Structure / Leadership Subcommittee
Dr. Allan Zaback, Chair
October 11, 2019

Structure / Leadership Subcommittee - Items requested from the Division of Developmental Disabilities Services (DDDS)

1. A Comprehensive Organizational Chart showing Director, Deputy Director and entire overview of DDDS Organizational Structure.

   DDDS shared all organizational charts as requested during the DDDS Task Force Meeting on, July 31, 2019. The overview and individual charts are available here:

   https://publicmeetings.delaware.gov/Meeting/63291

2. Job Description for the DDDS Deputy Director

   Appointed positions are not required to have job descriptions. The Deputy Director of the Division of Developmental Disabilities (DDDS) reports to the Division Director and is responsible for the achievement of division goals and objectives. Duties include managing and overseeing a state workforce and a network of contracted providers to ensure that persons with intellectual and developmental disabilities (including autism) can lead fulfilling lives in the community, while honoring abilities and respecting choice.

3. The number of Advisory Boards and a description of each of their roles.

DDDS Stakeholder Meetings

- *Day Services Provider Advisory Committee (monthly)*
  Provides an opportunity to engage with contract Employment and Day Service providers to identify service improvement areas, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD
- *Residential Services Provider Advisory Committee (monthly)*
  Provides an opportunity to engage with contract Residential Habilitation Service providers to identify service improvement areas, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD
- *Behavior Consultation Best Practice Committee (quarterly)*
  Provides an opportunity to engage with contract Behavior Consultation Service providers to identify service improvement areas, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD

- *Nurse Consultation Best Practice Committee (monthly)*
  Provides an opportunity to engage with contract Nursing Consultation Service providers to identify service improvement areas, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD
- *Focused provider advisory workgroups*
  Provides an opportunity to engage with a small Provider work group to address a specific area of need
- *DDDS Advisory Council (DE Code Title 29 7910) (monthly)*
  https://codes.findlaw.com/de/title-29-state-government/de-code-sect-29-7910.html
  Provides an opportunity to engage with parents of adult children with IDD to identify service improvement areas, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD
- *DDDS Quarterly Provider Meeting*
  Provides an opportunity to engage with all contract service providers to share information, discuss operational changes, answer questions and collaborate to improve services and supports for people with IDD

External Stakeholder Groups Related to Disabilities

- *State Council for Persons With Disabilities (monthly)*
  - *Brain Injury Committee Meeting (SCPD sub-committee) (monthly)*
  - *Employment First Oversight Commission Meeting (SCPD sub-committee) (monthly)*
    https://scpd.delaware.gov/ DDDS collaborates with the SCPD to remain informed about the needs of Delawareans with IDD
- *Developmental Disabilities Council (monthly)*
  https://ddc.delaware.gov/ DDDS collaborates with the DDC to remain informed about the needs of Delawareans with IDD
- *State Transition Council (Department of Education) (quarterly)*
  DDDS collaborates with the DOE and Local Education Agencies to coordinate services and supports for youth with IDD.
- *Center for Disabilities Studies Community Advisory Board (quarterly)*
  https://www.cds.udel.edu/who-we-are/cac/browse-all/ DDDS collaborates with the CAC to remain informed about the needs of Delawareans with IDD
- *Governor's Advisory Council on Exceptional Citizens (DE Code Title 14) (monthly)*
  https://gacec.delaware.gov/responsibilities-of-the-gacec/ DDDS collaborates with the GACEC to remain informed about the needs of Delawareans with IDD
- *Public hearings on any amendments or renewals to the DDDS Medicaid HCBS waiver (as needed)*
- *Public hearings on any amendments to the Targeted Case Management, Pathways to Employment or ACIST Medicaid State Plan Amendments (as needed)*

Enables the DDDS to understand how proposed changes to services will affect service recipients. Public comment is a required activity anytime states seek to propose, amend or renew the HCBS Lifespan waiver, Pathways to Employment, ACIST or State Plan TCM services

- *Ability Network of Delaware meetings (as invited)*
  Provides an opportunity to remain informed of the issues experienced by the Provider community
- *A-Team of Delaware (as invited)*
  Provides an opportunity to understand the needs of families and identify service gaps
- *Interagency Collaborative on Autism (ICA)*
  Provides an opportunity to collaborate with a variety of stakeholders to implement recommendations from the Autism Task Force
- *Behavioral Health Consortium*
  - *Access and Treatment subcommittee*
    https://ltgov.delaware.gov/behavioral-health-consortium/ Provides an opportunity to engage with other stakeholders to improve services and supports for people with IDD and a co-occurring Severe and Persistent Mental Illness
- *DMMA Children with Medical Complexity Advisory Committee (quarterly)*
  Provides an opportunity to collaborate with DMMA to improve services and supports for children with IDD and medically complex conditions
- *DHSS Special Populations Meeting (bi-monthly)*
  Provides an opportunity to engage with parents of adult children with IDD who have significant support needs
  - *NASDDDS/ICI Supported Employment Leadership Network (SELN) All-State call (monthly)*
    Provides an opportunity to become informed about issues affecting state systems and learn about promising/best practice initiatives across the country

4. Statistics on the Rate of employee turnover by unit.

   DDDS does not collect this data.

5. Statistics on the Division's Current vacancy rate

   DDDS has 447 budgeted positions. 92 of these budgeted positions are vacant as of Friday, October 25, 2019.

   - *46 vacant positions are assigned to Stockley Center*
   - *19 vacant positions are a result of the reduction and ultimate closure of the DDDS Day Programs*
   - *27 vacant positions assigned to Administration and Community Services are in some stage of the recruitment or hiring process*

6. Statistics on the number of seasonal positions performing the work of vacant full time positions.

   None of the seasonal positions assigned to DDDS work more than 29.75 hours per week.

7. Statistics on the total number of Cases per case manager, per county for the past three years. How many cases per Support Coordinators, Employee Navigators and Community Navigators (Columbus). Also, job descriptions for Support Coordinators, Employee Navigators and Community Navigators.

   DDDS does not routinely collect and evaluate caseload data according to a prescribed period of time. Discussions about caseloads often take place when supervisors identify an event that will affect caseloads and could have a negative impact on service delivery, i.e. staff vacancy, long-term leave, etc. Therefore, DDDS is unable to provide statistics reflecting the total number of cases per case manager, per county for the past three years.

Preferred Maximum Caseloads:

DDDS Support Coordinators:	*1:45*
Columbus Community Navigators:	*1:60**
** Contractually Required*	
DDDS Employment Navigators:	*1:60*

Current Caseloads:

DDDS Support Coordinators:	
NCC	*1:50*
KC	*1:50*
SC	*1:45*
Community Navigators:	*1:60*
DDDS Employment Navigators:	
NCC	*1:66*
KC	*1:59*
SC	*1:46*

Projected Caseloads:

DDDS is in the process of hiring three specialized Support Coordinators. Two will exclusively support 104 people who receive residential habilitation services in a Shared Living setting. The third will support 30 people who are deaf or hard of hearing who receive residential habilitation services in a Provider Managed Group Home or Apartment setting. These three new full-time Support Coordinators will reduce current caseloads to the following levels:

DDDS Support Coordinators:

NCC	*1:40*
KC	*1:35*
SC	*1:35*

DDDS has amended the Targeted Case Management contract with the Columbus Organization to include a reduction in the preferred caseload size for Community Navigators. This amendment allows the following caseload size:

Community Navigators: *1:45*

DDDS has just hired a new Employment Navigator in New Castle County, which will reduce the Employment Navigator caseloads to the following levels:

DDDS Employment Navigators:

NCC	*1:52*
KC	*1:59*
SC	*1:46*

***Targeted Case Management Service Definition* (Applies to DDDS Support Coordinators)**

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Targeted Case Management will be performed by individuals called Support Coordinators hereafter and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include functions necessary to inform the development of the person-centered plan:

- a. *Obtaining client histories and other information necessary for evaluating and/or reevaluating and recommending determination of the individual's level of care;*
- b. *Identifying the individual's support needs and providing assistance and reminders related to completing needed documentation for clinical and financial eligibility;*
- c. *Gathering information from sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;*
- d. *Providing necessary education and information to the individual and the individual's family to provide necessary familiarity with the program, requirements, rights and responsibilities.*

The Support Coordinator collects information to inform the plan and/or directly conducts an assessment of an individual's needs for services prior to waiver enrollment and at least annually thereafter or more frequently at the request of the individual or as changes in the circumstances of the person warrant. This is the frequency of review that is specified in the approved DDDS HCBS waiver.

2. Development (and periodic revision) of a specific person-centered plan in accordance with 42 CFR §441.301(c)(1) through 42 CFR §441.301(c)(4). This activity may be conducted through direct and collateral contacts. The plan must reflect what is important to the individual to lead the life they want to lead. The plan must also reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

The Support Coordinator:

- *a. Uses a person-centered planning approach and a team process to develop the individual's person-centered plan to meet the individual's needs and achieve the individual's goals in the most integrated setting and manner possible;*
- *b. Provides support to the individual to ensure that the process is driven by the individual to the maximum extent possible and includes people chosen by the individual, with the individual at the center of the process;*
- *c. Assists the person to select qualified providers who can best meet their needs;*
- *d. Ensures that the plan identifies risk factors and includes plans to mitigate them;*
- *e. Facilitates transition for new waiver enrollees moving from their family home to a waiver residence;*
- *f. Facilitates seamless transitions between providers, services or settings for the maximum benefit of the individual;*
- *g. Updates the person-centered plan annually or more frequently, if needed, as the individual's needs change;*
- *h. Provides individuals with information regarding their rights, including related to due process and fair hearings, and providing support to individuals as they exercise those rights; and*
- *i. Obtains necessary consents.*

3. Information, referral, facilitating access and related activities to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

The Support Coordinator:

- *a. Assists individuals and families in gaining information and establishing linkages with peers, professionals or organizations who can be key*

informants in supporting individuals with disabilities throughout the life course;

b. *Explores coverage of services to address individuals' needs through a full array of sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources;*
c. *Collaborates and coordinates with other individuals and/or entities essential in the delivery of services for the individual, such as MCO representatives, vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from other sources;*
d. *Coordinates with providers and potential providers to ensure seamless service access and delivery;*
e. *Facilitates access to financial assistance, e.g. Social Security benefits, SNAP, subsidized housing, etc.;*
f. *Facilitates continued enrollment in the DDDS HCBS Waiver by gathering or completing necessary documentation;*
g. *Assists individuals in transitioning to and from the Diamond State Health Plan Plus Medicaid LTSS benefit;*
h. *Assists an individual to access legal services;*
i. *May assist an individual to obtain transportation to appointments and other activities.*
j. *Informs and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.*
k. *Facilitates referral to a nursing facility when appropriate and when other available options have been fully considered and exhausted.*
l. *Participates in transition planning for an individual's discharge from a nursing facility or hospital within six months of the planned discharge date.*

4. Monitoring and follow-up activities and contacts are provided as necessary to ensure the person-centered plan is implemented and addresses the eligible individual's needs and the individual and individual's family's vision for the future. Monitoring ensures that: Monitoring and follow-up activities that include activities and contacts that are necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals. The contacts are conducted as frequently as necessary, in accordance with a minimum frequency as specified in the approved HCBS waiver application, to determine whether the following conditions are met:

a. *Services are being furnished in accordance with the individual's person-centered plan;*

b. *Services in the person-centered plan are adequate; and*

c. *Changes in the needs or status of the individual are reflected in the person-centered plan.*

Monitoring and follow up activities include making necessary adjustments in the person-centered plan and service arrangements with providers, including:

i) Monitoring of the health and welfare of the individual through monthly contacts that can include face-to-face, telephone or email contacts with the recipient or on behalf of the recipient, taking into account the communication preferences of the individual/guardian and incorporating the results into revisions to individual service plans as necessary to ensure that the individual can meet his or her goals;
ii) Activities and contacts necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual;
iii) Ensuring that services are provided in accordance with 42 CFR §441.301(c)(4);
iv) Providing advocacy on behalf of individuals to ensure receipt of services as indicated in their person-centered plan;
v) Responding to and assessing emergency situations and incidents and ensuring that appropriate actions are taken to protect the health, welfare and safety of the individual;
vi) Participating in planning meetings to address individual crisis needs, discuss options and ensure that an action plan is developed and executed;
vii) Assessing whether the individual's crisis is being mitigated, and following up when appropriate through contact with the individual and any service providers;
viii) Reviewing provider documentation of service provision and monitoring individual progress on goals identified in the person-centered plan, and initiating contact when services are not achieving desired outcomes;
ix) Participation in investigations of reportable incidents and integrating prevention strategies into revisions to individual service plans as necessary to remediate individual and systemic issues;
x) Ensuring that services are provided in accordance with the individual service plan and individual service plan services are effectively coordinated through communication with service providers;
xi) Activities and contacts that are necessary to ensure those individuals and their families (as appropriate) receive appropriate notification and communication related to unusual incidents and major unusual incidents;
xii) Soliciting input from the individual and/or family, as appropriate, related to their satisfaction with the services;

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. 42 CFR §440.169(e)).

***Targeted Case Management Service Definition* (Applies to Community Navigators)**

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Targeted Case Management will be performed by individuals called Community Navigators hereafter and includes the following assistance:

1. *Comprehensive assessment and periodic reassessment of individual needs, to assist the individual and family to plot a trajectory toward an inclusive, quality, community life. This may include the determination of need for any medical, educational, social or other services. These assessment activities include functions necessary to inform the development of the person-centered plan:*
    a. *Obtaining client histories and other information necessary for evaluating and/or reevaluating and recommending community based supports and services that may address individual or family needs;*
    b. *Identifying the individual's and/or family's support needs and providing assistance and reminders related to completing needed documentation for clinical and financial eligibility for assistance programs*
    c. *Gathering information from sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual*
    d. *Providing necessary education and information to the individual and his/her family to provide necessary support to assist them in developing a vision for their life, and to gain understanding of transitions that occur through the life course.*

    The Community Navigator collects information to inform the planning process and/or directly conducts an assessment of an individual's needs, both as targeted case management services begin, and at least annually thereafter or more frequently at the request of the individual.

2. *Development (and periodic revision) of a person-centered plan in accordance with 42 CFR §441.301(c)(1) through 42 CFR §441.301(c)(4). This activity may be conducted through direct and collateral contacts. The plan must reflect what is important to the individual to lead the life they want to lead. The plan must also identify and reflect the services and supports that are important for and to the individual to reach specified goals, to achieve desired outcomes and to meet needs identified through an assessment of functional need. The plan must also reflect the individual's preferences for the delivery of such services and supports. Individuals and families may focus on their current situation and stage of life but may also find it helpful to look ahead to start thinking about what they can do or learn now that will help build an inclusive productive life in the future.*

The Community Navigator:

a. *Uses a person-centered planning approach and a team process to discover what it takes to live the life the individual wants to live;*

b. *Uses a person-centered planning approach and a team process to develop the individual's person-centered plan to meet the individual's needs [and achieve the individual's goals] in the most integrated manner possible;*

c. *Provides support to the individual to ensure that the process is driven by the individual to the maximum extent possible and includes people chosen by the individual, with the individual at the center of the process;*

d. *Develops and updates the person-centered plan of care based upon the individual's needs and person-centered planning process annually, or more frequently, as needed;*

e. *Assists the person to select qualified providers who can best meet their needs;*

f. *Ensures that the plan identifies risk factors and includes plans to mitigate them;*

g. *Facilitates transition for new waiver enrollees moving from their family home to a waiver residence;*

h. *Facilitates seamless transitions between providers, services or settings for the maximum benefit of the individual;*

i. *Updates the person-centered plan of care annually or more frequently, if needed, as the individual's needs change; and*

j. *Obtains necessary consents.*

3. *Information, referral, facilitating access and related activities (such as assisting individuals in scheduling appointments) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.*

The Community Navigator:

a. *Assists individuals and families in gaining information and establishing linkages with peers and/or professionals who can be key informants in supporting individuals with disabilities throughout the life course;*

b. *Assists the individual and the individual's person-centered planning team in identifying and choosing resources and strategies that aim to promote the development, education, interests, and personal well-being of a person and that enhances individual and family functioning;*

c. *Explores coverage of services, as appropriate, to address individuals' needs through a full array of sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources;*

d. Collaborates and coordinates with other individuals and/or entities essential in supporting the individual, such as MCO representatives, vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from other sources.
e. Coordinates with providers and potential providers to ensure seamless service access and delivery.
f. Facilitates access to financial assistance, e.g. Social Security benefits, SNAP, subsidized housing, etc.
g. Facilitates continued enrollment in the DDDS HCBS Waiver by gathering or completing necessary documentation.
h. Assists individuals in transitioning to and from the Diamond State Health Plan Plus Medicaid LTSS benefit.
i. Assists an individual to access legal services.
j. May assist an individual to obtain transportation to appointments and other activities.
k. Informs and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.
l. Facilitates referral to a nursing facility when appropriate and when other available options have been fully considered and exhausted.
m. Participates in transition planning for an individual's discharge from a nursing facility or hospital within six months of the planned discharge date.
n. Provides advocacy on behalf of individuals to ensure receipt of services as indicated in their person-centered plan.
o. Empowers individuals and families to be their own advocates
p. Provides individuals with information regarding their rights, including related to due process and fair hearings, and providing support to individuals as they exercise those rights.

4. Monitoring and follow-up activities and contacts are provided as necessary to ensure the person-centered plan is implemented and addresses the eligible individual's needs and the individual and individual's family's vision for the future. Monitoring ensures that:
a. Supports and linkages are provided as indicated in the individual's person-centered plan;
b. Supports and services in the person-centered plan are adequate; and
c. Changes in the needs or status of the individual are reflected in the person-centered plan.
d. Monitoring and follow up activities include making necessary adjustments in the person-centered plan and service arrangements with providers as follows:
i. Monitoring through regular monthly contacts that can include face-to-face, telephone or email contacts with the recipient or on behalf of the

recipient, taking into account the communication preferences of the individual/guardian;

ii. *Monitoring of the health and welfare of the individual and incorporating the results into revisions to individual service plans as necessary to ensure that the individual can meet his or her goals;*
iii. *Activities and contacts necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual;*
iv. *Responding to and assessing emergency situations and incidents and ensuring that appropriate actions are taken to protect the health, welfare and safety of the individual;*
v. *Reviewing provider documentation of service provision, as appropriate, and monitoring individual progress on goals identified in the person-centered plan, and initiating contact when services are not achieving desired outcomes;*
vi. *Participation in investigations of reportable incidents, as appropriate and integrating prevention strategies into revisions to individual service plans as necessary to remediate individual and systemic issues;*
vii. *Ensuring that linkages are made and services are provided in accordance with the individual service plan;*
viii. *Activities and contacts that are necessary to ensure that individuals and their families (as appropriate) receive appropriate notification and communication related to unusual incidents and major unusual incidents; and*
ix. *Soliciting input from the individual and/or family related to information and supports that would be or have been most helpful.*

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case manager to changes in the eligible individual's needs. 42 CFR §440.169(e).

***Employment Navigation** (Applies to Employment Navigators)*

Employment Navigation services will assist participants in gaining access to needed employment and related supports. This service ensures coordination between employment and related supports and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Employment Navigators are limited to employees of the State of Delaware as per an approved 1915(b)(4) selective contracting waiver.

Employment Navigators are responsible for collecting information for evaluating and/or re-evaluating the individual's needs-based eligibility and for performing assessments to inform the development of the person-centered employment plan.

In the function of delivering Employment Navigation Services, the Employment Navigator will:

In the performance of providing information to individuals served through Pathways;

- *Informs individuals about the Pathways HCBS services, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks, and responsibilities.*
- *Informs individuals on fair hearing rights and assist with fair hearing requests when needed and upon request.*

In the performance of facilitating access to needed services and supports;

- *Collects additional necessary information including, at a minimum, preferences, strengths, and goals to inform the development of the individual's service plan.*
- *Assists the individual and his/her service planning team in identifying and choosing willing and qualified providers.*
- *Coordinates efforts and prompts the individual to ensure the completion of activities necessary to maintain Pathways program eligibility.*

In the performance of the coordinating function;

- *Coordinates efforts and prompts the individual to participate in the completion of a needs assessment to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Employment service plan.*
- *Uses a person-centered planning approach and a team process to develop the individual's Employment Plan to meet the individual's needs in the least restrictive manner possible.*
- *Develops and updates the Employment service plan based upon the needs assessment and person-centered planning process annually, or more frequently as needed.*
- *Explores coverage of services to address individuals' identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources.*
- *Coordinates, as needed, with other individuals and/or entities essential in the delivery of services for the individual, including MCO care coordinators, as well vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from such other sources.*
- *Coordinates with providers and potential providers of services to ensure seamless service access and delivery.*
- *Coordinates with the individual's family, friends, and other community members to cultivate the individual's natural support network.*

In the performance of the monitoring function;

- *Monitors the health, welfare, and safety of the individual and the Employment Plan implementation through regular contacts at a minimum frequency as required by the department.*

- *Responds to and assesses emergency situations and incidents and ensure that appropriate actions are taken to protect the health, welfare, and safety of the individual.*

- *Reviews provider documentation of service provision and monitor individual progress on employment outcomes and initiate meetings when services are not achieving desired outcomes*

- *Through the service plan monitoring process, solicits input from the individual and/or family, as appropriate, related to satisfaction with services.*

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other sources.

8. The results of the "Voice of DHSS Survey" – (Climate Survey) Two reports requested: DDDS data separated out of the DHSS overall survey and the overall survey results for comparison purposes. *(What initiatives has the Division implemented to respond to issues raised by employees?)*

   The results of the Voice of the DHSS Survey cannot be disaggregated to isolate only those responses from DDDS staff or any other division within the Department. The Department is using the information obtained from the survey to inform the Department's ongoing strategic planning activities.

9. Number of employee grievances filed during the most recent year.

   DDDS cannot disclose this type of information as it is confidential and part of personnel files

10. Number of all staff trainings, which have occurred during the most recent year.

   To date, DDDS has conducted 11 staff trainings during calendar year 2019. In addition to DDDS facilitated trainings, DDDS employees have additional opportunities to engage in trainings and learning opportunities via webinars, outside hosted events, etc.

11. Number of recognition events, which have occurred during the most recent year.

DDDS is authorized to conduct an employee recognition event per year. DDDS coordinates two employee recognition events: (1) for Stockley Center staff and (1) for Administration and Community Services.

- *Stockley Center's Employee Recognition Event is scheduled for December 2019*
- *Administration and Community Services' Employee Recognition Event occurred in September 2019*

12. Sick leave usage among DDDS employees

DDDS cannot disclose this type of information as it is confidential and part of personnel files

https://jobapscloud.com/DE/sup/bulpreview.asp?R1=101017&R2=MUPA15&R3=351100

Deputy Director (DDDS)

This position is exempt from the State of Delaware Merit System

Recruitment #101017-MUPA15-351100

Opening Date	10/17/2017 12:00:00 AM
Closing Date	10/30/2017 11:59:00 PM
Type of Recruitment	Open Competitive
Salary	Yearly: $71,870.00/Min - $89,837.00/Mid
Salary Plan	M37
Pay Grade	22
Shift Hours	8:00am - 4:30pm
Employment Type	Actual Vacancy
Employment Term	Regular
Agency	DHSS/Developmental Disabilities

Location(s)	Fox Run Building: (2540 Wrangle Hill Road, Bear, DE, 19701)
Contact Name	DHSS Applicant Services
Contact Phone	302-255-9100

Go Back View Benefits

Summary Statement

The Deputy Director of the Division of Developmental Disabilities (DDDS) reports to the Division Director and is responsible for the achievement of division goals and objectives. Duties include managing and overseeing a state workforce and a network of contracted providers to ensure that persons with intellectual and developmental disabilities (including autism) can lead fulfilling lives in the community, while honoring abilities and respecting choice. The division operates a single public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and manages a Medicaid Home and Community-Based Services Waiver (HCBS). The combined budget for these activities, inclusive of federal funds, for a division staff of over 400, is over $230 million. The Deputy Director oversees the following activities: planning, program development, fiscal administration, provider performance, contract monitoring and HCBS waiver administration.

Essential Functions

Essential functions are fundamental, core functions common to all positions in the class series and are not intended to be an exhaustive list of all job duties for any one position in the class. Since class specifications are descriptive and not restrictive, incumbents can complete job duties of similar kind not specifically listed here.

- Participates in the development, implementation and oversight of DDDS' statewide services for persons with intellectual and developmental disabilities. Develops, implements, and manages initiatives to enhance and ensure the quality of programs operated.
- Provides oversight in the development and management of the provider network to ensure high quality and fiscally responsible service delivery.
- Ensures implementation of HCBS waiver and supports strategic planning activities for future improvements.
- Supports with oversight of the administration and operation of the single state-operated Intermediate Care Facility for Individuals with Developmental Disabilities (ICF-IID) to ensure compliance with professional standards and Centers for Medicare and Medicaid (CMS) requirements. Establish and maintain collaborative partnerships with community hospitals, community health-care centers and various stakeholders.
- Analyzes compiled information related to quality outcomes. Determines through performance management the impact and efficacy of service initiatives.
- Collaborates with the Department of Justice and other regulatory agencies to ensure all complaints, allegations and/or adverse outcomes are promptly and thoroughly investigated and addressed accordingly.
- Participates in Division-level management planning, policy and decision-making regarding new programs/services and changes to existing programs/services. Develops and implements policy recommendations based on operational needs.
- Researches, analyzes, recommends and monitors fiscal activities.
- Identifies and maximizes the use of Medicaid eligible events and implements efficiencies to reduce expenses and improve client experience.

- Attends and participates in events and meetings hosted by advocates, providers or the general community as a way to continually engage stakeholders.
- Remains current on best practices for the delivery and oversight of institutional and community-based services for individuals with intellectual and developmental disabilities.
- Advances an expectation of high quality of services for clients, on-going development of employees, a strong culture of collaboration and a focus on person-centered planning.
- Handles special assignments at the discretion of the Division Director.
- May serve as acting director in the absence of the Division Director.

Job Requirements

JOB REQUIREMENTS for Deputy Principal Assistant
Applicants must have education, training and/or experience demonstrating competence in each of the following areas:

1. Possession of a Master's degree in Public Administration, Business Administration, Behavioral Health, Social Science or related field OR possession of a Bachelor's degree in Public Administration, Business Administration, Behavioral Health, Social Science or related field.
2. Applied knowledge of the management or oversight of service delivery systems serving individuals with disabilities in the community.
3. Five years experience providing leadership in a human service organization.
4. Possess strong analytical and critical thinking skills.
5. Must be able to demonstrate excellent written and oral communication skills.
6. Must be mission-driven, strategic, collaborative, and exhibit the ability to actualize goals and achieve results within a complex organization while addressing the demands of varied stakeholders.

Benefits

To learn more about the comprehensive benefit package please visit our website at http://ben.omb.delaware.gov/

Selection Process

Please attach a resume with your online application or use the resume tab in DEL to provide a detailed description of how your education, training and/or experience meets each job requirement including employer, experience/responsibilities and dates (month/year) of employment/training.

Once you have submitted your application on-line, all future correspondence related to your application will be sent via email. Please keep your contact information current. You may also view all correspondence sent to you by the State of Delaware in the "My Applications" tab at www.delawarestatejobs.com.

Accommodations

Accommodations are available for applicants with disabilities in all phases of the application and employment process. To request an auxiliary aid or service please call (302) 739-5458. TDD users should call the Delaware Relay Service Number 1-800-232-5460 for assistance. The State of Delaware – An Equal Opportunity and Affirmative Action Employer.

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