. Rufus Britt, Associate State Director, Operations; Ms. Lisa Weeks, Chief Financial Officer; Mrs. Susan Beck, Associate State Director, Policy; Ms. Tana Vanderbilt, General Counsel; Ms. Sandra Delaney, Administrative Coordinator (For other Administrative Staff see Attachment 1 – Sign In Sheet).

Guests

(See Attachment 1 Sign-In Sheet)

Coastal Regional Center (via videoconference)

(See Attachment 2 Sign-In Sheet)

Pee Dee Regional Center (via videoconference)

(See Attachment 3 Sign-In Sheet)

Whitten Regional Center (via videoconference)

(See Attachment 4 Sign-In Sheet)

Pickens County DSN Board

News Release of Meeting

Chairman Ravenel called the meeting to order and Commissioner Thompson read a statement of announcement about the meeting that was distributed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Adoption of the Agenda

On motion of Commissioner Broughton, seconded by Commissioner Lemel, the Commission adopted the February 21, 2019 Meeting Agenda. (Attachment A)

Invocation

Commissioner Thompson gave the invocation.

Approval of the Commission Meeting Minutes

On motion of Commissioner Broughton, seconded by Commissioner Lemel, the Commission approved the minutes of the January 17, 2019 Commission Meeting.

Public Input

The following individual spoke during Public Input: Susan John and Deborah McPherson.

Commissioners' Update

There were no Commissioners' Update.

Policy Committee Update

Committee Chairman Thompson stated the Policy Committee met on February 14, 2019. The meeting information was provided to the full Commission to give them the opportunity to review prior to today's meeting. Committee Chairman stated the Committee recommends the Commission adopt the revised Governance Policy. Discussion followed. Commissioner Broughton moved that the sentence involving the Chairperson removing themselves from debate be eliminated, otherwise adopt the policy leaving the direction as written and presented. The motion was seconded by Commission Thompson and passed.

The revised Regional Center Camera Policy 535-16-DD was discussed. Committee Chairman Thompson made the motion that the policy requiring the

use of surveillance video cameras in DDSN Regional Centers be passed. The motion was seconded by Commissioner Broughton and passed.

Committee Chairman Thompson stated the Committee does not feel it can make a recommendation on using cameras in community settings until they have more information. The list of eight questions need to be answered. It was suggested adding the question under Location of Providers, what percentage of ANE's have taken place where cameras are in place. (Attachment B)

State Director's Report

Director Poole reported on various topics. Discussion followed on the Case Management rate changes that will be implemented July 1, 2019. It was asked that a roadmap be provided at the next month's Commission Meeting to assist providers in the transition of the new rate. (Attachment C)

Legislative Oversight Committees Update

Director Poole gave an update stating nothing has changed from last month except for the approval of the Governance Policy.

Quarterly Quality Management Report

Ms. Ann Dalton provided a Quarterly Management Report. Discussion followed. (Attachment D)

Financial Update

Ms. Weeks provided an overview of the agency's financial activity and the agency's current financial position. (Attachment E)

Provider Contact Increases

Mr. Norman provided information on the 2019 Contract Amendments for Excalibur and Correct Care. Commissioner Thompson moved to approve the amendments presented. The motion was seconded by Commissioner Broughton and passed. (Attachment F)

Consideration of Bid-Generators for Emergency Shelters

Ms. Cooper presented information on the bid for the generators for emergency shelters located in Spartanburg, Laurens and Newberry Counties. Commissioner Thompson moved to accept the bid from Page Power Systems, Inc. of Gastonia, North Carolina for a total contract award of \$574,307.00 and to award to the second low bidder should low bidder be determined non-responsible. The motion was seconded by Commissioner Lemel and passed. (Attachment G)

Executive Session

On motion of Commissioner Thompson, seconded by Commission Lemel, the motion passed to enter into Executive Session to discuss an employment and contractual matter.

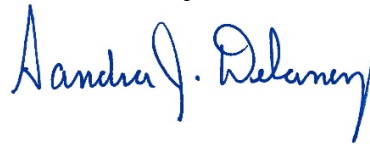
Enter into Public Session

The Commission entered into Public Session. It was noted that no action was taken in the Executive Session.

Next Regular Meeting

March 21, 2019.

Submitted by,



Sandra J. Delaney

Approved:



Commissioner Vicki Thompson
Secretary

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
February 21, 2019

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Susan John - Honey DSN
2. George Ulrich Honey DSN
3. Nancy Rumbaugh CO - Budget
4. Ella Timmons MDCBDSN
5. Victoria Hardway MDCBDSN
6. Linda Lee WCPC - PADD
7. Deborah + Hecke Mepheson Richland county
8. Robin Hillman SCDSNB
9. Billy Lee Clarendon Co DSN
10. Brooke Russell Babcock
11. Heather Waddell TDC
12. Jerry C Tizx Oconee
13. Ann Dalton DDSN
14. Margie Williamson DDSN
15. A. K. Mass Calhoun DSNB
16. CHUCK NORMAN DDSN
17. Dorothy Gooden Community Optics
18. Brooke Vennick CPS
19. Rebecca Godlam ARC of the Midlands
20. Kathleen Lint Agency with Flair

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
February 21, 2019

Guest Registration Sheet

(PLEASE PRINT)

Name and Organization

- 21. Bob Jones Newberry DSNTB
- 22. Kelli Mills. BIASC
- 23. Sophia Richardson Babcock
- 24. Lawrence M. Cole Criticon Publishing
- 25. JOAN COOPER DDSN
- 27. SARAH BRAWNSON SCSCIA
- 28. Kelly Cox AdvCoach
- 29. Thoyd Warren Babcock Center
- 30. Scott Tanner DHS
- 31. DAN ANDERSON COLLETON BISS
- 32.
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
January 17, 2019

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Evelyn Turner Dis Board Chair
2. Vicki Craft- Continuum Healthcare
3. Meko Elmore Continuum Pediatrics
4. Sloun Todd Path Finders
5. John Hitchman SCDDSN
6. Felita Martino SCDDSN Dist. II
7. Hester Swannaker MSN
8. Ronda Ritchie DDSN Dist. II
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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS

Commission Meeting

January 17, 2019

Guest Registration Sheet

(PLEASE PRINT)

Name and Organization

1. Deborah K. Smith District II

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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS Commission Meeting

January 17, 2019

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. *Sherry Caldwell, SC Brain Injury Association*

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SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS Commission Meeting

January 17, 2019

Guest Registration Sheet

(PLEASE PRINT)

Name and Organization

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|-----|---------------------|--------|
| 1. | Elaine M. Thoma | PCBDSN |
| 2. | John D. [Signature] | PCBDSN |
| 3. | Josh Kennella | PCBDSN |
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SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

A G E N D A

**South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251
Columbia, South Carolina**

January 17, 2019

10:00 A.M.

1. Call to Order *Chairman Eva Ravenel*
2. Welcome - Notice of Meeting Statement *Commissioner Vicki Thompson*
3. Adoption of Agenda
4. Invocation *Commissioner Sam Broughton*
5. Introduction of Guests
6. Approval of the Minutes of the December 13, 2018 Commission Meeting
7. Public Input
8. Commissioners' Update *Commissioners*
9. Policy Committee Report *Committee Chairman Vicki Thompson*
10. State Director's Report *Director Mary Poole*
11. Business:
 - A. 2018 Silver Palmetto Award *Director Mary Poole*
 - B. Legislative Oversight Committees Update *Director Mary Poole*
 - C. Provider Contract Increases *Mr. Chuck Norman*
 - D. 2019-2020 Budget Update *Ms. Lisa Weeks*
 - E. Financial Update *Ms. Lisa Weeks*
 - F. Analysis of Current Waiting Lists *Mrs. Susan Beck*
12. Executive Session
13. Next Regular Meeting (February 21, 2019)
14. Adjournment

All changes are highlighted in yellow with bold red font. Changes based on public comments are noted in the right margin. All other changes are from the Policy Commission Committee or staff recommendations.

Reference Number:	535-14-DD
Title Document:	Authorization to Discuss Medical Condition and Medical Treatment Plan
Date of Issue:	XX, 2018
Effective Date:	XX, 2018
Last Review Date:	XX, 2018
Date of Last Revision:	XX, 2018 (NEW)
Applicability:	Providers Rendering Health Care to Those Who Reside in a Facility Operated by or Contracted with DDSN

PURPOSE

The Adult Health Care Consent Act (the Act), S.C. Code Ann. § 44-66-75 (2018), requires health care providers or the provider's agent to provide each patient or client representative of a person with an Intellectual Disability/Related Disability the opportunity to designate a family member or other individual they choose as a person with whom the health care provider may discuss the patient's medical condition and medical treatment plan. The purpose of this directive is to implement this requirement.

DEFINITIONS

The following definitions are consistent with definitions included in the Act:

Health Care: As described in the Adult Health Care Consent Act, "health care" means a procedure to diagnose or treat a disease, ailment, defect, abnormality or complaint, whether of

physical or mental origin. It includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and includes if indicated by this directive the placement in or removal from a facility that provides these forms of care.

For the purpose of this directive, health care is grouped into four (4) categories:

- 1) Medical/diagnostic care;
- 2) Medical/diagnostic procedures;
- 3) Administration of medication; and,
- 4) Admissions/placement/programming/discharge to or from an ICF/IID.

Health Care Power of Attorney: A person designated by another person to make health care decisions on their behalf. The Healthcare Power of Attorney must be on a form as authorized by S.C. Code Ann. § 62-5-504 (2018).

Health Care Professional: A person who is licensed, certified or otherwise authorized by the laws of this State to provide health care to members of the public. For DDSN, DSN Boards and DDSN qualified providers, the following staff members fall within the definition:

- Physicians;
- **Physician Assistants;**
- Nurse Practitioners;
- Registered Nurses (RNs);
- Licensed Practical Nurses (LPNs);
- **Board Certified Behavior Analysts;**
- **Licensed Psychologists, Licensed Professional Counselors;**
- **Licensed Physical Therapists;**
- **Licensed Occupational Therapists; and**
- **Licensed Speech Therapists.**

Health Care Provider: A person, health care facility, organization, or corporation licensed, certified or otherwise authorized or permitted by the laws of this State to administer health care. For DDSN, DSN Boards and DDSN qualified providers, the following are considered health care providers:

- Physicians;
- **Physician Assistants;**
- Nurse Practitioners;
- Registered Nurses (RNs);
- Licensed Practical Nurses (LPNs); and
- ICFs/IID.

Patient: Is defined as an individual 16 years of age or older who presents to a health care provider for treatment. In this document “person” will be used in lieu of “patient.”

Reasonable Accommodations: Will include, but not be limited to, using technology and devices, receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.” (As defined in S.C. Code § 62-5-101 (23)(b)(1) Supp. 2017)

Commented [HC1]: Kathleen Warthen

IMPLEMENTATION

As indicated in the Act, a health care provider shall offer the person or client representative of an person with an Intellectual Disability/Related Disability the opportunity to designate a family member or other individual they choose as someone with whom the health care provider may discuss the person’s medical condition and medical treatment plan. This opportunity, in accordance with the Act, must be offered when the person presents for treatment/services.

For DDSN, DSN Boards and DDSN contracted service providers who directly render health care services, the person is considered to be presenting for treatment/services, in some situations, daily or multiple times daily. For this reason, the opportunity to designate a family member or other with whom the person’s medical condition or medical treatment plan may be discussed will be offered in the following manner:

- Prior to or at the time of the first presentation to a physician, or nurse practitioner for medical/diagnostic care or procedure and at least annually thereafter;
- Prior to or at the time of the first administration of medication by a nurse and annually thereafter;
- Prior to or at the time of admission to an ICF/IID and annually thereafter.

When the opportunity to designate is offered, it must be presented as a written question. The question must be in bold print and capitalized or by electronic means. The question must read “**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**” Along with the written question, the person or client representative of a person with an Intellectual Disability/Related Disability must be notified that he/she may revoke or modify their authorization with regard to any family member or individual designated and that any revocation or modification must be in writing.

Reasonable accommodations and support must be provided so the person can understand and respond.

Commented [HC2]: Kathleen Warthen

The Authorization to Discuss Medical Condition and Medical Treatment Plan form (attached) may be used to:

- Document that the person was afforded the opportunity to designate;

- Document the individual(s) designated; and
- Inform of the ability to revoke or modify the designation.

The completed form must be in the person's record.
Any questions related to your organization's responsibility for obtaining authorization to discuss the medical condition and treatment plan of a person or client representative of a person with an Intellectual Disability/Related Disability served by your organization should be referred to your organization's legal counsel.

Gary Lemel
Vice Chairman

Eva Ravenel
Chairman

To access the following attachments, please see the agency website page "Current Directives" at <https://www.ddsn.sc.gov/about-us/directives/current-directives>.

Attachment: Authorization to Discuss Medical Condition and Treatment Plan

**AUTHORIZATION TO DISCUSS
MEDICAL CONDITION AND TREATMENT PLAN**

Name: _____ DOB: _____

Name of Health Care Provider: _____

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL
WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?**

Yes

IF, YES WHOM:

Name

Relationship

Name

Relationship

No

You may revoke or modify this authorization at any time, but you must do so in writing.

Signature of Person

Or Legal Guardian: _____

Date: _____

Witness: _____

Date: _____

This authorization satisfies the requirements of Title 42 of the Code of Federal Regulations relating to public health and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

All changes are highlighted in yellow with bold red font. Changes based on public comments are noted in the right margin. All other changes are from the Policy Commission Committee or staff recommendations.

Reference Number: 535-15-DD

Title Document: Obtaining Health Care Consent for Minors and Adults with Head And Spinal Cord Injuries (HASCI)

Date of Issue: XX, 2018
Effective Date: XX, 2018
Last Review Date: XX, 2018
Date of Last Revision: XX, 2018 (NEW)

Applicability: Providers Rendering Health Care to Those Receiving DDSN Services under the Category of Head Injury and Spinal Cord Injury (HASCI)

PURPOSE

This directive establishes procedures to identify persons required to give legally valid consent for health care for people receiving residential services from the South Carolina Department of Disabilities and Special Needs (DDSN) under the categories of Head and Spinal Cord Injury. **These procedures are** based on the definition of health care as defined in the Adult Health Care Consent Act (AHCA) found at S.C. Code Ann. § 44-66-20 (2018). DDSN, Disabilities and Special Needs (DSN) Boards and qualified providers may render health care to those served under these categories in the following ways:

- 1) Medical/diagnostic care;
- 2) Medical/diagnostic procedures; and

3) Administration of medication.

NOTE: The authority of DDSN to consent to health care **for persons receiving services through DDSN or a contracted provider** only applies to persons determined **by DDSN** to have an Intellectual Disability or Related Disability and **receiving services have been deemed unable to provide consent** pursuant to statute.

Commented [HC1]: Kelly Eifert

PHILOSOPHY

People who are eligible for DDSN services under the category of Head and Spinal Cord Injury are fully entitled to all the human and legal rights available to other citizens. The presence of a disability is not, in and of itself, a reason to assume the person is unable to consent. **Because,** However, a person's disability may adversely impact his/her decision-making ability, scrutiny must be given when health care consent from a person with a disability is required.

The level of scrutiny to be given to someone's ability to consent to health care must be balanced by the risks associated with the proposed health care, the person's ability to understand his/her condition, and the health care proposed. In all cases where consent for health care is required, the person with a disability must give the consent, unless:

- 1) A legal guardian has been appointed and authority to give health care consent is within the scope of the guardianship;
- 2) A durable power of attorney has been executed;
- 3) The person is a minor under age 16;
- 4) The person's inability to consent has been certified by two (2) physicians; **or**
- 5) The person is a minor 16 or 17 years of age being asked to consent to an operation.

Commented [HC2]: Kelly Eifert

DEFINITIONS

The following definitions are consistent with definitions included in the Adult Health Care Consent Act, S.C. Code Ann. § 44-66-20 (2018):

Adult: In South Carolina, a person 18 years of age or older is an adult. For health care consent, an adult is anyone over 16 years of age who is proposed any health care, except an operation. Adults must be 18 years of age or older to consent to an operation.

Adult Health Care Consent Act: This statute provides a legally recognized method of obtaining valid consent from an authorized person when the person is unable to consent on his/her own behalf. The Act is found at S.C. Code Ann. § 44-66-10 (2018).

Authorized Person: An “authorized person” is a person listed in the priority of consent givers for minors and adults pursuant to S.C. Code Ann. § 44-66-30 (2018).

Consent: As used in this directive, “consent” means the voluntary agreement to proposed health care by a person or authorized person with sufficient mental ability to make an **intelligent informed** choice.

Commented [HC3]: Kelly Eifert

Emergency: In context of the Adult Health Care Consent Act, an “emergency” is a situation where a person is in immediate need of specific health care to prevent death, permanent disfigurement, loss or impairment of the functioning of a bodily member/organ, or other serious threat to the health of the person. The immediate need for such care would override any delay caused by attempting to locate an authorized person to give consent for the proposed health care and/or in locating two physicians to certify the person as unable to consent.

Guardian: A “guardian” is a person appointed by a court to act and make decisions on behalf of another (ward). The court order appointing the guardian should be read carefully to determine if any limitations have been placed on the guardian as to making decisions about health care. It should be noted that a “conservator” is not the same as a “guardian.” A “conservator” is a person appointed solely to conserve and protect the ward’s estate and property. A conservator does not have authority to make health care decisions for the ward.

Health Care: As described in the Adult Health Care Consent Act, “health care” means a procedure to diagnose or treat a disease, ailment, defect, abnormality or complaint, whether of physical or mental origin. It includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and includes if indicated by this directive the placement in or removal from a facility that provides these forms of care.

For the purpose of this directive, health care is grouped into three (3) categories:

- 1) Medical/diagnostic care;
- 2) Medical/diagnostic procedures; and
- 3) Administration of medication.

Health Care Power of Attorney: A person designated by another person to make health care decisions on their behalf. The Healthcare Power of Attorney must be on a form as authorized by S.C. Code Ann. § 62-5-504 (2017).

Health Care Professional: A person who is licensed, certified or otherwise authorized by the laws of this State to provide health care to members of the public. For DDSN, DSN Boards and DDSN qualified providers, the following staff members fall within the definition:

- Physicians;
- Physician’s Assistants (PAs);
- Nurse Practitioners;
- Registered Nurses (RNs);
- Licensed Practical Nurses (LPNs);

- **Board Certified Behavior Analysts;**
- **Licensed Psychologists, Licensed Professional Counselors;**
- **Licensed Physical Therapists;**
- **Licensed Occupational Therapists; and**
- **Licensed Speech Therapists.**

Health Care Provider: A person, health care facility, organization, or corporation licensed, certified or otherwise authorized or permitted by the laws of this State to administer health care. For DDSN, DSN Boards and DDSN qualified providers, the following are considered health care providers:

- Physicians;
- Physician’s Assistants (PAs);
- Nurse Practitioners;
- Registered Nurses (RNs); and
- Licensed Practical Nurses (LPNs).

Minor: A person under the age of 18 is considered a “minor” in South Carolina, excluding a person who has been legally married or emancipated as decreed by the family court, S.C. Code Ann. § 63-1-40 (1) (2010). A minor under the age of 16 is deemed unable to give consent for health care by virtue of the status of his/her age. A minor who has reached the age of 16 may consent to any health service except operations, unless the operation is essential to the health or life of the minor in the opinion of the attending physician and a consultant physician, if one is available, S.C. Code Ann. § 63-5-340 (2010) and § 63-5-350 (2010).

Patient: An individual 16 years of age or older who presents or is presented to a health care provider for treatment. In this Directive, “person” “minor” and “patient” may be used interchangeably to describe the person with a Head and Spinal Cord Injury receiving services from DDSN, a DSN Board or a DDSN qualified provider.

Physician: An individual who is licensed to practice medicine or osteopathy pursuant to S.C. Code Ann. § 40-47-5 et seq. (2011).

Reasonable Accommodations: Will include, but not be limited to, using technology and devices, receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.” (As defined in S.C. Code § 62-5-101 (23)(b)(1) Supp. 2017)

Supported Decision Making: The process by which an individual with a disability, with capacity, uses designated “Supporters” to assist in explaining information, weighing various options and communicating decisions, to the extent needed by the individual. The Supporter does not have any decision-making authority and services only to assist the individual in making informed decisions.

Treatment: The broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality or complaint, whether of physical or mental origin. Treatment includes, but is not limited to psychiatric, psychological, substance abuse, and counseling services.

Unable to Consent: The inability of someone to appreciate the nature and implications of his/her health condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner.

INITIAL PROCESS

Typically, the staff person who is responsible for developing the service/support plan or the health care provider **for each individual event** will initially raise the question of a person's ability to give valid consent for health care. The issue would not arise in isolation, but in connection with an identified health care need for which specific health care services are proposed, such as the following:

1. Medical/diagnostic care (e.g., physical examinations, prescribing medications, x-rays, swallowing studies, etc.);
2. Medical/diagnostic procedures (e.g., surgery/operation, colonoscopy, etc.); or
3. Medication administration.

When health care is proposed, valid written, informed consent must be obtained prior to initiation and implementation of the health care.

The staff person responsible for developing the service/support plan or the health care provider who is employed by DDSN, a DSN Board or contracted provider must ensure that the requirements of this directive are met. If the proposed health care is based on traditional medical activities such as treatment/diagnostic care and/or procedures, then the health care provider is responsible for the obtaining valid consent. However, if proposed health care involves the administering of medications, then the staff person responsible for developing the service/support plan must ensure compliance with this directive. This does not negate a person's right to privacy under the Health Insurance Portability and Accountability Act (HIPAA).

ASSESSMENT OF ABILITY TO CONSENT

The process of obtaining consent involves a verbal dialogue that is reduced to a written consent form. The dialogue will focus on the following topics:

- 1) The person's current health condition or problem;
- 2) The intended or proposed health care;
- 3) The anticipated benefits of the health care;
- 4) The potential risks, adverse outcomes or side effects;

- 5) Possible alternative approaches and their risks and benefits; and
- 6) Risks/benefits of not having the proposed health care.

If the person cannot appreciate the nature and implications of his/her condition and the proposed health care, make a reasoned decision concerning the proposed health care, or communicate his/her decision in an unambiguous manner, **even with reasonable accommodations and support**, then the person is suspected to be unable to give valid consent. **The person must be provided any needed augmentative or alternative communication devices/technology to assist in that dialogue.**

If suspected to be unable to give valid consent, the person shall be referred to two (2) physicians. **Of the two (2) physician's, one (1) has to not be involved with DDSN.** Each physician must examine the person and make a judgement about ability to consent. **An individual may designate supporters to assist them in understanding information related to their healthcare, consistent with the Supported Decision Making Model.**

Commented [HC4]: This language came from Policy Committee. Staff would like to suggest an alternative wording to convey the same meaning: Of the two (2) physicians, one (1) should be independent of DDSN affiliation.

If the two (2) physicians, based on their examination **and knowledge of accommodations and support available to the individual**, determine that the person can give consent, then the person shall give consent for him/herself. This determination must be documented (see Attachment 3).

If the two (2) physicians determine that the person cannot give consent, an authorized person will be selected by the health care provider from the statutory list of priorities. The physicians must document their determinations and include their opinions regarding the cause and nature of the person's inability to consent, its extent, and probable duration.

If, in the opinion of the two (2) physicians, the person is unable to consent, but the person's inability to consent is temporary, and the health care professional responsible for the care of the person determines that the delay occasioned by postponing treatment until the person regains the ability to consent will not result in significant detriment to the person's health, then no authorized person will be selected and the proposed health care will be postponed until the person is able to provide consent.

AUTHORIZED PERSONS

I. Minors

In accordance with S. C. Code Ann. § 44-26-60 (2018), if a person is a minor under the age of 16 or is 16-17 years of age and in need of an operation, consent for his/her health care must be given by an authorized person selected by the health care provider based on the following order of priority:

1. Legal guardian with court order;
2. Parent;
3. Grandparent or adult sibling;

4. Other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the minor;
5. Other person who reasonably is believed by the health care professional to have a close relationship with the minor; or
6. Authorized designee of DDSN. "Authorized designees" include the State Director of DDSN, DDSN Regional Center Facility Administrators, DDSN Autism Division Director, Executive Directors of Boards of Disabilities and Special Needs, and Executive Directors/Chief Executive Officers of DDSN Qualified Provider Agencies (see Attachment 4).

Documentation of efforts to locate an authorized person identified in the priority listing shall be recorded in the minor's medical record (see Attachment 2).

Should persons of equal priority disagree on whether certain health care should be provided, the health care provider or any person interested in the welfare of the minor may petition the probate court for an order to determine what care is to be provided or for the appointment of a temporary or permanent guardian.

Priority should not be given to someone the health care provider determines is not reasonably available, or is not willing or unable to make health care decisions for the minor.

In an emergency, health care may be provided to a minor without consent under the same emergency provision applicable to adults, even where the inability of the minor to consent is based solely on his/her minority.

II. Adults

The Adult Health Care Consent Act, S.C. Code Ann. § 44-66-10 (2018), sets forth a process for obtaining consent when an adult is unable to consent for health care.

In accordance with S.C. Code Ann. § 44-66-30 (2018), when an adult has been determined by two (2) physicians to be unable to consent to proposed health care, then consent for his/her proposed health care must be given by an authorized person selected by the health care provider based on the following order of priority:

1. A guardian appointed by the court, pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of guardianship;
2. An attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to S.C. Code § 62-5-501 (Supp. 2017), if the decision is within the scope of his authority;
3. A person given priority to make health care decisions for the patient by another statutory provision;

4. A spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:
 - a) Entry of a pendente lite order in a divorce or separate maintenance action;
 - b) Formal signing of a written property or marital settlement agreement; or
 - c) Entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;
5. An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
6. A parent of the patient;
7. An adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;
8. A grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;
9. Any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation.

Documentation of efforts to locate an authorized person identified in the priority listing must be recorded in the person's medical record (see Attachment 2).

Priority must not be given to an authorized person who the health care provider determines is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent.

EXCEPTIONS

For those unable to consent, health care for the relief of pain and suffering may be provided without consent at any time an authorized person in the priority list is unavailable. In an emergency, the person's inability to consent may be certified by a health care professional responsible for the care of the person if the health care professional states in writing in the person's record that the delay occasioned by obtaining certification from two (2) physicians would be detrimental to the person's health. The health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent and its probable duration. This opinion must be documented.

For those unable to consent, in emergency situations, health care may be provided without consent if no person on the priority list is immediately available, and in the reasonable medical judgment of the health care professional responsible for the care of the person, the delay occasioned by attempting to locate an authorized person to make the health care decision would present a substantial risk of death, permanent disfigurement, impairment of a bodily member/organ, or other serious threat to the health of the person.

Health care decisions on behalf of a person who is unable to consent may be made by an authorized person identified by the priority list if no other authorized person having a higher priority is available immediately, and in the reasonable medical judgment of the health care professional responsible for the care of the person, a delay occasioned by attempting to locate an authorized person having a higher priority presents a substantial risk or serious threat to the health of the person.

For those unable to consent, health care may be provided without consent where there is no authorized person who is reasonably available and willing to make the decision, and in the reasonable medical judgment of the health care professional responsible for the care of the person, the health care is necessary for the relief of suffering, restoration of bodily function or to preserve the life, health or bodily integrity of the person.

ADDITIONAL NOTES

The Adult Health Care Consent Act does not authorize the provision of health care where the attending physician or other responsible health care professional has actual knowledge that the health care is contrary to the religious beliefs of the person, unless the person, while able to consent, stated contrary intent to the physician or health care professional.

The Adult Health Care Consent Act does not authorize health care to a person unable to consent if the attending physician or responsible health care professional has actual knowledge that the proposed health care is contrary to the person's unambiguous and un-contradicted instructions expressed at the time when the person was able to consent.

A person who in good faith makes a health care decision as provided in the Adult Health Care Consent Act is not subject to civil or criminal liability on account of the substance of the decision.

A person who consents on behalf of a person unable to consent does not by virtue of that consent become liable for the costs of the health care provided to the person.

A health care provider, who in good faith relies on a health care decision made by an authorized person, is not subject to civil and criminal liability or disciplinary penalty on account of reliance on the decision.

Gary Lemel
Vice Chairman

Eva Ravenel
Chairman

To access the following attachments, please see the agency website page "Current Directives" at <https://www.ddsn.sc.gov/about-us/directives/current-directives>.

Attachment 1	Health Care Consent Instructions
Attachment 2	Health Care Consent - Identification and Selection of Authorized Person
Attachment 3	Health Care Consent - Physician Certification
Attachment 4	Establishment of Authorized Designees of DDSN for Health Care Decisions and Responsibilities

Health Care Consent Instructions

Thoroughly read DDSN [Directive 535-15-DD: Obtaining Health Care Consent for Minors and Adults \(the Directive\)](#)

If someone who, by virtue of their age and competency status, would be able to consent for their health care is suspected to be unable to give valid consent for the health care proposed, the person shall be referred to two (2) physicians who will determine the person's ability to do so. **NOTE:** Exceptions to this requirement are explained in the "Exceptions" section of the directive.

When referred, each licensed physician should be provided an **Adult Health Care Consent Certification** Form (535-15-DD Attachment 3) with the person's name and date of birth (DOB) entered. Additionally, Section I must be completed on each form. **NOTE:** Examination and certification by two (2) physicians is required; therefore, two (2) **Adult Health Care Consent Certification** Forms shall be completed.

Section II of the **Adult Health Care Consent Certification** Form is completed by the physician. The physician's determination of the person's ability to consent should be documented in Section II.A.

If the two (2) physicians agree that the person "is able" to consent, no further action is needed. The person will make his/her own health care decision.

If the physician determines the person "is temporarily not able" or "is not able," then questions B, C, and D in Section II must be answered by the physician. The form must be signed and dated by the physician.

If the two (2) physicians agree that the person "is temporarily not able," then the health care professional responsible for the care of the person must determine if the delay occasioned by postponing the proposed treatment will result in significant detriment to the person.

If the two (2) physicians agree that the person "is not able" to consent, then the health care provider proposing the health care must identify and select an authorized person to consent or refuse the proposed health care. The **Health Care Consent Identification and Selection of an Authorized Person** Form (Identification and Selection, 535-15-DD Attachment 2) should be used for this purpose.

If the two (2) physicians disagree, the person is considered able to give valid consent.

Section I of the "**Identification and Selection**" Form (535-15-DD Attachment 2) requires that the name(s) and, as appropriate, relationship(s) of those identified by the "Priority Category" be entered. When no one is identified, "not applicable" or "n/a" should be entered. The person's record must reflect all efforts to locate anyone identified by a priority category on the "**Identification and Selection**" Form (535-15-DD Attachment 2).

Once all authorized persons have been identified, then the authorized person who will make the health care decision must be selected/contacted by the health care provider proposing the health care.

The Priority Categories are listed in priority order with “1. Guardian appointed by the court...” having the highest priority and “9. Adult relative...having lowest priority.”

The authorized person(s) who may consent to or refuse the proposed health care is/are the one(s) who, among all listed, is:

- Identified in the highest priority category;
- Reasonably available;
- Willing to make the health care decision; and
- Him/herself able to consent.

If more than one authorized person is identified in the highest priority category, the health care decision will be made by the majority of those identified.

The name(s) of the selected authorized person(s) must be entered into Section II of the “**Identification and Selection**” Form (535-15-DD Attachment 2) along with the priority category in which he/she was identified and his/her address and phone number.

If an authorized person identified by a higher priority category than the selected authorized person’s category was not selected (i.e., if #5 is selected before #4), his/her priority category, name and the reason he/she was not selected (e.g., not reasonably available, not willing, unable to consent) must be noted.

The health care provider making the selection must enter his/her name and title, then sign and date the completed form.

**Health Care Consent
Identification and Selection of Authorized Person**

Name: _____

DOB: _____

I. Identification of Authorized Persons

For each priority category listed below, enter the names(s) of each person identified by the priority category and, as appropriate, the person's relationship to the person who is unable to consent to the proposed health care. If the priority category does not identify anyone, enter "not applicable" or "n/a." All efforts to locate those identified by the priority category must be documented in the person's record.

Priority Category	Name(s)/Relationship
1. Guardian appointed by the court, pursuant to Article 5, Part 3 of the South Carolina Probate Code, if health care decisions are within the scope of guardianship.*	
2. An attorney-in-fact appointed by the person in a durable Power of Attorney executed pursuant to S.C. Code Ann. § 62-5-501 (Supp. 2017), if the decision is within the scope of his authority.*	
3. Person given priority to make health care decisions for the patient by another statutory provision.	
4. The spouse of the person, unless the spouse and the person are separated pursuant to one of the following: a) Entry of a pendente lite order in a divorce or separate maintenance action; b) Formal signing of a written property or marital settlement agreement; or c) Entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties.	
5. Adult child or children of the person.	
6. Parent(s) of the person.	
7. Adult sibling(s) of the person.	
8. Grandparent (s) of the person.	
9. Adult relative(s) by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the person.	

**The person's record must contain legal documents supporting the authority of the person named in the priority category*

II. Selection of the Authorized Person

When an adult is certified by two (2) physicians to be unable to consent to health care, an authorized person must be selected from the statutory list of priorities established by S.C. Code Ann. § 44-66-10, et. seq. (2018) and DDSN Directive 535-15-DD: Obtaining Consent for Minors and Adults. The Priority Categories in Section I of this document are listed in priority order, 1- 9. When the person has been certified by two (2) physicians to be unable to consent to the proposed health care, the person, among all who are listed, who is identified in the highest priority category and who is reasonably available, willing to make the health care decision for the person and is him/herself able to consent, will be considered the authorized person who can make the decision regarding the proposed health care.

The selected **Authorized Person(s)**:

Name(s): _____

Relationship (priority category) to the person: _____

Address: _____

Phone Number: _____

If someone from any higher priority category was not selected as the authorized person, enter the person's name, the priority category, and the reason he/she was not selected (*e.g., not reasonably available, not willing, unable to consent*).

Priority Category	Name	Reason Not Selected

Printed Name of Health Care Provider

Title of the Health Care Provider

Signature of the Health Care Provider

Date of Completion

ADULT HEALTH CARE CONSENT

Physician Certification

Patient's Name: _____

DOB: _____

Section I. Proposed Health Care and Timeframe for Initiation

Section II. Certification by Physician

A. Based on examination, it is my professional opinion that the person named above (*choose one*):

Is able to give valid consent for the proposed health care.

Is temporarily not able to consent for the proposed health care.

Is not able to give valid consent for the proposed health care.

B. This person is noted to be: temporarily not able or not able to give valid consent (*indicate why*)
He/she: (*check all that apply*):

Is unable to appreciate the nature and implications of his/her conditions and the proposed health care;

Is unable to make a reasoned decision concerning the proposed health care; or

Is unable to communicate a decision concerning the proposed health care in an unambiguous manner.

C. This person is noted to be: temporarily not able or not able to give valid consent and the following facts and observation that support this medical opinion and conclusion include:

1. The **cause** of the person's inability to consent is: _____

2. The **nature** of the person's inability to consent is: _____

3. The **extent** of the person's inability to consent is: _____

4. The **probable duration** of the person's inability to consent is: _____

D. **If noted to be temporarily unable to consent, will a delay in rendering** the proposed health care beyond the time noted present a substantial risk of death, impairment of functioning of a bodily organ or other serious threat to the health and safety of the person named?: Yes No N/A

I, the undersigned, hereby state that I am a licensed physician and have personally examined the above named person and my opinion and conclusions are stated above.

Signature of Physician

Printed Name of Physician

Date: _____

Establishment of Authorized Designees of DDSN for Health Care Decisions and Responsibilities

When a person who is eligible for DDSN services under the categories of Intellectual Disability/Related Disability (ID/RD) and is receiving DDSN-sponsored residential services is, in accordance with the Adult Health Care Consent Act, certified to be unable to consent to or refuse health care and when no other authorized person identified by the statutory list of priorities is reasonably available, willing, or able to make the health care decision, an authorized designee of DDSN may do so.

Authorized designees of DDSN include:

- DDSN State Director,
- DDSN Regional Center Facility Administrators,
- Executive Directors of DSN Boards
- Executive Director/CEO of DDSN Qualified Provider Agencies

In keeping with S.C. Code Ann. § 44-26-50 (2018), when making a health care decision, the authorized designee of DDSN shall be informed of:

- The need for the health care,
- The alternative treatments, and
- The nature and implications of the proposed health care.

The authorized designee of DDSN shall consult with the attending physician or the health care professional proposing the health care before making the decision and, when feasible, shall observe or consult with the person who has been certified to be unable to consent to or refuse the proposed health care.

The authorized designee of DDSN shall document their compliance with the requirements noted herein and shall include the name of the attending physician or health care professional proposing the health care with whom the authorized designee of DDSN consulted and the date of the consultation. Documentation of the consultation shall be in the person's record.

All changes are highlighted in yellow with bold red font. Changes based on public comments are noted in the right sided margin. All other changes are from the Policy Commission Committee or staff recommendations.

Reference Number: 603-03-DD
Title of Document: **Medical and Dental Treatment for Uncooperative Consumers Safety Precautions for Medical and Dental Treatment**
Date of Issue: August 1, 1989
Effective Date: August 1, 1989
Last Review Date: XX, 2018
Date of Last Revision: XX, 2018 (REVISED)
Applicability: DDSN Regional Centers

Commented [HC1]: Kathleen Warthen

PHILOSOPHY/PURPOSE

It shall be the philosophy of Regional Center Health Services Programs to provide the highest quality of medical and dental services to all individuals **consistent with their abilities**. Since many individuals do not cooperate during treatment procedures, the use of behavior modification techniques, medical or dental management strategies, restraints, sedation, and/or general anesthesia it may be necessary to safely accomplish needed medical and dental treatment, and to allow medical or dental services to be provided in the least restrictive manner. It is understood that without the use of dental restraints, sedation, and on occasion, general anesthesia, comprehensive medical and dental services for some individuals would be impossible.

Commented [HC2]: Kelly Eifert

The definition of the words as used in this document are as follows:

- Must or shall: indicates mandatory;
- Should: indicates desirable; and
- May or could: indicates discretionary.

This policy is intended to support, not supplant, the clinical judgment of the individual medical or dental practitioner.

USE OF BEHAVIOR MODIFICATION/FAMILIARIZATION TRAINING

One should not automatically consider a person with developmental disabilities to **be pose** a medical or dental management problem. A small percentage of those individuals who do present behavioral/cooperation problems can be treated using behavioral modification techniques adapted from those employed by psychologists and special educators.

Commented [HC3]: Kathleen Warthen

Many physicians and dentists automatically use many of these approaches (e.g. verbal praise) with selected medical and dental patients. One limitation to these methods is the time factor. It is simply not feasible for the physician or dentist to spend multiple hours attempting to encourage a patient to comply with treatment. An additional point is that these techniques tend to be preventive, not prescriptive, in nature and their success is limited to managing mild maladaptive behaviors.

Once an individual is behaving in an unsafe manner (e.g., injuring himself), these measures are frequently ineffective to **obtain create** an environment where medical or dental procedures can be performed safely. The following are some preventive behavior management techniques available to the physician or dentist and are used based upon specific characteristics of individuals.

Commented [HC4]: Kelly Eifert

- A. Use of longer periods of instruction;
- B. More frequent repetition of instructions;
- C. Use of concrete terminology;
- D. Greater use of visual cues;
- E. Reducing distractions;
- F. Encouraging consistency within the medical or dental environment;
- G. Higher frequency of positive reinforcement, training and other behavioral management techniques; and
- H. Medical and Dental Familiarization Training.

Based upon current DDSN health care guidelines, it would be important, when indicated, It is required to document those behaviors which cannot be managed by less restrictive techniques including familiarization training before proceeding to restraints and/or sedation. Continuing efforts to fade the use of restraints and/or sedation via medical and dental familiarization should take place as appropriate.

Commented [HC5]: Kathleen Warthen

Necessary treatment should not be delayed for behavior modification training if such a delay could result in increased morbidity.

MEDICAL AND DENTAL RESTRAINTS DURING MEDICAL AND DENTAL PROCEDURES

There are individuals with behavioral problems who can be treated with the use of simple restraints without the concomitant use of sedation. These restraints vary from simple arm/ wrist and body restraints to the use of full body wraps (e.g., Pedi-Wrap, Papoose board or sheets).

Medical and dental restraints are medical and therapeutic in character, temporary in employment and should not be guided by many of the limitations and restrictions associated with use of general behavioral restraints.

When an individual requires restraints to receive medical or dental treatment, a record of this shall be made in the medical or dental process notes and referenced in the Individual's Program Plan. Use of planned medical or dental restraints requires the informed consent of the ~~designated consent-giver person or the person required to give legally valid consent for health care in accordance with the Adult Health Care Consent Act found at S.C. Code Ann. § 44-66-10 et seq. (2018) (authorized person)~~. These planned restraints must also be reviewed and approved by the Regional Center Human Rights Committee. This documentation/consent/Human Rights Committee approval must be updated at least annually. If an individual is approved to receive planned dental restraints, dental familiarization will be utilized as appropriate to support dental treatment.

Since the necessity for use of physical restraints cannot always be predicted prior to medical or dental treatment, unplanned restraint use and the reasons for it will be documented in the medical or dental progress notes following treatment. Recurring use of unplanned restraints will require review by the interdisciplinary team to determine if a plan of intervention is needed.

For certain individuals, health protection devices are necessary for positioning and support. ~~Due to physical conditions, such as spasticity or involuntary muscle contractions, the same devices used as medical or dental restraints on some individuals, serve as positioning and support devices for others, and used in this manner, are health protection devices~~ *Due to physical conditions such as spasticity or involuntary muscle contractions, the same devices used as medical or dental restraints on some individuals serve as positioning and support devices for others. When health protection devices are used for positioning and support,* justification for the planned use of these devices will be made in the medical or dental progress notes and referenced to in the Individual's Program Plan. Use of these devices will require informed consent of the ~~designated consent-giver person or authorized person~~ but should not require review/approval by the Regional Center Human Rights Committee.

Commented [HC6]: Donna Hall

If a restraint device is used, appropriate monitoring of the individual will occur. The head position should be checked to ensure a patent airway. At no time shall a restrained individual be left unobserved while in the ~~medical or dental~~ clinic.

Commented [HC7]: Donna Hall and Kelly Eifert

USE OF SEDATION

When an individual requires sedation to receive medical or dental treatment, a record will be made in the physician's or dentist's notes and the Individual's Program Plan. Use of sedation requires consent by the ~~designated consent-giver person or authorized person~~ and approval by the Regional Center Human Rights Committee. This documentation/consent/Human Rights Committee approval must be updated at least annually. If an individual is approved to receive planned sedation, medical or dental familiarization will be utilized as appropriate to support medical or dental treatment.

A. Introduction

These guidelines address three (3) major issues:

1. The choice of drugs, dosage and route of administration during medical or dental procedures are the responsibility of the individual dental practitioner and/or physician with the following exceptions:
 - a. Ketamine, Propofol, Etomidate, Sodium Thiopental, Methodexital, Fentanyl or similar agents will not be utilized.
 - b. The lowest level of sedation should be provided in order to accomplish the indicated medical or dental procedures. When sedation is indicated minimal sedation/anoxiolysis is the goal. Planned deep sedation will not be utilized at DDSN Regional Facilities.
2. It is the responsibility of the Facility to provide the medical or dental staff with access to continuing education and programs necessary to maintain and/or improve current levels of skill (e.g., meetings, CPR certification and infection control updates).
3. The Facility must assure that medical and dental services are provided by trained professionals and are provided in a safe, properly equipped environment in which individuals requiring medical or dental sedation may be treated and monitored post operatively by appropriate, trained staff.

B. Indication

Procedures must follow the Adult Health Care Consent Act to obtain consent based on capacity to make health care decisions. Sedation is indicated for uncooperative individuals, including many with accompanying medical and physical disabilities, for whom less restrictive management modalities are ineffective and/or unsafe. The goals of sedation are similar to those in the private sector (e.g., allaying anxiety and fear, and raising pain threshold), but it is primarily used at DDSN Regional Centers to address severe medical or dental management problems characterized by aggressive, combative behavior and self-abuse. The goal of sedation procedures should be to provide optimal and comprehensive medical and dental services with maximum safety and comfort to the individual without the use of more involved procedures such as general anesthesia.

Commented [HC8]: Kathleen Warthen

C. Definition of Sedation

Anxiolysis (minimal sedation): Anxiolysis (minimal sedation) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilation and cardiovascular functions are unaffected.

Moderate (Conscious) Sedation: Moderate (conscious) sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone

or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation: Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilation function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

THE TERM SEDATION, WHEN USED WITHIN THESE GUIDELINES, ALWAYS REFERS TO ANXIOLYSIS (MINIMAL) OR MODERATE (CONSCIOUS) SEDATION.

D. Facilities and Equipment

It is the responsibility of the Facility Administration to provide a safe environment in which to treat individuals who require sedation for medical or dental services.

It is the responsibility of the medical/dental practitioner and Facility Administration to assure that use of sedation is utilized in a manner that is consistent with applicable state regulations to include the American Dental Association's Guidelines for the Use of Sedation and General Anesthesia by Dentists.

The medical and dental clinic shall have a positive pressure oxygen delivery system that is capable of administering greater than 90% oxygen at a 5 liter/minute flow for at least 60 minutes. This equipment should accommodate both children and adults. If the Facility provides nitrous oxide/oxygen sedation, this equipment should provide a maximum of 100% and never less than 25% oxygen concentration at a flow rate appropriate to the individual's needs and have the standard fail-safe system which is in place on all DDSN nitrous equipment.

When sedation is provided at a Facility, it shall be the responsibility of that Facility to provide the physician or dentist with equipment that is appropriate for the technique being used. It is the responsibility of the administering physician, dentist and Facility Administrator to assure the accessibility and proper functioning of this equipment.

An emergency kit must be readily accessible and will include the necessary drugs and equipment to manage a non-breathing and unconscious patient and to provide continuous support until that individual can be transported to a medical facility. The drugs contained on the emergency kit should be checked and maintained appropriately, according to DHEC, Labor, Licensing and Regulation/State Board regulations.

E. Monitoring

During the medical or dental procedure, a sedated individual's consciousness and responsiveness shall be appropriately monitored by licensed dentists or physicians who are trained in monitoring and resuscitation procedures. The monitoring process may be performed by visual, mechanical or electrical means. However, many individuals present with combative, aggressive and totally uncooperative behavior which renders recording of vital signs impossible and meaningless. Thus, the practitioner should utilize other signs of the degree of the individual's consciousness or responsiveness.

If a restraint device is used in conjunction with sedation, appropriate monitoring of the individual will occur. The head position should be checked to ensure a patent airway. At no time shall a sedated individual be left unobserved while in the medical or dental clinic.

F. Documentation

The practitioner shall be familiar with the **individual's** current medical history and physical examination information **regarding the individual**. This information should be readily available. When utilizing sedation medications, pertinent information should be clearly entered into the medical or dental progress notes and Individual's Program Plan. All entries shall be signed and titled by the appropriate practitioner.

Commented [HC9]: Kelly Eifert

G. General Anesthesia

1. General anesthesia is necessary for only a small percentage of individuals. Although general anesthesia is indicated for only a small percentage of individuals, it is a vital component in the array of medical or dental treatment modalities for people with an Intellectual Disability or a Related Disability. The major considerations that influence the requirement for general anesthesia are:
 - a. The existence of a severe medical or dental management problem not amenable to the use of sedation and/or restraints, and/or
 - b. An extensive amount of medical or dental treatment needed.
2. Since general anesthesia is not administered at DDSN Regional Centers, the Regional Center physician or dentist will make a referral to an appropriate specialist.
3. Documentation of informed consent is the responsibility of the attending specialist.

Summary

When treating individuals who do not cooperate with medical or dental treatment, it is the responsibility of the medical or dental practitioner to determine whether behavioral modification management, physical restraints, sedation, general anesthesia or any combination is appropriate to allow for safe medical or dental treatment. The use of sedation for some medical or dental patients is a necessary and routine treatment modality and in no way should be confused with use of psychotropic medications employed on a regular basis to address general behavioral problems. It is the responsibility of the Facility Administrator to provide a safe environment for medical and dental sedation and to help provide the practitioner with access to the most current information and professional training **for medical and dental treatment of individuals with disabilities**.

Commented [HC10]: Kelly Eifert

Gary Lemel
Vice Chairman
(Originator)

Eva Ravenel
Chairman
(Approved)

The term “client representative” in S.C. Code Ann. § 44-20-10 et. seq., violates the Americans with Disabilities Act (ADA) as it discriminates against persons with disabilities. Both Protection & Advocacy for People with Disabilities, Inc. and Able South Carolina find that the use of this term is in violation of the rights of the persons served by DDSN as well. DDSN will request an opinion of the Office of the Attorney General as to the use of this terminology and the notification of family.

All changes are highlighted in yellow with bold red font. Changes based on public comments are noted in the right margin. All other changes are from the Policy Commission Committee or staff recommendations.

Reference Number:	600-05-DD
Title of Document:	Behavior Support, Psychotropic Medications, and Prohibited Practices
Date of Issue:	June 1, 1987
Effective Date:	June 1, 1987
Last Review Date:	XX, 2018
Date of Last Revision:	XX, 2018 (REVISED)
Applicable for Persons Receiving:	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Residential Habilitation, and Employment/Day Services (Day Activity, Career Preparation, Community Services, Employment Services, Support Center Services)

PURPOSE

The purpose of this directive is to establish the expectations of the South Carolina Department of Disabilities and Special Needs (DDSN) regarding interventions used to address concerning or

problem behaviors exhibited by those served in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), those receiving Residential Habilitation in a DDSN-sponsored residential setting, and those for whom such interventions are necessary in order for them to participate in a DDSN-licensed employment/day program. Those interventions include:

- Behavior Support Plans which are defined as specific plans that teach or assist someone to build positive behaviors to replace or reduce problem behaviors and, when necessary, include strategies to be used to protect the person when dangerous and unsafe behaviors are exhibited.
- Psychotropic Medications which are defined as any medication used for the primary purpose of affecting overt maladaptive behavior, mood, or thought processes, or alleviating symptoms related to a specific diagnosed psychiatric condition.
- Emergency Interventions which are defined as procedures used to provide protection from harm in situations where the person is endangering him/herself or others with severely aggressive, self-injurious, or destructive behavior. These behaviors could not reasonably have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.
- Health-Related Protections which are defined as restraint (chemical, physical, or mechanical) used during the conduct of a specific medical, dental, or surgical procedure or used out of necessity during the time a medical condition exists. Examples of devices used as a health-related protection include, but are not limited to: splints, braces, bed rails, wheelchair harnesses, helmets, and lap belts.

NOTE:

- Throughout this directive, DDSN Regional Centers and ICFs/IID operated by DSN Boards or contracted service providers will be referred to as “facility.” When referring to agencies (DDSN, DSN Boards or contracted service providers) that provide Residential Habilitation and/or Employment/Day Services, “provider” will be used.
- *Throughout this directive, “client representative” is used. In the context of this directive, “client representative” means the parent, guardian, legal counsel or other person who acts on behalf or in the best interest of a person with Intellectual Disability or a Related Disability (ID/RD) including Autism. This definition is consistent with S. C. Code Ann. § 44-26-10 et. seq. (2018).*
- *Client representative does not apply to those receiving services under the category of HASCI as there is no statutory authority for such.*

PHILOSOPHY

Consistent with DDSN’s values, it is expected that all supports and interventions to address problem behavior:

- Ensure the health, safety, and well-being of each person;

- Ensure that each person is treated with dignity and respect;
- Encourage participation, choice, control and responsibility;
- Encourage relationships with family and friends, and connections in the community; and
- Result in personal growth and accomplishment.

Consistent with DDSN's principles, it is expected that supports and interventions to address problem behavior will:

- Be person-centered and community inclusive;
- Be responsive, effective and accountable;
- Be practical, positive and appropriate;
- Be strengths-based and results-oriented;
- Offer opportunities to be productive and maximize potential; and
- Feature best and promising practices.

As a foundation of all supports, DDSN embraces positive behavior support. Positive behavior support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation/circumstances. The focus of positive behavior support begins with understanding the purpose or function of the problem behavior. Once it is known why the behavior occurs, interventions to promote positive behavior that serves the same function can be developed.

The goal of positive behavior support is not solely to eliminate problem behavior but to create environments and patterns of support that make the problem behavior irrelevant, inefficient or ineffective while making the positive behavior that is promoted as an alternative, relevant, effective and efficient.

DDSN believes that all who develop intervention strategies for people with disabilities must be knowledgeable in the values, theory, and practices of positive behavior support. Literature such as Functional Assessment and Program Development for Problem Behavior: A Practical Handbook (O'Neill, Horner, et. al., 2014) or similar guides to evidence-based practices in positive behavior support are recommended for review and study.

POLICY

Those supported will be free from any serious risk to physical and psychological health and safety at all times, including while the function of the problem behavior is being determined and while the interventions to address the behavior are being developed.

DDSN prohibits the use of the following:

- Procedures or devices used for disciplinary purposes, for the convenience of staff, or as a substitute for needed supports;
- The use of medication for disciplinary purposes, for the convenience of staff, as a substitute for training or engagement, or in quantities that interfere with someone's quality of life;
- Seclusion which is defined as placing someone alone in a locked room;
- Enclosed cribs;
- Interventions that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
- Encouraging/using someone supported to discipline a peer;
- Prone basket-hold restraint (i.e., person held face down with arms folded under the chest);
- Time out rooms;
- Aversive consequences which are defined as the use or threatening the use of startling, unpleasant or painful consequences;
- As needed (PRN) orders for psychotropic medications or mechanical restraint except when prescribed by a physician while treating the person in a hospital setting or prescribed as part of the palliative care provided by Hospice;
- Use of psychotropic medications in the absence of a Behavior Support Plan for problem behavior and/or psychiatric symptoms that pose a risk to the person, peers, or the environment and interfere with the person's daily functioning;
- The planned use of restrictive procedures and/or restraint (manual or mechanical) prior to the exhaustion of less intrusive measures;
- The use of restraint (manual or mechanical) for more than one (1) continuous hour (60 continuous minutes);
- The use of restraint (manual or mechanical) when not necessary to protect the person or others from harm;
- Coercion/use of intimidation or use of force to gain compliance.

Each DDSN Regional Center, DDSN-operated Residential Services, DSN Board or contracted service provider of ICF/IID, Residential Habilitation and/or DDSN-sponsored Employment/Day

Services shall adopt written policies and procedures governing the prevention and management of problem behavior. These policies and procedures shall focus on the prevention of problem behavior and specify the facility, program or DDSN-approved procedures that may be used. If consequence-based procedures are approved for use, the policies and procedures shall include each procedure on a hierarchy ranging from most positive/least restrictive to least positive/most restrictive. The policies and procedures shall address the use of restraint, the use of medications to manage problem behavior, and the practices prohibited by the facility, program or board/provider.

For ICF/IID residents, consent for programming, including Behavior Support, must be obtained pursuant to DDSN Directive 535-07-DD: Obtaining Health Care Consent for Minors and Adults.

In accordance with DDSN Directive 535-02-DD: Human Rights Committee, each facility or provider must designate and use a Human Rights Committee to review and approve planned interventions which involve risk to individual protection and rights. Pursuant to the DDSN Directive 535-02-DD: Human Rights Committee, the Human Rights Committee must review and approve of the use of planned interventions prior to implementation and appropriate consents/approvals have been obtained. Additionally, the Human Rights Committee must be notified of the use of any Emergency Interventions.

I. BEHAVIOR SUPPORT PLANS

Behavior Support Plans must be developed and monitored in accordance with the regulations governing ICFs/IID when developed for ICF/IID residents and in accordance with DDSN Residential Habilitation Standards for those receiving Residential Habilitation.

Behavior Support Plans include specific procedures or techniques to be utilized to prevent and respond to behavior. These procedures or techniques may be nonrestrictive, restrictive, or employ restraint.

A. BEHAVIOR SUPPORT PLANS: NONRESTRICTIVE

When the procedures or techniques within a Behavior Support Plan do not limit freedom, rights, or allow for the loss of access to personal property, the Behavior Support Plan is considered nonrestrictive. Examples of nonrestrictive procedures or techniques include, but are not limited to, teaching appropriate and functionally-equivalent replacement behavior; differential reinforcement, social disapproval, simple correction, re-directions and interrupting with educative prompts.

NOTE: Behavior Support Plans which accompany the use of psychotropic medications **ARE** considered restrictive.

Prior to implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for an ICF/IID resident, the Behavior Support Plan must be approved by the ICF/IID resident's Interdisciplinary Team which includes the person, his/her legal guardian

or the person authorized to make health care decisions on behalf of the person, or client representative of a person with an Intellectual Disability/Related Disability and incorporated into the person's Individualized Program Plan (IPP).

Prior to implementation of a Behavior Support Plan for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person, *client representative of a person with ID/RD, or his/her legal guardian* and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is to also be implemented by other service providers (i.e., Employment/Day Services providers), the Behavior Support Plan must be approved by the person(s) who develop the Service Plan(s) for the other services (i.e., the person who develops the Individual Plan for Supported Employment if the plan is to be implemented as part of the provision of Employment Services).

Prior to the implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and participate in a DDSN-sponsored Employment/Day Service, the Behavior Support Plan must be approved by the person, *client representative of a person with ID/RD, or his/her legal guardian* and the person who develops the Employment/Day Service Plan.

Behavior Support Plans that utilize only nonrestrictive procedure/techniques must be monitored in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, DDSN Residential Habilitation Standards, Day Activity Standards, etc.).

B. BEHAVIOR SUPPORT PLANS: RESTRICTIVE

When the procedures or techniques within a Behavior Support Plan limit the person's rights, freedom of movement, or cause loss of access to personal property, the Behavior Support Plan is considered restrictive. Examples of restrictive procedures/techniques include, but are not limited to, increasing the level of supervision provided in response to behavior, one-on-one supervision, response cost, overcorrection, and separation lasting more than five (5) minutes (excluding time-out rooms which are prohibited).

NOTE: Behavior Support Plans which accompany the use of psychotropic medication are considered restrictive.

Prior to implementation of a Behavior Support Plan that includes restrictive procedures/techniques, appropriate approvals must be obtained.

For ICF/IID residents, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with an Intellectual Disability/Related Disability or the person authorized to make health care decisions on behalf of the ICF/IID resident.

Additionally, for ICF/IID residents, the Behavior Support Plan must be approved by the person's Interdisciplinary Team which includes the person, his/her legal guardian, or person authorized to make health care decisions on behalf of the person and the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person or his/her legal guardian and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is also to be implemented by other service providers (i.e., Employment/Day Service providers), it must be approved by the person responsible for developing the Service Plan or the other service (i.e., person who develops the Individual Plan for Supported Employment if being implemented as part of Employment Services). The Behavior Support Plan must be approved by the provider's Human Rights Committee.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and who receive DDSN-sponsored Employment/Day Services, the Behavior Support Plan must be approved by the person or ***client representative of a person with ID/RD, or his/her legal guardian***, the person who develops the Employment/Day Service Plan, and the provider's Human Rights Committee.

Behavior Support Plans that include restrictive procedures/techniques must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, Career Preparation Standards, etc.).

C. BEHAVIOR SUPPORT PLAN: RESTRAINT

Restraint is defined as a procedure/technique that involves holding someone (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of one's own body.

Only when necessary to protect the person or others from harm and only when the procedure/technique is the least restrictive/intrusive alternative possible to meet the needs of the person may restraint procedures/techniques be included in Behavior Support Plans.

NOTE: The use of mechanical devices to support proper body positioning, even when movement may be restricted, is not considered restraint. Devices used for proper body positioning must only be used when the medical necessity for the device is clearly documented.

NOTE: Restraint (manual or mechanical) procedures may be included in Behavior Support Plans as a planned response to behavior that will immediately result in harm. Mechanical restraint procedures may also be included in Behavior Support Plans to address behavior that does not immediately result in harm, but due to the chronic/long term nature of the behavior (i.e., hand mouthing that results in skin breakdown, head banging, removing/picking post-operative sutures, etc.), will result in harm.

When restraint procedures (manual or mechanical) are included in Behavior Support Plans, the Behavior Support Plan must include strategies directed toward decreasing or eliminating their use. These Behavior Support Plans must also include provisions for the use of less intrusive techniques prior to the application of the restraint when the problem behavior is occurring.

When restraint procedures (manual or mechanical) are included in Behavior Support Plans as a planned response to problem behavior that will immediately result in harm, the plan must direct that, when applied, the person will be released from the restraint when he/she is calm and no longer dangerous (not to exceed one continuous hour). When mechanical restraint procedures are utilized, the procedures must be designed and used in a manner that causes no injury and minimizes discomfort.

When mechanical restraint is utilized as a response to behavior that will immediately result in harm, the Behavior Support Plan must specify how the person will be supervised during the time the mechanical restraint is applied. The person's response to the restraint application and his/her physical condition (i.e., breathing, circulation) must be monitored at least every 30 minutes. Documentation of response and condition must be completed and maintained.

When mechanical restraint is utilized in response to chronic/long term behavior that will result in harm, the Behavior Support Plan must specify the schedule for the use of the mechanical restraint. The schedule must provide for release from restraint for 10 minutes every hour. The Behavior Support Plan must include the specific plan for supervising the person when the restraint is not in use (i.e., during times of release) and specify that the restraint is not to automatically be reapplied unless the behavior recurs. The person's response to restraint application and his/her physical condition (i.e., breathing, circulation), must be monitored at least every 30 minutes. Documentation of response and condition must be completed and maintained.

When, for an ICF/IID resident, a physician-ordered mechanical restraint is employed during sleeping hours to avoid interruption of sleep, release from the restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

When, for those receiving Residential Habilitation, mechanical restraints are employed during sleeping hours to avoid interruption of sleep, release from the restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

Prior to the implementation of a Behavior Support Plan that includes restraint (manual or mechanical) procedures, appropriate approvals must be obtained.

For ICF/IID residents, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with an Intellectual Disability/Related Disability, or the person authorized to make health care decisions on behalf of the ICF/IID resident.

Additionally, for ICF/IID residents, the Behavior Support Plan that includes manual or mechanical restraint must be approved by the person's Interdisciplinary Team, which includes the person, his/her legal guardian or person authorized to make health care decisions on behalf of the persons and either the DDSN Regional Center Facility Administrator or the Executive Director of the facility. The Behavior Support Plan must be approved by the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan that includes manual or mechanical restraint procedures must be approved by the person or ***client representative of a person with ID/RD, or his/her legal guardian*** the staff responsible for developing the Residential Habilitation Support Plan, the Executive Director of the Residential Habilitation provider, and the provider's Human Rights Committee.

If the Behavior Support Plan requires implementation by other service providers (i.e., Employment/Day Service providers), it must also be approved by the staff responsible for developing the service plan for the other service (i.e., the person who develops the Day Activity Plan of Service) and as appropriate, the other service provider's Executive Director/CEO.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and receive DDSN-sponsored Employment/Day Services, a Behavior Support Plan that includes restraint (manual or mechanical) must be approved by the provider's Human Rights Committee, the person or ***client representative of a person with ID/RD, or his/her legal guardian***, the provider staff responsible for developing the Employment/Day Service Plan and the Executive Director of the Employment Day Service board/provider.

Behavior Support Plans that include restraint (manual or mechanical) procedures must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, etc.). Additionally, the use of restraint procedures will be monitored by DDSN. When a Behavior Support Plan which includes restraint procedures (manual or mechanical) is approved, the approved Plan must be submitted to DDSN

within 20 business days of approval. When the restraint procedure is employed, its **actual** use must be reported to DDSN. A report of the use of planned manual or mechanical restraint will be made to DDSN quarterly. Reports must be made to DDSN by the 15th day of January, April, July and October for any planned restraint employed during the previous quarter.

Commented [HC1]: Kelly Eifert

January 1st – March 31st	April 15
April 1st – June 30th	July 15
July 1st – September 30th	October 15
October 1st – December 31st	January 15

II. PSYCHOTROPIC MEDICATION

Before psychotropic medications are used as an intervention to address problem behavior, the potential risks of those medications must be carefully weighed against the risk of the behavior for which the medication will be given. The specific concerning behaviors/symptoms for which the medication will be given must be documented along with the consideration of the associated risk.

When psychotropic medications are given, DDSN Directive 603-01-DD: Tardive Dyskinesia Monitoring, must be followed.

When given, psychotropic medications must be reviewed based on the person's needs as determined by the psychiatrist or physician but must be reviewed at least quarterly. Through this review, the Psychotropic Drug Review, the combination of the psychotropic medication and Behavior Support Plan are monitored using the behavioral data collected as part of the Behavior Support Plan for effectiveness with addressing the specific behaviors/symptoms for which the medication is given. The Psychotropic Drug Review should provide for gradually diminishing medication dosages and ultimately discontinuing the medication unless clinical evidence justifies that the medication is necessary. The Psychotropic Drug Review should be completed with those who know the person well. Those involved in the Psychotropic Drug Review should include, but are not limited to, the physician and/or psychiatrist, the person and/or his/her legal guardian, the person responsible for the Behavior Support Plan, the person responsible for the ICF/IID Individual Program Plan or Residential Habilitation Support Plan, the ICF/IID Nurse and a direct support professional who knows the person well. The health care provider responsible for prescribing the psychotropic medication is responsible for ensuring compliance with the Adult Health Care Consent Act.

For ICF/IID residents, when psychotropic medication is given, a Behavior Support Plan is also required. The Behavior Support Plan must address the behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and, if possible, eliminating the problem behavior and/or psychiatric symptoms for which they are employed.

For those receiving Residential Habilitation in a DDSN-sponsored residential setting, when psychotropic medication is given to address problem behavior that poses a significant risk to the person (i.e., self-injury), others (i.e., physical aggression), or the environment (i.e., property destruction), a Behavior Support Plan is required. The Behavior Support Plan must address the

specific behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and if possible, eliminating the behaviors/symptoms for which they are employed. For those receiving Residential Habilitation, a Behavior Support Plan is not required in conjunction with psychotropic medication when the person's record clearly documents that he/she:

- Does not exhibit behavior that poses a significant risk to him/herself, others or the environment, and/or;
- Has reached the lowest effective dosage of the medication based on data regarding the occurrence of the specific behavior/symptoms for which the medication is prescribed which is confirmed in writing each quarter by the physician/psychiatrist prescribing the psychotropic medication.

When, for those receiving Residential Habilitation, a Behavior Support Plan is not used in conjunction with psychotropic medication, the specific behavior/psychiatric symptoms targeted for change by the use of psychotropic medications must be clearly noted. Data must be collected on the occurrence of those behaviors/symptoms targeted for change. The collected data must be provided as part of the Psychotropic Drug Review to inform the decisions made therein. Any other problem behavior, especially those which pose a significant risk to the person, others, or the environment, must also be documented and shared as part of the Psychotropic Drug Review.

When psychotropic medications are prescribed for those who participate in a DDSN-sponsored Employment/Day Program and reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation), efforts must be made to obtain information about those medications and the specific problem behaviors or symptoms for which they were prescribed. If those behaviors/symptoms interfere with the person's ability to fully benefit from Employment/Day Services or are sufficiently severe to likely jeopardize the person's ability to continue to live in his/her own home, the need for Behavior Support Services must be discussed with the person's case manager.

NOTE: Services are available through:

- State Funded Community Supports;
- State Funded Follow Along;
- Intellectual Disabilities/Related Disabilities (ID/RD) Waiver;
- Community Supports Waiver; or
- Head and Spinal Cord Injury (HASCI) Waiver.

III. EMERGENCY INTERVENTIONS

DDSN Directive 567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations, establishes the requirement that all DDSN-operated facilities/programs, DSN Board

operated facilities/programs and DDSN-qualified service providers utilize a DDSN approved system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations. Only the techniques that are part of a DDSN-approved system may be used in situations where someone is endangering him/herself or others with severely aggressive, self-injurious, or destructive behavior and, because the behavior could not have reasonably been anticipated, there is no approved plan or program in effect that provides adequate protection from harm. When manual restraint techniques are employed as an emergency response, the Facility Administrator or the provider Executive Director must be immediately notified. Within 24 hours of the incident, a written report of the incident must be provided to the Facility Administrator/Executive Director and either the person's Interdisciplinary Team or the staff responsible for the person's service plan development.

The emergency use of manual restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.

As soon as possible following the emergency use of manual restraint, the person's legal guardian must be notified of the incident. With the consent of the person, his/her family or correspondent should be notified of the incident **unless the person communicates that they do not want their family to be contacted. If the person is unable to communicate, the family will be contacted. The person must be provided any needed augmentative or alternative communication devices/technology to assist in that dialogue.**

Commented [HC2]: Lewis Stephens

The facility or provider's Human Rights Committee must be notified of the emergency use of manual restraint. The notification must be made in accordance with facility/board/provider policy.

Each time manual restraint is used as an emergency response, consideration must be given to the circumstances under which the incident occurred and the frequency with which the emergency use of manual restraint is necessary for the person. Once a pattern emerges or when manual restraint is employed twice in a 30 day period or employed three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and/or respond to the behavior.

In rare circumstances, psychotropic medications or mechanical restraints may be used to provide protection from harm in unanticipated situations where the person is endangering him/herself or others. Prior to use, authorization by the Facility Administrator or provider Executive Director must be given. When possible, prior written authorization should be given. When not possible, prior verbal authorization may be given, but must be followed with written authorization that is completed, signed, and available within 24 hours of the verbal authorization. The written authorization must justify the use of the emergency intervention including the less intrusive measures that were tried but failed. The written authorization must include the specific medication and dosage to be given or the specific mechanical restraint to be applied. If prior verbal authorization was given, the time of the verbal authorization must be included. The authorization must specify the date and time period for which the authorization is valid; authorizations may not exceed 12 hours.

When mechanical restraint is authorized as an emergency intervention, the restraint may only be applied until the person is calm and no longer dangerous or for a maximum of one (1) continuous hour. While the restraint is applied, the person's response to its application and his/her condition must be monitored at least every 30 minutes. Documentation of the monitoring must be maintained.

The emergency use of psychotropic medications or mechanical restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.

As soon as possible following the emergency intervention, the person's legal guardian must be notified of the incident. With the consent of the person, his/her family or correspondent should be notified of the incident **unless the person communicates that they do not want their family to be contacted. If the person is unable to communicate, the family will be contacted.**

Commented [HC3]: Lewis Stephens

The facility or provider's Human Rights Committee must be notified of the emergency use of these interventions. The notification must be made in accordance with facility/board/provider policy.

Each time these interventions are used as an emergency response, consideration must be given to the circumstances under which the incident occurred and with which emergency interventions are necessary for the person. Should a pattern emerge, or if mechanical restraint or psychotropic medications are employed in response to an emergency twice in a 30 day period or three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and respond to the behavior.

IV. HEALTH RELATED PROTECTIONS

When during the conduct of a specific medical, dental or surgical procedure or during the time in which a medical condition exists, the person requires protection, restraint (chemical, manual or mechanical) may be used. These health related protections must be ordered by the person's physician/dentist. The physician/dentist must specify the schedule for its use and how the use of the protection is to be monitored. Examples of restraints that may be used as a health-related protection include, but are not limited to, splints, braces, bed rails, wheelchair harness, helmets, lap belts and abdominal/torso belts. Because the primary purpose of a health-related protection is not to manage behavior, a Behavior Support Plan is not required.

For an ICF/IID resident receiving services in a DDSN Regional Center, DDSN Directive 603-03-DD: Medical and Dental Treatment of Uncooperative Consumers, must be followed.

Gary C. Lemel
Vice Chairman
(Originator)

Eva R. Ravenel
Chairman
(Approved)

To access the following attachments, please see the agency website page "Current Directives" at <https://www.ddsn.sc.gov/about-us/directives/current-directives>.

Attachment: Reporting the Use of Planned Restraint

Reporting the Use of Planned Restraint to DDSN

Submitting Behavior Support Plans That Include Restraint Procedures

When any approved Behavior Support Plan (BSP) includes planned restraint (mechanical or manual) procedures, a copy of the BSP must be provided to DDSN. Additionally, a copy of any amendments to BSPs which include planned restraint (mechanical or manual) procedures must be provided to DDSN. “Planned restraint” is intended to mean when mechanical or manual restraint is specifically indicated in the BSP as a response to problem behavior. This does not include the use of restraint as a response to unanticipated disruptive behavior or crisis situations.

A copy of any BSP which includes planned restraint procedures in use on October 1, 2017 must be provided to DDSN no later than November 1, 2017. Any amendments to these BSPs must be submitted to DDSN within 20 days of approval.

After October 1, 2017, when a new BSP which includes the use of planned restraint (mechanical or manual) procedures is approved for use or when any existing BSP is amended and approved to add planned restraint procedures, the BSPs must be submitted to DDSN within 20 days of approval.

Copies of BSPs and amendments must be submitted to Mark Morgan through Therap’s S-Comm system.

Reporting the Use of Restraint

When, in accordance with the Behavior Support Plan, planned restraint (manual or mechanical) is employed, the use of the planned restraint must be reported to DDSN. These reports should be made quarterly based on the following schedule:

Reporting Period	Report to DDSN
January 1 – March 31	April 15
April 1 – June 30	July 15
July 1 – September 30	October 15
October 1 – December 31	January 15

The report must include the following:

- The Residential Habilitation or ICF/IID provider’s name.
- The name of the person for whom restraint was employed.
- The date the restraint was employed. If released and restraint reapplied, two (2) applications should be-reported.
- The nonoccurrence of planned restraint procedures during the review period.

These quarterly reports should be submitted to Mark Morgan and should be submitted through Therap’s S-Comm system.

Director's Report:

We have established provider and agency Committees to address significant system changes that are on the horizon:

1. Un-winding the bands
2. Divesting of the 11% of properties the agency owns which are operated by boards
3. Switching to fee for service in Early Intervention
4. Moving to the market rate in Case Management
5. I do see these committees being task orientated and long term since I believe more issues will have to be addressed at some point – such as conflict free case management – just to name one.
 - a. Finance – identified concerns to answer for the providers regarding the un-banding of Band B's and I's; discussion of the transfer of DDSN operated buildings which compromise a mere 11% of community programs
 - b. Case Management –discussed – at length – issues with the 15 minute rate. The providers are very doubtful their business models can be supported by the market rate and
 - c. EI – this group walked through the current billing process to help ensure all aspects of the process are considered as we make the transition to fee for services for the boards.

We are expanding our partnerships:

1. DSS – developing a protocol to assist them in placing DDSN eligible individuals in their custody via Adult Protective Services
2. Dept. of Education – we continue to develop the criteria for the DSP certification to be taught in high school. Have identified one pilot location and still looking for another.
3. Met with ABLE and requested their assistance with the development of an advisory committee for me. However, I do not want the committee to be a token group but one with purpose and influence. Complete with structure – including by-laws, application process and succession planning
4. Completed agency-wide discussion of the strategic planning process previously completed with the agency management team.
5. Completed Risk Management training with executive staff and we will implement the system wide review process on January 28th – the last Monday of the month – we will use our director's meeting as the agency RM meeting. That process will filter down to the regional centers as well as providers.

Budget Update:

I have met with the new chair of our Ways and Means subcommittee – Representative Bill HERB KERS MAN

The meeting was very productive and we will present our budget to the full subcommittee on January 23rd at 11:00.

House Oversight:

14 recommendations in total were made by the subcommittee with 2 additional added at the full oversight committee hearing.

2 were agency directed:

1. Direct Care Professionals – Dept. of Ed, Training Survey, Risk Management Process
2. I will be reporting back to the Oversight Committee in March with regards to the progress we have made on their recommendations

1 was commission directed:

1. Regulatory Environment – we are reviewing all directives as we move through our system changes to see what needs to be changes, removed or created

1 was subcommittee directed

And 11 were directed to the General Assembly

Recommendations

The Subcommittee has 14 recommendations arising from its study of the agency. These recommendations fall into four categories: (1) recommendations to the Department of Disabilities and Special Needs; (2) recommendations to the Commission on Disabilities and Special Needs; (3) recommendations to the Healthcare and Regulatory Subcommittee; and (4) recommendations to the General Assembly.

Table 1. Summary of recommendations arising from the study process.

Recommendations to the Department of Disabilities and Special Needs	
Direct Care Professionals	1.) The Department of Disabilities and Special Needs seek funding to create a grant program or incentives for providers to expand the pool of direct care professionals through shadowing programs, recognition programs, grassroots campaigns and training efforts designed to expand awareness about the profession and encourage greater participation by potential employees, specifically students preparing to graduate high school.
Agency Progress Report	2.) The State Director should report to the Healthcare and Regulatory Subcommittee in six months regarding changes implemented as a result of the Legislative Oversight process and the agency's internal improvement processes.
Recommendation to the Commission on Disabilities and Special Needs	
Regulations	3.) The Commission on Disabilities and Special Needs should undertake a complete review of the agency's regulatory environment, including existing and needed regulations. If that review reveals regulations that should be promulgated, amended, or repealed, the Commission should proceed through the procedures in Title 1, Chapter 23 of the South Carolina Code of Laws, related to state agency rulemaking.
Recommendation to the Healthcare and Regulatory Subcommittee of the House Legislative Oversight Committee	
Regulations	4.) The Subcommittee should formally communicate to the House Regulations and Administrative Procedures Committee that the Commission on Disabilities and Special Needs has reviewed some regulations, and determined they should be amended. This study will be available as a resource whenever the Commission promulgates new regulations or proposes amendments to existing regulations.
Recommendations to the General Assembly	
Commission	5.) The General Assembly should consider amending S.C. Code Ann. § 44-20-210 to establish knowledge and expertise criteria for membership on the Commission on Disabilities and Special Needs.
Service Providers	6.) The General Assembly should consider amending S.C. Code Ann. § 44-20-370(A) to reflect that services are offered through private qualified providers as well as county Disabilities and Special Needs (DSN) boards. In addition, the Subcommittee recommends the agency develop a definition of "qualified provider," for inclusion in Title 44, Chapter 20 of the S.C. Code of Laws.
Self-Sufficiency Fund	7.) The General Assembly should consider repealing S.C. Code Ann. § 44-28-10 through § 44-28-80 because the fund was not established and in 2016, the General Assembly established the South Carolina ABLE savings program, which serves the same purpose, and is made possible by the federal Achieving a Better Life Experience Act.
Disability Trust Fund	8.) The General Assembly should consider repealing S.C. Code Ann. § 44-28-310 through § 44-28-370 because the fund was never established and in 2016, the General Assembly established the South Carolina ABLE savings program, which serves the same purpose.
Intellectual Disability Definition	9.) The General Assembly should consider amending S.C. Code Ann § 44-23-10(22) so that the definition of intellectual disability is consistent with the definition in S.C. Code Ann. § 44-20-30(12). ³⁴ 10.) The General Assembly should consider amending S.C. Code Ann. § 44-25-20(g), to replace "mental deficiency" and its definition with "intellectual disability," as defined in S.C. Code Ann § 44-20-30(12). In addition, the Subcommittee recommends that "mental deficiency" be replaced with "intellectual disability" through Title 44, Chapter 25.
Federal Fair Housing Law	11.) The General Assembly should consider amending S.C. Code Ann. § 6-29-770 to remove the requirement that notice be given for a home for persons with disabilities, as it violates federal Fair Housing Laws. ⁵
Healthcare Decision Priority List	12.) The General Assembly should consider amending S.C. Code Ann. § 44-66-30(A) to give last priority in health care decisions for persons unable to consent to "a person given authority to make health care decisions for the patient by another statutory provision." Section 44-26-40, § 44-26-50, and § 44-26-60(C) should all be amended to refer to the correct priority number in § 44-66-30.
Day Programs	13.) The General Assembly should consider amending S.C. Code Ann. § 43-35-10(4) to include day programs in the definition of "facility" in the Omnibus Adult Protection Act.
Case Dispositions	14.) The General Assembly should consider amending S.C. Code Ann. § 43-35-60 to require investigating agencies to share specific abuse, neglect, or exploitation case dispositions with the relevant state agency.

There are no specific recommendations with regards to continuance of agency programs or elimination of agency programs.

+ Gov. Cab.
+ make Boards State entities⁶

Senate Oversight Report:

To recap:

There were 34 recommendations in the report.

6 directed at the legislature regarding possible legislation

7 commission directed recommendations

And 28 agency specific recommendations

Many of the recommendations have a pattern of overlapping but we can put them under a small amount of themes.

The main themes from the Senate report are:

1. Change the funding method away from the band into a clearer easily understandable model such as fee for service or something better.
2. Reduce non-productive and sometimes antagonistic communications between Commission members
3. Get out of real estate
4. Engage problems using policy, analysis, and then act to resolve situations in the public domain with support, sanction, and/or change policy to adapt.
5. There were some smaller recommendations and generic recommendations like ensure successful implementation of Therap, consumers' use of debit cards, and electronic consumer inventory. These should be placed in a bucket of organizational weakness from a lack of proactive management – and we have identified additional areas in need of improvement that are not included in either report.

All of these issues have a common thread which points to a history of hands off management and a habit of going with the flow of the status quo rather than proactive and rigorous analysis to seek continuous improvement across the agency.

We have an agency wide training/development opportunity to improve business acumen which encourages analysis and innovative solutions to long standing as well as new challenges to the service delivery system.

Out of the 6 legislature directed recommendations, there is one we have already working on – without having legislation. I am currently working with ABLE to develop a working advisory council. I want to make it a formal process so it is sustainable and has the participation of our broad spectrum of stakeholders.

Out of the 7 – Commission specific directives **3 are complete**

1. Term expiration notification process
2. Commission training
 - a. Pre-service training modules
 - b. Weekly written updates to commissioners
 - c. Training survey available at all times to the members
3. The addition of the Legislative Committee – *if I may suggest that the legislative committee take up the monitorship of the both the Senate and House Oversight recommendations*

1 policy recommendation is being worked on at this time via the Executive Risk Management Team

1. The establishment of system-wide Risk Management Executive Review to institute a rigorous incident review system – this has already begun with initial training, incident review and action.
2. To suggest a policy that would establish ramifications for a provider who does not meet minimum requirements.

The remaining 21 recommendations which are agency directed:

14 have been completed

7 are in process

Of those which are in process, 5 of those have a decision point has been made but the path we take relies heavily on the joint project we have with DHHS of rate review and the recommendations of the Mercer Healthcare Consultants. Basically we have committed to the necessary changes but how we proceed depends on the information in that report.

The 2 remaining recommendations which are currently in process include:

One is Conflict free case management – this is not a DDSN solo issue – we are fully engaged with DHHS on the implementation however, DHHS realizes that this action must proceed with an abundance of caution since 76% of our case managers work for DSN boards and with the switch to market based rates may destabilize the system if

Conflict free case management were to occur immediately. Individuals always have the right to choose a case manager who is not affiliated with the provider of their services.

The second recommendation in process is looking at our provider dashboard to see if we can make it more meaningful and consumer friendly. As we establish our advisory committee, risk management system and review our current list of indications we will also be rebuilding this system.

2019 Amendments for Review

	Amendment #3	2019	Annual	Description
Babcock Center	Capitated- Band B	\$ 308,542	\$ 327,336	<i>Net increase of 24 Band B consumers</i>
Babcock Center	Capitated- CSW	\$ (1,272)	\$ (14,541)	<i>Net reduction of 1 Band I consumer</i>
	Total	\$ 307,270	\$ 312,795	
	Amendment #3	2019	Annual	Description
Greenville/Thrive	Capitated- Band B	\$ 226,671	\$ 245,502	<i>Net increase of 18 Band B consumers</i>
Greenville/Thrive	Capitated- CSW	\$ 105,570	\$ 116,328	<i>Net increase of 8 Band I consumers</i>
	Total	\$ 332,241	\$ 361,830	
	Amendment #4	2019	Annual	Description
Georgetown DSN Board	Capitated- CRCF	\$ 99,311	\$ 101,822	<i>Restoration of vacancy @Jessamine</i>
Georgetown DSN Board	Capitated- CTH II	\$ 129,990	\$ 165,467	<i>2 new CTH II beds at Middleton</i>
	Total Payment- Georgetown	\$ 229,301	\$ 267,289	

**South Carolina Department of Disabilities and Special Needs
FY 2019-2020 Budget Request Items In Priority Order
Approved by the Commission on 12/13/2018**

Program Need – Recurring Funds		Budget Request for FY 2019-2020	2019-2020 Executive Budget
1	<p>Safety and Quality of Care/Workforce Needs Workforce issues must be addressed in order to recruit and retain quality staff who provide essential 24/7 care to consumers. This request is the third year of a multiyear request and has two components:</p> <p>(1) Increase the hiring wage for direct care staff and immediate supervisors. Direct care wages are not competitive. An increased hiring wage of at least \$13.00 per hour is needed to be competitive. This request supports moving toward that goal by increasing the hiring wages to \$13.00 per hour, an increase of 8.3 percent from \$12.00 an hour. Potential candidates will not apply if the starting pay is not reasonable. Experience has demonstrated that direct support employees can be hired, but often terminate within the first year to seek employment with large private companies like Walmart and Lowe’s with similar pay and easier jobs than the demands of a direct support caregiver in a 24/7 operation. The current 44% turnover rate in DDSN regional centers is a direct result of erosion of pay, forced overtime and inability to take earned leave days. Flexibility will be requested to give providers some latitude to incentivize new hires, such as \$13/hour starts after a probationary period, but all funds must be only be used for direct care staff.</p> <p>(2) Retain essential staff to maintain service quality. Service quality cannot be reduced and staffing ratios must meet compliance standards and be maintained. Wage compression exists at supervisory and manager levels where longtime quality employees make the same wage as new hires. Loss of longtime quality employees due to wage levels not keeping up with industry benchmarks increases turnover, affects the quality of consumer care, results in higher contract costs and increases the cost of training new staff to perform these vital services.</p>	<p>\$10,400,000</p> <hr style="width: 20%; margin: 10px auto;"/> <p>Increase Hiring Wage \$9.1M</p> <p>Compression & Retention \$1.3M</p>	
2	<p>Community Service Rates: Community service provider rates have not been rebased across the board since 2006. Through survey, interview, and cost analysis, all evidence suggests community service provider rates are not adequate to meet current level of provider costs for services. Mercer Healthcare Consultants, Inc. (Mercer) is currently conducting a payment system review and a community service rate study, to include Community ICFs, due in January 2019 at the earliest. DDSN does not have a validated rate study from which to seek increase appropriations to meet consumer needs. However, given the estimate of receiving the Mercer rate study early in calendar year 2019, DDSN plans, if time available after receiving the rate study, to submit an amended budget request to address this critical funding issue in the DDSN service delivery system. DDSN’s current \$5 million estimate is likely only a partial payment of the anticipated rate increase needs. This \$5 million with its Medicaid match would be a 3.2% increase in community service rates (FY 2018-2019 budget \$543 million). DDSN anticipates a multi-year budget request approach to implement recommendations from the rate study.</p>	\$5,000,000	

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Program Need – Recurring Funds		Budget Request for FY 2019-2020	2019-2020 Executive Budget
3	<p>Intermediate Care Facility (ICF) Regional Center Service Rates: DDSN’s four ICF Regional Centers have undergone significant de-population over the past decade requiring shifting resources to community providers creating a substantial risk of under-resourcing ICF Regional Centers. Under new agency leadership and having operated with an interim executive staff for nearly nine months, DDSN addressed this situation through an internal cost study during the Fall 2018.</p> <p><u>Result of Cost Study:</u> 29 additional LPN nurses are needed in DDSN’s Regional Centers. This is based on the fact current on-board nurse resources (LPN & RN) are insufficient to meet nurse Targeted Staffing Level (TSL) needs by approximately 15%. Required nurse resources were short of actual staffing needs even after including substantial nurse supplements in the form of state temps, contractors, and overtime (63% FTE & 37% supplemental). DDSN’s current hiring salary for LPNs is \$38,000, which is below market and not attracting sufficient LPN candidates. As a result, the LPN hiring range requires an increase to \$41,000 - \$43,000 based on the candidate’s experience (\$42,000 average) to attract sufficient qualified candidates. The cost for this increase is \$517,040 plus \$100,860 to increase on-board LPNs to be equitably raised to the minimum thresholds to prevent turnover for a total of \$617,900. As LPNs are hired to reduce stress in the system from nurse shortages, the increased LPN salary will be used to attract additional LPNs to replace existing dependency on supplemental resources (state temps, contractors, and overtime).</p> <p>An analysis of the direct care staffing shortages at Whitten (26%) and Coastal (28%) would require 71 (\$2.3 million) and 50 (\$1.6 million) direct care worker (\$3.9 million), respectively. Currently, the lack of funding does not need legislative appropriations because, fortunately or unfortunately, these two Regional Centers have no expectations of sufficient candidates to address these shortages. It is hopeful “Budget Priority #1 - \$1 raise” will stimulate applicants for hire at Whitten and Coastal Centers. Midlands and Pee Dee have challenges, but are at the 90+% staffing level.</p> <p>DDSN maintains adequate maintenance reserves to address Regional Centers’ maintenance components that have failed or near failure. However, the funding has not kept up with delayed maintenance short of a crisis, particularly in the interior of the facilities. Delayed maintenance estimate at the four centers is \$8.6 million with \$5.9 million as a top tier need. The highest priority needs, Tier 1, include such items as carpeting, flooring, furniture, remodeling bathrooms, food service chillers, buses, vans, wheelchairs, hospital beds, blinds, security cameras, campus lighting, gym bleachers, keyless entry, building door/window frames, PT equipment, drainage, and degraded HVACs. The requested \$882,100 funds will start the process of re-constituting while establishing a more robust recurring maintenance program to maintain operations at higher levels rather than operate to failure as is the current practice.</p>	<p>\$1,500,000</p> <hr style="width: 100%;"/> <p>Nursing Resources \$617,900</p> <p>Delayed Maintenance \$882,100</p>	<p>\$750,000</p>
4	<p>Intermediate Care Facility (ICF) Regional Center Institutional Respite: To increase system capacity by creating 12 institutional respite beds for individuals at home and in a waiver who exhibit high behaviors and need intense respite intervention. This institutional respite would provide time limited intensive supports by highly trained staff in temporary residential services and may be used for medication stabilization, dually diagnosed behavior interventions and other services recommended by a physician. This institutional respite service is critical to the system as the ultimately goal is to return the individual to his/her home or to a less restrictive residential setting in the community. Addressing this intense, short-term need would prevent emergency hospitalizations, more expensive long-term residential placements and also incentivize providers to accept individuals with high behavior needs for initial placement.</p>	<p>\$580,500</p>	

**South Carolina Department of Disabilities and Special Needs
 FY 2019-2020 Budget Request Items In Priority Order
 Approved by the Commission on 12/13/2018**

Program Need – Recurring Funds		Budget Request for FY 2019-2020	2019-2020 Executive Budget
5	<p>Increase and Improve Access to Residential Supports: This request will provide necessary residential supports and services to 36 individuals with aggressive, intensely challenging behaviors requiring high management and/or forensic residential beds. These funds will be used to develop eleven homes and day supports in the community, including one-time capital and startup costs associated with the new services, and provide necessary residential and day supports and services for 33 individuals. Additionally, the funds will be used for one home developed and operated directly by DDSN staff to provide immediate residential services to judicially committed consumers suitable for a community setting with intensive supervision. Costs will include one-time capital and startup costs associated with the new services, and provide necessary residential and day supports and services for three (3) individuals.</p> <p>This population can be very difficult to serve as they often are a threat to themselves and/or others. The number of providers willing to serve this population is extremely limited. If rates are not adequate to cover the actual cost of high management services, the state cannot increase the service capacity necessary to address this ongoing need. Each year DDSN receives more court ordered residential placements for individuals with challenging behaviors and the agency must comply with judges' orders.</p> <p>DDSN requests a four bed CTH II for juveniles in the community meeting Medicaid requirements for reimbursement. DDSN's current juvenile residential capacity of 22 beds is full. Eight beds are eligible for Medicaid reimbursement and 14 are state funded due to institutional group home settings. If funded, the new four bed residence will provide immediate capacity. DDSN will also work on a cost savings plan to self-fund new four-bed residences meeting Medicaid requirements to provide better services at less cost to juveniles suitable for the community currently in state funded group homes.</p>	<p>\$1,533,575</p> <hr/> <p>High Management/ Forensic Residential Beds \$1,440,000</p> <p>4 Bed CTH II – Juveniles \$93,575</p>	
6	<p>Child Protective Custody Transition: Annually, DDSN avails residential services to DDSN eligible children who are approaching the age of majority in the custody and or care of the South Carolina Department of Social Services (SCDSS). It is the intent of our agency to provide residential habilitation to these individuals in a community training home I or specialized family home setting. This residential model allows children and adults eligible for SCDDSN services and requiring long-term residential care to live in the home of a vetted caregiver offering care, supervision, skills training, and ancillary support based on the individual's needs. The home will require licensure and serve a maximum of two consumers. DDSN is requesting \$140,000 to develop 5 community training home I or specialized family home settings. This initiative will cost effectively serve approximately 10 individuals.</p>	<p>\$140,000</p>	

**South Carolina Department of Disabilities and Special Needs
 FY 2019-2020 Budget Request Items In Priority Order
 Approved by the Commission on 12/13/2018**

Program Need – Recurring Funds		Budget Request for FY 2019-2020	2019-2020 Executive Budget
7	<p>Early Intervention: DDSN has absorbed BabyNet and Early Intervention (EI) service increases through internal reallocations for many years without requests for corresponding budget increases. There exists no capacity for increased early intervention services to three through six-year-old children without additional funding to meet increase consumers eligible for EI services.</p>	\$800,000	
8	<p>Increase Access to Post-Acute Rehabilitation that is Specialized for Traumatic Brain or Spinal Cord Injuries: DDSN has a recurring appropriation of \$3.6 million to provide a post-acute rehabilitation program for individuals who experience a traumatic brain or spinal cord injury. During the last three months of the FY 17/18, DDSN only funded one new TBI/SCI inpatient due to a lack of funds. This resulted in an estimate of 12 TBI/SCI uninsured/under-insured citizens not receiving treatment. The lack of funding is estimated at \$500,268 (12 patients x \$41,689 avg. inpatient cost). This request for additional permanent funding of \$500,000 would serve an additional 12 individuals and bridge the funding gap at the estimated number of TBI/SCI consumers in the upcoming FY 19/20.</p> <p>For best outcomes, specialized rehabilitation should begin as soon as possible following medical stabilization or discharge from acute care. Without appropriate rehabilitative treatment and therapies in the first weeks or months after injury, people are not able to achieve optimal neurological recovery and maximum functional improvement. Research shows these results in more substantial levels of permanent disability and limits the ability to work. As a consequence, there are greater needs for long-term care, and other health, mental health and social services. Lack of rehabilitation options causes extended acute care hospital stays following injury for many people. There are also higher rates of subsequent hospitalizations for people who do not receive rehabilitation.</p>	\$500,000	\$200,000
TOTAL RECURRING FUNDS		\$20,454,075	\$950,000

**South Carolina Department of Disabilities and Special Needs
 FY 2019-2020 Budget Request Items In Priority Order
 Approved by the Commission on 12/13/2018**

Program Need – Non-Recurring Funds		Budget Request for FY 2019-2020	2019-2020 Executive Budget
1	<p>South Carolina Genomic Medicine Initiative:</p> <p>This request will assure statewide access to genetic services for individuals with complex developmental disabilities and their families. It also supports development of a systematic and comprehensive application of new genomic technologies. Despite the success of the collaboration between DDSN and Greenwood Genetics Center (GGC), we are still unable to identify the underlying cause for intellectual disability in approximately 40% of the individuals evaluated. For individuals with autism, we are unable to determine an underlying cause in 80% of those evaluated. The lack of a specific cause is not acceptable to families and physicians, and significantly limits optimum medical management, treatment options and informed reproductive decision making.</p> <p>The GGC is embarking on a major genomic initiative that will have a transformative impact on the GGC, the state, and the provision of personalized medicine for South Carolinians. This South Carolina Genomic Medicine Initiative will combine clinical care, a “multi-omics” technological approach and big data/machine learning to create a powerful and unique resource serving patients, healthcare providers, and state agencies. This bold initiative is being pursued to significantly increase the diagnostic yield for individuals with intellectual disabilities and autism, with the ultimate goal of providing information necessary to provide personalized and precise medical treatment and management for patients with disabilities and autism. In addition, the data accumulated with this initiative will provide precise genomic information that will help develop and guide personalized public health policies.</p> <p>The request of \$2,000,000 non-recurring state funds is in conjunction with funds from the private sector. Anticipated partners in the private sector, such as foundations, Clemson University, other academic partners and individual donors. It is the intention of the GGC to work with SCDHHS to pursue an administrative Medicaid match for this project to demonstrate the impact and value of this approach to CMS.</p>	\$2,000,000	
TOTAL NON-RECURRING		\$2,000,000	
TOTAL FUNDS REQUESTED		\$22,454,075	\$950,000

FY 18/19 Legislative Authorized & Spending Plan Budget VS Actual Expenditures (as of 12/31/2018)

Funded Program - Bud	Original Budget	Budget Adjustments	Current Budget	YTD Actual Expense	Balance
ADMINISTRATION	\$ 8,256,999.00	\$ 0.00	\$ 8,256,999.00	\$ 2,961,018.75	\$ 5,295,980.25
PREVENTION PROGRAM	\$ 657,098.00	\$ 0.00	\$ 657,098.00	-\$ 15,495.00	\$ 672,593.00
GREENWOOD GENETIC CENTER	\$ 13,185,571.00	\$ 0.00	\$ 13,185,571.00	\$ 7,562,705.00	\$ 5,622,866.00
CHILDREN'S SERVICES	\$ 16,302,094.00	\$ 3,477,000.00	\$ 19,779,094.00	\$ 15,428,212.00	\$ 4,350,882.00
BABYNET	\$ 5,587,500.00	\$ 0.00	\$ 5,587,500.00		\$ 5,587,500.00
IN-HOME FAMILY SUPP	\$ 89,589,624.00	\$ 797,612.00	\$ 90,387,236.00	\$ 30,061,156.00	\$ 60,326,080.00
ADULT DEV&SUPP EMPLO	\$ 81,402,960.00	\$ 0.00	\$ 81,402,960.00	\$ 42,925,584.00	\$ 38,477,376.00
SERVICE COORDINATION	\$ 22,656,140.00	\$ 0.00	\$ 22,656,140.00	\$ 11,200,149.00	\$ 11,455,991.00
AUTISM SUPP PRG	\$ 26,355,826.00	\$ 0.00	\$ 26,355,826.00	\$ 8,044,226.00	\$ 18,311,600.00
Pervasive Developmental Disorder (PDD) Program	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
HD&SPINL CRD INJ COM	\$ 5,040,532.00	\$ 0.00	\$ 5,040,532.00	\$ 2,310,120.50	\$ 2,730,411.50
REG CTR RESIDENT PGM	\$ 84,032,120.00	\$ 150,263.00	\$ 84,182,383.00	\$ 33,688,260.00	\$ 50,494,123.00
HD&SPIN CRD INJ FAM	\$ 28,742,376.00	\$ 0.00	\$ 28,742,376.00	\$ 9,355,719.00	\$ 19,386,657.00
AUTISM COMM RES PRO	\$ 29,739,084.00	\$ 0.00	\$ 29,739,084.00	\$ 17,002,894.00	\$ 12,736,190.00
INTELL DISA COMM RES	\$ 317,799,712.00	\$ 2,649,142.00	\$ 320,448,854.00	\$ 167,553,280.00	\$ 152,895,574.00
STATEWIDE CF APPRO		\$ 3,121,104.75	\$ 3,121,104.75		\$ 3,121,104.75
STATE EMPLOYER CONTR	\$ 32,745,158.00	\$ 1,198,348.00	\$ 33,943,506.00	\$ 13,139,533.00	\$ 20,803,973.00
DUAL EMPLOYMENT			\$ 0.00	\$ 0.00	\$ 0.00
Legislative Authorized Total	\$ 762,092,794.00	\$ 11,393,469.75	\$ 773,486,263.75	\$ 361,217,362.25	\$ 412,268,901.50
Legislative authorization capacity above actual spending plan budget			-\$54,952,946.75		
DDSN spending plan budget			\$ 718,533,317.00	\$ 361,217,362.25	\$ 357,315,954.75
Percent of total spending plan budget			100.00%	50.27%	49.73%
% of FY completed (expenditures) & % of FY remaining (available funds)			100.00%	50.00%	50.00%
Difference			0.00%	0.27%	-0.27%

REASONABLE

Carry Forward + Cash Flow Analysis Indicates Sufficient Cash to Meet FY 19 Estimated Expenditure Commitments: YES ; At-Risk ; NO

Expenditures categorized to provide insight into direct service consumers costs vs. non-direct service costs:

Expenditure	FY 18 - % of total	FY 17 - % of total
Central Office Admin & Program	2.37%	2.36%
Indirect Delivery System Costs	1.56%	1.42%
Lander University	0.00%	0.05%
Board & QPL Capital	0.14%	0.59%
Greenwood Autism Research	0.03%	0.10%
Direct Service to Consumers	95.90%	95.48%
Total	100.00%	100.00%

NOTE: Prior FY data will be calculated and presented to provide assurance as to the consistent pattern of direct service & non-direct service expenditures and explanation for increases/decreases

Methodology & Report Owner: Lisa Weeks

South Carolina Department of Disabilities and Special Needs				
FY 19 Monthly Report-- Waiver Process Performance				
January 1, 2019				
	CSW	HASCI	ID/RD	Total
Analysis of Waiver Slots:				
Budgeted Waiver Slots	3,409	1,055	8,876	13,340
Enrolled Waiver Slots	2,956	924	7,919	11,799
Available Waiver Slots	453	131	957	1,541
Available Waiver Slots Comparison:				
Three Months Ago	401	147	718	1,266
Six Months Ago	366	159	755	1,280
Twelve Months Ago	287	179	1,056	1,522
Analysis of Pending Waiver Slots:				
Total Pending	570	99	849	1,518
Avg. Days Pending	287	337	224	255
Pending Greater than 6 Months	373	53	355	781
Avg. Days Pending Comparison:				
Three Months Ago	373	338	256	
Six Months Ago	343	297	224	
Twelve Months Ago	290	256	168	
Analysis of Waiver Slot Movement-Rolling				
Average 12-18 Months Prior:				
Awarded	570	113	1,537	2,220
Enrolled	160	41	501	702
Removed	342	52	880	1,274
Pending > 1 year	68	20	156	244
Conversion Rate (Enrolled/Award)	28%	36%	33%	
Conversion Rate Comparison:				
Three Months Ago	27%	33%	34%	
Six Months Ago	25%	32%	46%	
Twelve Months Ago	26%	54%	41%	
Estimated Cost to Eliminate Waiver				
Waiting List:				
Current Waiver Waiting List	5,453	none	8,718	
X Current Conversion Rate	x 28%		x 33%	
Estimated Waiver Slots Required	1,527		2,877	4,404
X \$14,000 B or I Band	x \$14,000		x \$14,000	
X 30% State Match	x .30		x .30	
Estimated Cost to Elim. Waiver Wait list	\$6,413,400	\$0	\$12,083,400	\$18,496,800
NOTE: CURRENT System Capacity to Reasonably Enroll is 1200/year				
Waiting List Length of Time (Years):				
Jan-19	1.9	0	3.5	
Jul-18	1.5	0	3.4	
Jul-17	0.8	0	4.0	
Jul-16	2.3	0	3.5	
Jul-15	4.5	0	4.6	
Opportunities to Improve -- Process Improvement Initiatives:				
PROBLEM-INORDINATE TIME TO CONVERT SLOT AWARD TO ENROLLMENT; ACTIONS: 1) Require Medicaid prior to slot award; 2) case worker assigned prior to slot award; 3) education prior to slot award; 4) CSW to ID/RD without starting enrollment over; 5) six month limit on holding the slot award; 6) Re-examine respite model				
Report & Methodology Owner Ben Orner				

South Carolina Department of Disabilities and Special Needs

January 1, 2019

Waiting List Summary Analysis

Total Count: 5,453 on CS Waiting List and 8,718 on IDRD Waiting List:	<u>14,171</u>	Remaining on List
Number of Individuals on both lists (to show "unduplicated individuals waiting"):	<u>4,543</u>	9,628
Number already receiving waiver services:	<u>1,787</u>	7,841
Of those remaining...number that has declined a slot in the past 4 years:	<u>1,689</u>	6,152
Of those remaining...number with a closed case in the DDSN System:*	<u>897</u>	5,255
Of those remaining...number under 21 years old with active Medicaid:**	<u>2,766</u>	2,489
Of those remaining...number under 21 years old with NO Medicaid (per our info):***	<u>988</u>	1,501

* Not open in DDSN System could indicate they are not eligible for DDSN services, no longer desired services, or moved out of state.

** Individuals under 21 have access to a large array of State Plan services. The only additional service that Waivers would offer this population would be respite.

***If these children are DDSN eligible they likely could qualify for TEFRA Medicaid and have access to the full array of Medicaid Services for Children.

**South Carolina Department Of Disabilities & Special Needs
Summary of Waiting Lists as of December 31, 2018**

Waiting List	11/30/18	Added	Removed	12/31/18
Critical Needs	96	19	24	91
Intellectual Disability and Related Disabilities Waiver	8827	174	283	8718
Community Supports Waiver	5306	178	31	5453
Head and Spinal Cord Injury Waiver	0	13	13	0