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New Policy X

Modifying Policy ______

Adult Services X

E.C. Services ______

All Services ______

POLICY TITLE

POLICY GOVERNING PRIMARY RECORDS AND DOCUMENTATION REQUIREMENTS

POLICY CONTENT

This policy ensures consistency in the documentation of records maintained by case management agencies. This policy requires a single record documenting all activities and services provided to individuals with developmental disabilities.

POLICY NUMBER

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AUTHORIZATION

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POLICY GOVERNING PRIMARY RECORD DOCUMENTATION REQUIREMENTS

I. INTRODUCTION AND PURPOSE

The purpose of this policy is to ensure consistency in the documentation of records maintained by case management providers. This policy requires a single record documenting all activities and services provided to individuals with developmental disabilities. This policy describes the responsibility for maintenance of each individual's primary client record and the required contents of each record by case management agencies. This policy is applicable to individuals with developmental disabilities receiving community based services.

II. SCOPE OF POLICY

All individuals shall have a primary record kept and maintained by the case management agency. The record shall document activities and services provided to individuals with developmental disabilities receiving community based services.

In the event the individual does not have an independent case manager (i.e. those receiving only State general funded services) the primary client record shall be maintained by the service coordinator of the individual's residential provider.

III. APPLICABILITY

This policy shall apply to *all* individuals with developmental disabilities living in the community and receiving services, regardless of the service delivery model used, except for those receiving only ancillary services such as respite or therapies.

4. Any assessments required by the Developmental Disabilities Medicaid Waiver such as Comprehensive Individual Assessment, AAMD, ICAP, Vineland, etc.;

5. Behavior Support Plan, as included in the Individual Service Plan according to "Policy Governing Behavioral Support Service Planning for Persons with Developmental Disabilities" (New Policy, January 19, 1996);

6. Medicaid Waiver Level of Care (LOC) abstract "form MAD 378";

7. Documentation of service orientation provided to the individual and parent/guardian regarding Client Rights Regulations (DOH 94-05), Client Complaint Procedures Regulations (DOH 94-06), and Dispute Resolution Process Regulations (DOH 94-02). (DRP orientation for deinstitutionalized individuals only);

8. Signed primary and secondary Freedom of Choice forms;

9. Confidentiality statement;

10. Standard case notes documenting contact with the individual, direct service, ancillary or generic service providers. Documentation should include date, time, purpose, outcome of contact, narrative entries and progress notes;

11. Internal Quality Assurance documentation. This refers to any documentation to verify the case management provider's periodic assessment of the quality of each record.

12. Documentation of rationale for lapse or change in service provision if not stated in the ISP;

13. Documentation of client guardianship status - including type of guardianship, expiration date, etc.;

14. Programmatic correspondence applicable to services received by the individual;

15. Quarterly reports from therapists;

This policy is consistent with all regulations as set forth by the Department of Health and the Developmental Disabilities Division including standards established for Individual Service Plan development in "Regulations Governing the Individual Service Plan Development Process" [May 3, 1994][DOH 94-04 (DDD)]. This policy is also consistent with standards as set forth by the Commission on the Accreditation of Rehabilitation Facilities [CARF] and other program accreditation approved and adopted by the Developmental Disabilities Division and the Department of Health.

The following are **EXCLUDED** from this policy as their service and service delivery are addressed in other regulation.

1. **Children, aged birth to three,** who are recipients of services covered by the federal Individuals with Disabilities Education Act (IDEA), Part H, as administered under the New Mexico Family, Infant and Toddler Program.

2. **Early Periodic Screening, Diagnosis and Treatment (EPSDT)** case management recipients, unless allocated to the DD Waiver.

3. **Medically Fragile Waiver recipients**

4. **State General Funded recipients** of ONLY ancillary services (non-residential and non-day program services), such as respite and/or the various therapies.

5. **Community ICF/MR Group Home residents** EXCEPT persons discharged from State institutions.

IV. CONTENTS OF PRIMARY RECORD

Each individual's primary record file should contain, at minimum, copies or originals of the following items:

1. Current Individual Service Plan (ISP), any amendments added as a result of a Re-IDT, semi-annual meeting, or Dispute Resolution Process (DRP), and the Individual Service Plan (ISP) budget form(s) and revisions.

2. Individual Preference Assessment;

3. Assessments, evaluations, and reports performed pursuant to the Individual Transition Plan (ITP) or Individual Service Plan (ISP);

16. Quarterly reports from day and residential providers documenting progress towards Individual Service Plan goals;

17. Annual Medical Assistance Worker (MAW form DLH 052) letters and approval for Medicaid;

18. Copy of annual medical History and Physical filled out by physician or physician's assistant;

20. Any other relevant medical reports; and

21. Medication documentation, including:

    A. Diagnosis (including primary and secondary diagnoses);

    B. Current list of <u>all</u> medication(s), including psychotropic and anti-convulsant medications, with dates of last entry or prescription, physician's current name and dosage amount;

    C. For residential providers, documentation of review by consulting pharmacist. (Reference Board of Pharmacy Regulations for Medication in Supportive Living homes)

In addition, the following documents are required for all individuals placed in the community from the Ft. Stanton Hospital and Training School or from the Los Lunas Center for Persons with Developmental Disabilities pursuant to the <u>Jackson</u> Lawsuit (<u>*Jackson v. Ft. Stanton, et al.*</u>). These documents are to be kept for three years following termination of the providers' contract:

A. Individual Transition Plan (ITP) produced by the Transition Interdisciplinary Team (TIDT) and all subsequent amendments as a result of the Dispute Resolution Process (DRP) or Re-TIDT;

B. Minutes of the 14 Day Community Interdisciplinary Team (CIDT) meeting and any subsequent CIDT meetings that take place prior to the 60 Day CIDT meeting;

C. ISP resulting from the 60 day CIDT

D. Facility record review (performed pursuant to <u>Jackson Management Manual</u>, <u>Appendix "A" Amended</u>, <u>Activity</u> 4 see

Developmental Disabilities Division Transition Planning Policy Memorandum #003);

E. Self-Report/Pre-Placement Quality Assurance forms; and

F. Approved Cost Proposal(s) form(s).

V. PERIODIC REVIEW OF DOCUMENTATION POLICY

The Developmental Disabilities Division will review this policy at least annually, to evaluate the current requirements and make recommendations for amendments to the Adult Services Task Force. The Division will issue periodic amendments and revisions, as appropriate.