

# *A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver*



**Developed by:**

**The New Mexico  
Department of Health  
Developmental Disabilities Supports Division**

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# Use of this Guide



*A Resource Guide for Independent Case Managers for the Developmental Disabilities (DD) Waiver* was designed as a resource for New Mexico independent case managers (CM) who serve individuals with developmental disabilities. It serves as a ready-reference to information, resources, and tools you can use to enhance individuals' experiences with the service system and, most importantly, to support attainment of outcomes they personally seek to achieve.

This guide is structured in such a manner as to represent key aspects of the CM's role in his/her relationships with individuals and their families, guardians, advocates, all types of service providers, and others involved in the individual's life. Each chapter addresses a different process that the CM and team assist individuals to complete to secure and receive services and supports that are personally important to their health, safety, and growth as human beings. All chapters describe the rationale(s) for the activities described, the necessary procedures to complete them, and references to relevant policies and/or Regulations.

The guide is comprised of an **Introduction**, nine (9) **Chapters** and an **Appendix**.

<b>Chapter</b>	<b>Title</b>
I	How Individuals Become Eligible for Developmental Disabilities Waiver Services
II	Getting to Know the Individual
III	Making the Most of Meetings
IV	Planning with the Individual
V	Community Resources and Supports
VI	Keeping Things on Track
VII	Record Keeping on Behalf of the Individual
VIII	Creating the Individual's Budget & Billing for Services
IX	When an Individual Changes Services

The guide illustrates the role and responsibilities of CMs with the use of scenarios commonly encountered by individuals, their CMs and teams. These are real life examples of personal experience in services and supports.

The material in this guide can be used in different ways. The guide in its entirety can be used as a handy 'desk reference' for guidelines, protocols, tips, and samples of forms a CM uses on a regular basis. In addition, sections within chapters can serve to refresh knowledge and skills of a particular case management function, particularly those that address situations that arise only on occasion.

This guide can also be made available to colleagues, especially provider agency service coordinators, as well as other team members who play different roles in the lives of individuals. It can expand their understanding of CM interactions with and on behalf of individuals served.

**Note:** *To review regulatory citations, refer to the hyperlink entered by each reference.*

# Introduction



◇ Mission

◇ Philosophy

◇ Components of the Case Management System

◇ Case Management Process Flow Chart

## Introduction

### Mission

Independent case management is committed to promoting quality of life for individuals with developmental disabilities by supporting their personal choices, promoting opportunities for growth, and encouraging participation as active community members by:

#### ◆ **Advocating for the Individual's Rights, Choices, and Self-determination**

*Shane is a lively man who receives twenty-four hour supported living services through the DD Waiver; he recently turned forty. He has lived in the same town and received services from the same residential agency for thirteen years. Shane possesses many skills; he often cooks for his housemates, is able to manage money (if he so chooses), and has been employed by a local business for two years.*

*Shane's has major health issues (he is obese, and has diabetes, leg edemas, and asthma), but will not make the healthy choices his team, doctor and family have recommended. He refuses to exercise, eats what he wants, and will sit at his computer playing video games for hours, without keeping his legs elevated. Shane does monitor his own sugar levels and schedules his own medical appointments. Although he wants to live alone, the team is caught in the "readiness trap" (Shane has to change his health and behaviors prior to moving) and will not discuss a transition plan into Assisted Living.*

*After a few visits, the case manager (CM) heard Shane's deep desire and advocated for Shane's right to move into his own place. With support from his CM, Shane was able to speak to his mother about his wishes and inform his team of his vision to live alone within one year and wanted a program implemented now. The CM reminded the team of Shane's rights and his ability to make informed choices. With Shane's input, the team developed a transition plan that includes contacting other providers and researching affordable and desirable apartments close to his job. The CM closely*

*monitored the plan and kept the team on track; Shane was able to move into his own apartment within 10 months of the initial meeting. Shane is very proud of his new life, loves being independent, and is gaining self-esteem each day. His staff, family, friends, and CM continue to encourage him to eat healthy and exercise, but respect his ability to choose for himself.*

***Katie** is a personable, young energetic lady with a diagnosed seizure disorder and mild cerebral palsy. She receives services through the Medicaid Waiver program and is extremely close to her CM, Jill. Jill works for Sunnydale Case Management and has provided case management to Katie since she was sixteen. Katie is now 22 years of age, lives at home with her parents, has a vision of living on her own some day and works at a local jewelry making factory.*

*Her parents have been informed of the legalities of guardianship and that per law Katie is now her own guardian. Katie is very close to both parents and an elder sister. Both parents expressed concerns over Katie's vulnerability and her inability to understand what others may tell her. The parents decided to petition for full (plenary) guardianship, after speaking with a lawyer. This upset Katie who felt there were decisions about her life that she was quite capable of making as an adult. She asked to meet with Jill and her older sister. Katie said she wanted to go to court and ask that her parents be allowed to make only some decisions for her. Jill asked her what she would need to do to assure this happens. Katie decided she would work on what she wanted to tell the judge with her speech therapist. She even suggested she would write it down. Katie also asked for a meeting with her parents to inform them of her wishes. Because she did not want them to think she hated them, Katie asked her sister and Jill, the CM to attend the meeting to advocate for her wishes.*

*The meeting with the parents was a little bumpy because they continued to think of Katie as their little girl and wanted to protect her. Katie informed the guardian ad litem that she wanted to testify during the court proceedings and worked real hard with her speech therapist to formulate her thoughts prior to court. On the day of the hearing, Katie was accompanied by her parents, sister, CM, and speech therapist. She did have the opportunity to explain to the judge what she wanted for her life. Her*

*parents were assigned limited guardianship over her medical and financial decisions. After the hearing both parents remarked on how proud they were of Katie and how they saw her in a different light in court. They realized their little girl was an adult, who was prepared to exercise her rights.*

***Karen** is a pretty woman with Down syndrome. She is now 32 years old and has a very nice boyfriend who lives about an hour away. Neither has a guardian. Karen and Tony met at work and have known each other for several years. Karen is more independent and mature than Tony and really is the "lead" in their relationship. She frequently talks about her deep feelings for Tony with her CM (Peggy), her mom and her team. Although she desires to have an intimate relationship with him, she is also a bit afraid and is willing to accept advice and guidance from her friends and family. Tony wants to live with Karen, have a sexual relationship and get married.*

*Because of the intimate nature of the situation, her mom, CM and other team members talk with Karen outside of regular team meetings. Peggy and Karen also meet for coffee every few weeks. During these visits Peggy asks Karen how things are going and talks with Karen about relationships in general and boyfriend-girlfriend relationships in particular. They sometimes go to romantic movies together and then talk afterwards. Peggy also occasionally goes out for a meal with Tony and Karen and they talk openly about their relationship, including issues they want to talk about. Karen's team continues to support the relationship as best they can, providing opportunities to spend time alone as well as with other couples in social situations.*

*Peggy informs Karen, her mom, and the team that the DDSD office of Behavior Supports OBS can provide some counseling and assistance with these issues. With their approval, she refers them to OBS. A consultant from OBS provides information on birth control, pregnancy, and child rearing. Both Karen and Tony's parents worry about marriage and pregnancy and frequently call Peggy to talk. Peggy listens to the parents' concerns, but maintains Karen's privacy. She does her best to explain their adult children are being educated on the meanings and consequences of*

*relationships as well as having opportunities to experience a relationship together. Peggy also talks to the couple about birth control and some of the basics of raising a child. When Karen decided she didn't really want a child, OBS provides supports to Karen and her mom to see her doctor for birth control. This relationship is clearly a loving and meaningful one to Karen and Tom; the team continues to be willing to take it one step at a time and support them as it develops.*

### ◆ **Assisting and Supporting the Individual/Family to Direct and Participate in Service Planning and Decision Making**

*The Munoz family recently transferred to the Big Sky Case Management agency; Beth was assigned to be the new CM. When she met with the Munoz family to review the DD Waiver services **Danielle**, who is now twenty-five years of age, was receiving on the DD Waiver, she was informed of the following:*

- ◆ *Danielle had participated in a local day habilitation program for approximately two and a half years.*
- ◆ *Danielle's SLP provides services at the day habilitation site.*
- ◆ *Danielle wants a job at a local bookstore, but the team has been consistently resistant to discuss community employment for Danielle.*
- ◆ *SLP services should be provided occasionally in the home so that the family could learn and reinforce the support plan throughout the day.*

*In addition, Mrs. Munoz felt that issues appeared to be settled before the meeting actually started and the team only came to sign papers.*

*Beth spent the time necessary to review the purpose of the DD Waiver with Danielle and her mother. She emphasized the person-centered philosophy that governed the provision of waiver services and stated that the ISP meeting is Danielle's meeting; the team is there to support her desired outcomes. To encourage Danielle to take ownership of the team process, Beth suggested Danielle may want meetings to be held somewhere other than the agency conference room. Danielle became very excited and said she would like to have the meeting in the clubhouse on the premises of her condo; her mother and CM helped Danielle practice asking for use of*

*the clubhouse. Beth informed the Munoz family that Danielle could develop an agenda for the meeting, listing the issues she wanted to discuss, and could co-facilitate the meeting. Beth helped Danielle complete a draft agenda for the meeting; Danielle would continue to work on the agenda with her mother and SLP.*

*The ISP meeting at the clubhouse felt very festive to the family. Danielle facilitated the meeting, with assistance from her mother, CM, and SLP. The day habilitation staff became very excited about community employment for Danielle and committed to complete a DVR referral. After the meeting, Danielle and her mother thanked Beth and both stated that for the first time they left a team meeting feeling empowered.*

### ◆ Supporting Informed Lifestyle Choices

*Cathy was quite overweight and had met little success in her efforts to shed pounds. She began having difficulty walking. Her CM and sister talked with Cathy about how important losing weight is to her health and her ability to get around as she likes. They explained how her problems with walking can limit her ability to fully enjoy the things she likes to do. This includes shopping at the mall with her sister, one of her favorite activities. Cathy doesn't like to talk about her weight and is uncomfortable when others raise the issue.*

*Cathy's CM and sister want to support Cathy any way they can. They met with her to offer suggestions to consider in making decisions about her weight and her health. Other members of Cathy's team were invited to share their insights, including a nutritionist, behavior support consultant, and nurse.*

*During the meeting, each team member expressed their support for Cathy and her role as a decision maker. They shared their appreciation for how hard it is to make lifestyle changes and gave examples of challenges they faced in their own lives. The team came up with a menu of options for Cathy to think about. These included support groups, programs such as Weight Watchers™, reinforcement for incremental achievements, nutritional counseling for education, menu planning, and meal preparation, scheduled 'mall walks' with her sister, fitness programs such as Curves™, and others.*

*Cathy knew she would not have to struggle alone and decided to try various suggestions. Over several months Cathy lost weight and had fewer difficulties in getting around. She continues to receive her team's support in maintaining a strong and healthy lifestyle.*

◆ **Linking with natural and generic supports and services in the individual's own community**

*David, a 22 year old man, talked a lot to his CM and behavior support consultant about abusing alcohol and wanting to stop drinking. He had attended AA meetings in the community yet never felt comfortable participating, even when a staff member accompanied him. David noted that it was hard to understand what people were talking about and often no one spoke about things important to him. He knew there were others like him with similar problems and wished he could find a meeting where those people could share their thoughts and feel supported in not drinking.*

*David's CM asked if he ever thought about starting his own group. After consideration, David came up with a list of ideas and things he would need to do to get a group up and running. First he needed to find a place for the meetings. His CM obtained permission for the group to use the agency conference room. With assistance from his behavior support consultant, David met a local grocer and described his plans. The grocer thought David's plan was worthy of support and donated snacks and beverages.*

*David then invited people who were in the same situation to attend the first meeting. David had a volunteer from a local AA chapter help the group set ground rules and answer questions about the program. David's group now has 20+ members who attend regularly. The group has moved from the agency to space in a local church. With the group's support and regular contact with his behavior support consultant and CM, David continues to find ways to support people with disabilities to stop abusing alcohol. David is very proud of his accomplishments. He has made friends for life, become more involved in his community, and stayed sober throughout this personal journey.*

### ◆ Promoting opportunities to develop and maintain significant relationships in their own communities

*Josh is 24 years old; next to his grandmother, his music is the most important thing in his life. He loves to play guitar although he has never had a lesson. At the last team meeting, Josh told everyone that he wanted to take guitar lessons at the local community college. He had already done his homework; he could take a continuing education class for \$50.00. His residential program coordinator verified that he had the money in his account. Josh knew the class was on Monday and Wednesday mornings, which would interfere with his job schedule. The team brainstorming session resulted in several strategies that would allow Josh to take the class while maintaining his job. Josh asked his job coach to help him discuss the matter with his employer. As it turned out, the employer was very happy to change his workdays. As Josh also needed transportation to and from class, the CM helped the team to identify transportation supports. One of his favorite staff volunteered to help Josh register. The CM monitored all start up and ongoing supports.*

*Josh did so well in his class, his instructor John asked him to be one of the volunteers at a weekend guitar class for children. With their shared love of guitar music, John and Josh soon became close friends. John and his family invited Josh to join his family for dinner, holidays, and special community music events. Eventually Josh joined John and his family at out of state workshops and concerts. At times the scheduling and logistics of these trips were difficult, but the CM continued to help the team brainstorm new strategies and monitored their implementation.*

### ◆ Coordinating and monitoring services

*Kellie, a 26-year-old recipient of DD Waiver services, lived at home with her parents and wanted to move out on her own. Kellie's uncle moved away from the area and asked if she wanted to rent his small house. Kellie works at a local deli. With the help of her CM she figured out that she could afford the rent, utilities, and other household expenses. Kellie felt she would need help with cooking, laundry, and grocery shopping but was adamant about not needing someone to be with her all the time.*

*Kellie's CM contacted the Assisted Living providers in Kellie's county and made arrangements for Kellie to interview them. Kellie chose the one she liked best. Kellie's CM scheduled a team meeting with the new provider so that all arrangements for Kellie's move into her new home could be made and finalized. Once she moved, Kellie's CM arranged to visit Kellie at her home every month to monitor the services Kellie was receiving. During these visits she made sure Kellie was comfortable in her new home and that the new Assisted Living provider was meeting Kellie's household needs.*

## Philosophy

The New Mexico Developmental Disabilities Medicaid Waiver (DD Waiver), a community based program, offers case management as a **core service** to eligible individuals who have developmental disabilities. Case management services are person-centered and quality driven. CMs place the individual's desires, values and preferences as the priorities when planning for and accessing natural and specialized supports.

CMs promote the individual's right to fully participate in the planning process, to be integrated into his/her community and to live a satisfying, safe and productive life. The CM's role extends to supporting the individual to make as many of their own decisions as possible and to ensure that the individual's desires and preferences are known and understood, regardless of guardianship. Emphasis should be placed in promoting the individual's management of his or her own affairs to the greatest extent possible. To this end, an appreciation for '**Person-Centered Planning**' is key.

Person-Centered Planning revolves around the fundamental respect for the individual and a strong commitment to community inclusion. Distinctly different from traditional planning principles that have been deficit-driven, Person-Centered planning focuses on each individual's innate capacities and gifts when envisioning the future. The individual is involved in all aspects of planning and, whenever possible is supported to take the lead in

the process. Family members and friends are heartily welcomed to assist the individual in looking forward in his or her life. The individual's team exists to provide information, support, and encouragement as the individual considers options for the generic and specialized supports needed to achieve his or her desired outcomes in life.

Another critical aspect of the CM's role is that of advocacy. Advocating for the individual may take many forms: breaking through barriers to the individual's personal outcomes, maneuvering through layers of regulatory requirements, and providing a voice for those individuals who may not possess the skills or experience in speaking for themselves. CMs should position themselves as advocates by getting to know what is important to the individual and being a liaison to resources for the services and supports that match those priorities.

A CM is required to have specialized skills, education, and competencies to provide the following functions in conjunction with the team: 1) completion of a comprehensive assessment of the individual's desired outcomes, functional capacity, strengths, abilities, needs and resources; 2) development of an Individual Service Plan (ISP) based on the comprehensive assessment; 3) monitoring implementation of the ISP to promote health, safety, high quality services, and cost-effectiveness; 4) re-evaluation of services for efficiency, effectiveness, and relevance to the individual's desires; and 5) on-going advocacy to promote self-determination by the individual.

⇒ [7 NMAC 26.5; DD Waiver Standards 2.3 ISP Development Process](http://www.nmcpr.state.nm.us/nmac/title07/T07C026.htm)  
[http://www.nmcpr.state.nm.us/nmac/ title07/T07C026.htm](http://www.nmcpr.state.nm.us/nmac/title07/T07C026.htm)

### **Training Resources**

DDSD provides training on all of the above topics. The ***Pre-Service Manual*** provides a mandatory self-study guide to basic responsibilities that must be completed within thirty (30) days of hire. The ***Two-Day ISP Training*** provides detailed information on person-centered planning and best practices for the CM. ***ISP Critique*** provides hands-on experience with the process. ***Participatory Communication and Choice-Making***

### **Training Resources**

provides information about promoting communication and choice making throughout the person's life, with the cooperation of the entire team. **Positive Behavior Support Strategies** provides an overview of behavioral supports and the consideration of unusual behaviors as a form of communication. **Promoting Effective Teamwork** is designed to help the CM be an effective facilitator and team member. **Advocacy Strategies for Case Managers and Service Coordinators** is designed to promote rights of individuals and advocacy strategies for teams. With the exception of the 30-day requirement for the **Pre-Service Manual**, each of these courses must be completed within one year of hire. **Level One Health for Case Managers and Services Coordinators** and **Sexuality for People with Developmental Disabilities** must also be completed within the first year.

## **Components of the Case Management System**

The following processes comprise the system a CM uses to coordinate services and supports needed and desired by individuals served.

**Assessment:** The process of collecting information about an individual's interests, strengths, preferences, needs, desired outcomes, and availability of resources and supports. The CM uses his/her expertise, observations and judgment to synthesize, prioritize and integrate the information and recommendations collected in the assessment process into individual service planning. Getting to know the individual requires spending quality time on an informal basis, as well as completion of the formal assessment process.

### **Pre-ISP: Greg and the CM prepare for his meeting**

*Greg had not been happy with his last CM. He has a new CM (Jenny). After reading record information, Jenny schedules a visit with Greg to start to get to know him. She goes to Greg's parent's house when he is visiting and finds out that Greg has always been close to his family. She takes notes and uses the information to fill out as much of the strengths, preferences and needs section of the ISP as she can before the meeting.*

*She notes Greg wants to be heard by the team and not be told what to do. He had some bad experiences with being ignored (then having jobs he was not successful or happy with); he is reluctant about the upcoming meeting. Jenny tells Greg she works for him, the team is there to support him in what **he** wants to do and she will honor his decisions and advocate for him. When she leaves they both feel more confident about the upcoming meeting.*

*Greg has lots of medical issues; the team who works with him has recommended many evaluations by doctors and therapists. With the recommendations from the therapists the team has helped Greg become healthier and more independent.*

*Still Greg does not seem happy with his life; the team suggests a fresh look at what Greg likes and who he wants the world to see him as. Jenny lets Greg know he can use his Annual Resource Allotment (ARA) to have an experienced facilitator conduct a personal planning session to help clarify his dreams and identify resources (beyond his waiver services) that can support his success.*

### ⇒ **Chapter VIII: Creating the Individual's Budget & Billing for Services**

*After interviewing several facilitators and discussing various planning methods, he selects the one who has experience with '**Personal Futures Planning**' because that process sounds like a good approach to Greg. Greg and the CM work together to schedule the planning session and invite people Greg knows and likes from his past and present life.*

*At the personal planning session he is the focus of positive attention. The emphasis is on discovering with Greg what roles he is already living and those he wants to develop. His medical needs are not discussed at the meeting. He feels like a regular guy and opens up, telling the group about his love of horses, his dream to someday own a horse, how important it is to him to have a girlfriend and his dream of marrying someday. When his neighbor says they know someone who has a riding stable Greg is open to applying for a job there.*

**Service Planning:** A person-centered ISP must be based on an individual's dreams, aspirations, values, and preferences. The ISP also identifies the individual's challenges and the supports available and/or necessary to address these challenges. A team works with the individual to develop the ISP on an annual basis. A team, identified and invited by the individual, develop the ISP on an annual basis. In addition to the CM, this team may include family members, guardian, friends, and service providers. The ISP is revised as needed to accommodate changes in the individual or in his/her life.

*The team then met to develop a new ISP based upon the information from Greg's personal planning session. Now the team sees Greg in a new light. The therapists suggest ways they can help Greg be successful and comfortable at the riding stable. The team can now see how the efforts of working together can help Greg become a truly involved member of his community. It becomes obvious that the medical assessments, evaluations and resulting recommendations are only supports for Greg; they are not the end result.*

*The team addressed ways to support Greg's personal growth, dreams and aspirations in a safe and respectful way. The CM asked team members to brainstorm ways they could help Greg meet girls, be successful at his new job, and become involved in the ranching community.*

*They had to really work together to cover all the supports he needed; making sure his health needs were addressed without preventing him from being a part of community groups and activities he was interested in. The residential provider had to make allowances and write an agreement with the Community Access provider so they could pick up Greg and take him to events that take place after 3:00 pm and also on weekends. The Supported Employment provider had to get additional training from the nurse to be sure they could adequately take care of Greg's medical needs at the job site. It took some time, but the team worked it out with the great facilitation the CM provided.*

*Once the team had information from the personal planning process they knew Greg better and everyone knew their part in making sure his life was*

*what he wanted it to be. The team now sees how the efforts of all of them working together can help Greg become a truly involved member of his community. The outcome all of them can feel good about (especially Greg) is Greg becoming a member of the local 4-H and Rancher's Association, getting a job he likes and meeting a girl he can have fun with; Greg as a rancher, friend, employee and a full member of his community.*

**Monitoring:** Effective case management requires monitoring to oversee health and safety, identify and resolve issues, and determine if services are 1) provided at an appropriate level of intensity to meet the individual's needs, 2) implemented in accordance with the ISP, 3) of high quality, and 4) provided to the satisfaction of the individual.

*Greg's ISP was written including therapy recommendations, medical crisis prevention plans, outcomes and action plans that directly relate to Greg achieving his desired outcomes. The CM then needed to make sure the team kept up with the services. The CM visited Greg at home and found new staff that did not know some of Greg's medical needs. The CM documented this in her notes and contacted the service coordinator. The service coordinator informed the CM that new staff would be trained the following week and they would not be working alone with Greg until completing the training.*

*When the CM visits Greg at the job site, Greg excitedly showed off his new grooming equipment. It is obvious he was satisfied with this job.*

**Eligibility/Re-evaluation:** Becoming eligible to participate in the DD Waiver occurs when an individual meets criteria for both an Intermediate Care Facility for the Mentally Retarded (ICFMR) and financial eligibility. The individual and/or the family work together with the DDSD Eligibility Unit, the CM, and the Income Support Division (ISD) to establish initial clinical and financial eligibility for Waiver services. Annual re-evaluation is done by the CM and determines the individual's continued eligibility, required frequency and preferences for services. Re-evaluation is based on ongoing or new assessments and the CM's clinical judgment of changes in the individual's situation or condition. In some cases, a change in

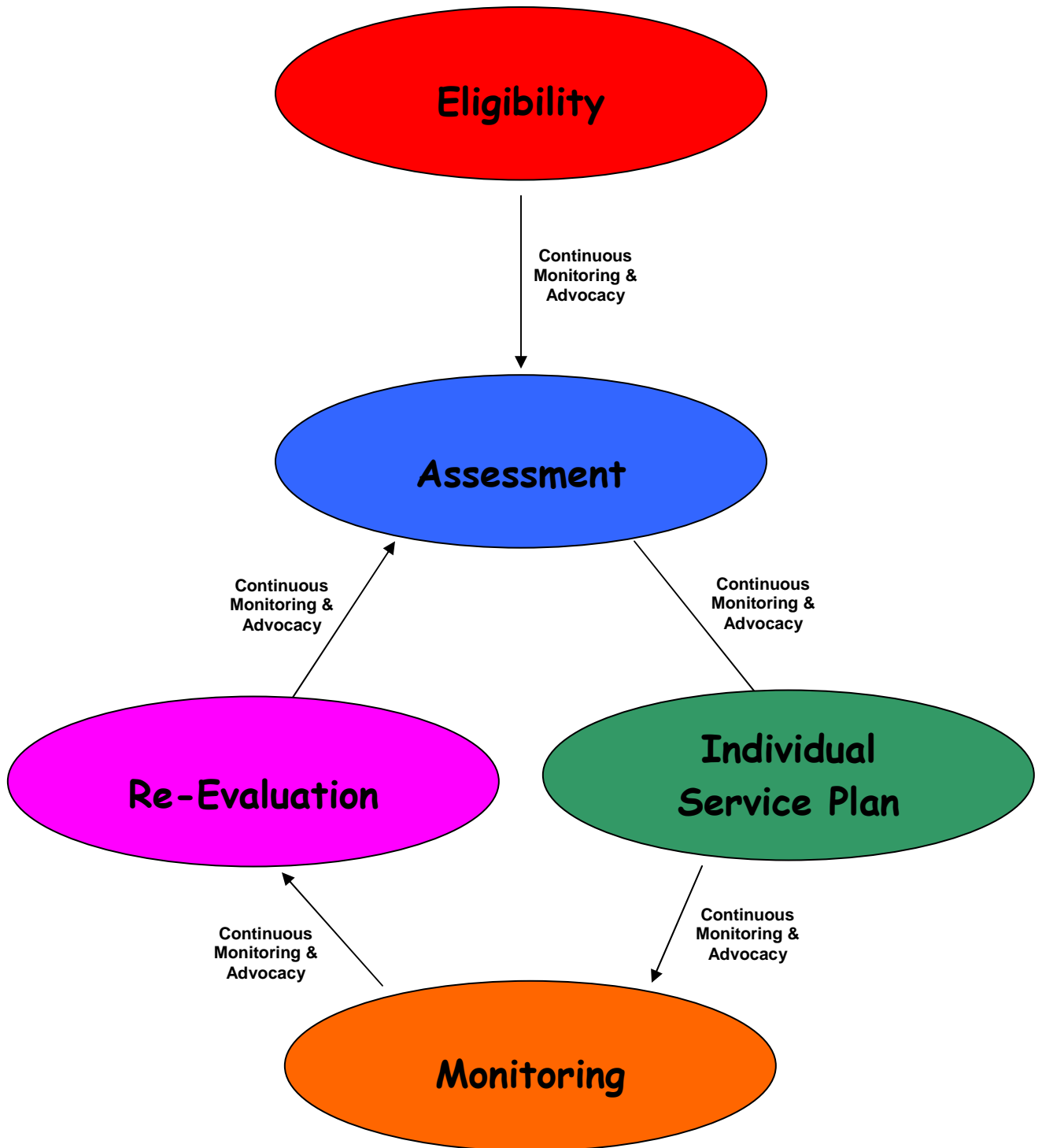
the individual's situation or condition may result in a new level of care that must then be submitted to Blue Cross/Blue Shield (BC/BS) for approval. A new LOC packet is completed annually by the CM.

**Record Keeping:** Accurate documentation on the individual's quality of life, ISP implementation, successes, challenges, medical issues and supports is required for reimbursement of case management services. Timely, thorough and accurate documentation 1) provides legal evidence of the CM's efforts to promote health and safety and support the individual's quality of life; 2) allows coverage by others to continue case management services if the assigned CM is unavailable; and 3) allows the case management supervisor to conduct quality reviews.

*The CM enjoys writing about Greg's successes and makes sure to document he is successful because the team provides the supports he needs. If any one of those supports is not in place the whole plan can fall apart. The CM documents Greg's needs and how they are being met. If another CM took over the case they should be able to clearly see his needs and how they are being met with both paid and natural supports.*

The flow chart on the following page illustrates the basic components of the case management process. Please note that **continuous monitoring and advocacy** provide support and linkage to all components. They are the glue that cements the process.

# Case Management Process Flow



# Chapter I

## How Individuals Become Eligible for DD Waiver Services



- ◆ Eligibility Criteria
- ◆ Applying for Waiver Services
- ◆ Initial Financial Determination
- ◆ Clinical Eligibility
- ◆ Ongoing Eligibility & Reassessment

# Chapter I

## How Individuals Become Eligible for Developmental Disabilities Waiver Services

### Eligibility Criteria

To qualify for the Developmental Disabilities Waiver program (DD Waiver), an individual must meet clinical and financial criteria. The DD Waiver eligibility criteria are as follows:

1. The individual has a developmental disability, defined as a severe chronic disability, other than mental illness, that is:
  - a) Attributable to a mental or physical impairment, including the result of trauma to the brain, or a combination of mental and physical impairments
  - b) Manifested before the person reaches the age of twenty-two years;
  - c) Expected to continue indefinitely; and
  - d) Responsible for substantial functional limitations in three or more of the following areas of major life activity:
    - i. Self-care
    - ii. Receptive and expressive language
    - iii. Learning
    - iv. Mobility
    - v. Self-direction
    - vi. Capacity for independent living
  - e) Reflects the individual's need for a combination and sequence of special coordinated treatment, generic or other support and services that are of lifelong or extended duration and are individually planned and coordinated.

2. The individual also has mental retardation or a specific related condition, limited to:
  - ◇ Cerebral palsy
  - ◇ Autism (including Asperger's syndrome)
  - ◇ Seizure disorders
  - ◇ Chromosomal disorders (e.g. Down syndrome)
  - ◇ Syndrome disorders
  - ◇ Inborn errors of metabolism
  - ◇ Developmental disorders of brain formation
  
3. The individual must also meet the level of care required in an Intermediate Care Facility for Persons with Mental Retardation (ICFMR). This Level of Care (LOC) determination is the responsibility of the independent case management agency once an individual is allocated; and
  
4. The individual must also meet all applicable financial eligibility requirements, as verified annually by the Income Support Division.

⇒ **Appendix: Decision Tree: DD Waiver Eligibility**

## Applying for Waiver Services

### Step 1: Initial Financial Determination Registering at the Income Support Division (ISD)

1. The first step of the application process is to register at the Income Support Division (ISD); also known as the Welfare Office, Medicaid Office, or Food Stamp Office.
2. The applicant fills out a **Waiver Services Registration** form (**MAD 325**).
3. All Waiver programs are listed on the **Waiver Services Registration** form. An individual can apply for more than one Waiver program, but may only receive services from one Waiver program at a time. An application can also be made for an ICFMR facility; but ICFMR and Waiver program services cannot be **received** at the same time. However, an individual can be waiting for an opening on the DD Waiver while being served by an ICFMR.
4. The Registration form may be mailed or turned in at the ISD office. The application must be stamped with the current date. **Individuals should keep a copy of the registration form for their records.**
5. ISD will send a copy of the registration form to the Developmental Disabilities Supports Division (DDSD).

If an individual moves during any part of the application process, ISD *and* the local DDSD Regional Office must be informed of the individual's new address and phone number. It is important that this information is current so that he/she can be notified when funds are available for allocation to the DD Waiver Program.

## Step 2: Initial Clinical Disability Determination Registering at DDS

1. Within two (2) weeks of submission of the **Waiver Services Registration** form (**MAD 325**), DDS will send the applicant a packet of documents. The packet will include instructions for filling out the **Central Registry Match for Services** form and the **Authorization for Release of Information**.
2. The applicant should call DDS if they have not received the packet within three (3) weeks of submitting the **MAD 325**.
3. The applicant must fill out the **Central Registry Match for Services** form completely and return it to the local DDS Regional Office.
4. The applicant must fill out the **Authorization for Release of Information** forms. This gives permission to doctors, hospitals, schools or others to send information to the DDS Regional Office to determine if they match the clinical eligibility definition.
5. The applicant sends the forms **directly** to the professionals and/or agencies that have been granted authorization to release records to DDS.
6. The applicant must have the forms signed, copied and returned to DDS.
7. The applicant should keep copies of all documents sent to DDS.
8. Upon receipt of the **Authorizations for Release of Information** forms, DDS will process the **Central Registry Match for Services** form.
9. The applicant can contact the local DDS Regional Office to check on the status of his/her application. DDS will let the applicant know if the office has received everything that is needed to make a determination. If not, DDS will let the applicant know what is still needed to complete the process. The applicant should make note of the name of person(s) contacted and keep copies of all documents sent to the Regional Office.
10. Initial disability screening may take several months to complete. The applicant

- will receive a letter stating whether the applicant meets the criteria established in the developmental disability definition and will therefore be placed on the central registry; or if not, how the applicant may request a fair hearing if he/she wishes to appeal the decision. If the applicant is placed on the central registry, the letter will also indicate his/her eligibility for state general funds or other services.
11. Once the money is available, a person on the Central Registry (“waiting list”) will receive a letter of allocation from the DDSD/Eligibility Unit stating there is an opening on the waiver for them and they are to choose a case management agency.
  12. Once the individual and/or family member chooses a case management agency, a representative of the DDSD/Eligibility Unit will send a copy of the Allocation letter, the signed Freedom of Choice and any other pertinent information to the selected agency.
  13. The case manager then has **five (5) working days** in which to contact the individual and schedule an initial meeting. During this call, it would be beneficial for the case manager to request that an appointment be made with the primary care physician so that the individual is able to have an annual physical exam, as part of the process of receiving waiver services.
  14. At the initial meeting, the case manager will take the opportunity to explain the waiver and services and providers available in the applicant’s area of the region.
  15. At this meeting it is imperative that the case manager provide the individual and/or family member with a Long Term Care Assessment Abstract (LTCAA) and a blank history and physical form to take with them to the doctor’s appointment. The case manager may score and complete the LTCAA with the family at this meeting or after the doctor’s appointment. The case manager is to

- highlight areas on the LTCAA, which the doctor is to complete and sign. [NOTE: The Long Term Care Assessment Abstract is the primary document which determines medical eligibility which enables a person to receive services from the DD Medicaid Waiver.]
16. During this first meeting, the case manager will also take the opportunity to explain the need to go to the local Income Support Division office to the individual and family. The ISD office will determine if the individual meets financial eligibility to receive services through the DD Medicaid Waiver.
  17. During this initial meeting, the case manager may take the opportunity to explain and score the Norm-Referenced Adaptive Behavior Tool with the individual and family or schedule a follow-up meeting.
  18. Whether at the initial meeting or a scheduled follow-up meeting, the case manager will explain and score the Norm-Referenced Adaptive Behavior Tool with the individual and/or family and also obtain information concerning medical concerns, skill ability in Activities of Daily Living and any pertinent social history in order to complete the Comprehensive Individual Assessment (CIA).
  19. Once the case manager receives the signed Long Term Care Assessment Abstract and completed history and physical form from the doctor, the case manager is ready to submit the entire **Level of Care Packet** to New Mexico Medicaid Utilization Review (NMMUR) for approval or denial. [It is important to note that meeting the criteria in the developmental disability definition does not guarantee the individual will meet the medical and financial eligibility to enable them to receive services from the Medicaid Waiver]. The entire Level of Care packet consists of the LTCAA, current physical exam and medical/clinical history, a norm-referenced Adaptive Behavioral Tool, the Comprehensive Individual Assessment (CIA) and a copy of the Allocation Letter.
  20. The entire process listed above is to take no longer than 90 days from the time

the case management agency receives the allocation from the DDS/Eligibility Unit.

21. Once the case manager receives notification that the individual meets financial and medical eligibility, the case manager is responsible to schedule the Individual Service Planning meeting.

## **Ongoing Eligibility Reassessment by the Case Manager**

Once an individual is allocated, found medically and financially eligible, and placed on the DD Waiver, the assessment process continues. On a yearly basis, the individual must be assessed clinically and financially to assure he/she is still eligible for waiver services. The CM coordinates this process.

The CM is responsible for completing the annual Level of Care (LOC) process with input from the individual, medical personnel, and team members. The results of the Norm-referenced Behavioral Tool of the Long Term Care abstract.

The CM then gives the abstract and history/physical form to the individual or the individual's primary care giver (be it a parent or agency), and instructs them to make an appointment for an annual physical. While waiting for the abstract and physical to be signed by the physician, the CM is responsible for completing the Client Individual Assessment (CIA).

For the two years the LOC packet is not submitted for approval to the NMMUR contractor, the CM is responsible for completing a new LOC abstract, including obtaining the physician's signature and a new history and physical. On the third year the individual is on the waiver, the CM is responsible for submitting the complete new LOC packet to the NMMUR contractor, 30 days prior to expiration. Nancy to check last sentence.

While the LOC (medical eligibility) is in the process of being completed, the county ISD office is responsible for sending a **Redetermination** form to the individual, guardian, or the assigned Representative Payee to complete and resubmit to ISD. This determination is done yearly to determine if the individual is still financially eligible for waiver services.

**Remember:** *An individual may be clinically eligible for the waiver, but not financially eligible.* If the Medical Assistance Worker (MAW) at ISD determines the individual continues to be financially eligible, he/she will submit a **MAW** letter to the CM, after receiving a copy of the **LOC Authorization** from NMMUR or the CM. Although the CM does not determine the individual's financial eligibility, he/she is responsible for ensuring all paperwork is completed in a timely manner and sent to ISD.

Once the individual is assessed as continuing to be clinically and financially eligible for waiver services, the CM is responsible for coordinating and facilitating the annual Individual Service Plan (ISP) meeting.

# Chapter II

## Getting to Know the Individual



- ◆ **The Role of Assessment**
  
- ◆ **Assessment Responsibilities**
  
- ◆ **Case Management Responsibilities**
  
- ◆ **Assessment Matrix**

## Chapter II

# Getting to Know the Individual

### The Role of Assessment

Assessments are an essential part of case management and the foundation of services for the individual. Current, valid and functional assessments help the case manager (CM) and team establish and maintain eligibility for funding (ICFMR eligibility criteria) and ensure team planning is thorough and person-centered.

The Individual Service Plan (ISP) Regulations require a comprehensive assessment process that is respectful of the culture of the individual and family. Assessment information should be gathered from a review of historical information, formal assessments, informal observations, and conversations with the individual and his/her family and friends. The team completes clinical assessments that are person-centered and relevant to the individual; with assistance from the CM they review, analyze and compile relevant findings and recommendations into a holistic picture of the individual. A thorough assessment process results in relevant services and supports, development of a quality ISP, and an appropriate budget.

Assessment must be ongoing, as team members will continue to learn new information through the provision of ongoing supports and services; in addition, the individual may experience changes in his/her life. The ISP Regulations require service providers to relay updated information through 1) ongoing status reports and 2) formal re-assessment (prior to the annual ISP meeting and/or when significant changes in an individual's life warrants revisions to planning and services).

⇒ **Chapter IV: Planning with the Individual**

⇒ **7 NMAC 26.5; DD Waiver Standards 2.3 ISP Development Process**  
<http://www.nmcpr.state.nm.us/nmac/ title07/T07C026.htm>

## **Assessment Responsibilities**

The ISP Regulations state formal assessments must be completed by qualified personnel and relevant findings and recommendations integrated into the ISP document. The following provides a summary of team responsibilities and the purpose of each assessment. Formal assessments and status reports are maintained in the primary case management record.

### **Case Manager**

All assessments must be reviewed and updated annually, signed and dated. A new CM will receive training on completion of these assessments from his/her supervisor. Technical assistance may be requested from the regional Developmental Disabilities Supports Division (DDSD) case management coordinator. Each of the following is completed by the CM with input from the individual, family and/or team members.

- ◇ Level of Care (LOC) abstract determines medical eligibility for Developmental Disabilities Waiver (DD Waiver) services; the score also establishes the level of an individual's DD Waiver funding.  
⇒ **Appendix: Level of Care forms**
- ◇ The Adaptive Behavior Scale (ABS) is a review and summary of health care and adaptive behaviors that support the LOC score. **Note: The Vineland may be substituted for individuals under the age of 16.**
- ◇ The Client Individual Assessment (CIA) is a review and summary of an individual's interests, preferences and skills that support LOC determination and score, as well as team planning.

⇒ **Appendix: Client Individual Assessment**

- ◇ The Health Assessment Tool (HAT) documents health status and medically related supports; results are used for service planning. The agency nurse will be responsible for completing the HAT unless it is a person without residential or day services in his/her plan, then it will fall back to the case manager.
- ◇ The Strengths, Needs and Preferences Summary of the ISP is the team's analysis of an individual's preferences, dreams, needs, likes and dislikes, based on information from team assessments and CM visits (with individual and/or family). It is updated at the annual ISP meeting, documented on the ISP form, and used as the basis for planning.

## **Medical Clinicians**

All assessments must be reviewed and updated annually (as relevant to the individual, signed and dated. The local Continuum of Care (COC) Medical Champion, DDSD Regional Office and/or Transdisciplinary Evaluation and Support Clinic (TEASC) can provide technical assistance to identify qualified clinicians, as needed. Family and/or providers must submit copies of medical reports to the CM.

1. The history and physical is updated annually by the primary care physician (PCP) to support the individual's medical diagnosis, treatment and LOC score. Progress notes from the medical record are only accepted if they are signed by the PCP and include a review of all body systems
2. The psychiatric evaluation is updated annually by the psychiatrist to support the diagnosis and treatment of individuals with mental health conditions.
3. The neurology evaluation is updated annually by the neurologist (or the PCP as appropriate) to support the diagnosis and treatment of individuals with seizure disorders.

4. The nutrition evaluation is updated annually by a licensed nutritionist to identify treatment for individuals with medical and/or mental health conditions that may result in nutritional concerns, as identified by the team.
5. The nursing plan is updated annually by a nurse to support medical treatment, including the Health Care Plan and Medical Crisis Plan(s).
6. Specialist evaluations are completed as necessary to support medical treatment for individuals who have existing or suspected chronic medical conditions (i.e. diabetes, cancer, pulmonary or orthopedic conditions, etc.) or complex mental health issues, not sufficiently addressed by the PCP.
7. Ancillary medical evaluations are completed to identify and/or support treatment for needs in vision (annually), dental (annually), and auditory (per direction of audiologist).

## Therapists

All assessments must be reviewed and updated annually (for individuals currently receiving services), signed and dated. In addition, progress reports to the CM are required quarterly for behavioral supports consultation and semi-annually for other therapies (unless team requests quarterly reports). The annual report must include findings and recommendations that support an individual's desired outcomes and environments.

- ◇ Occupational therapy evaluations are updated annually to identify technology and supports that enhance environmental access, job success and/or activities of daily living, as requested by the team.
- ◇ Physical therapy evaluations are updated annually to identify technology and supports that enhance physical capacity, comfort, seating and/or mobility, as requested by the team.

- ◇ Speech/Language therapy evaluations are updated annually to identify technology and supports for communication and/or mealtime plans, as requested by the team.
- ◇ Behavioral Supports Consultation evaluations are updated annually to identify supports that minimize challenges and enhance desired behaviors, as requested by the team.

If requested by the team, Eating/Swallowing evaluations are addressed through Speech/Language evaluations to identify supports for individuals who are at risk for aspiration. Assistive technology evaluations are conducted by any of the above therapists to identify technology and/or environmental adaptations that enhance physical capacity, work, mobility and/or communication.

## Residential Providers

Assessments must be reviewed and updated annually, signed and dated. Providers must also submit quarterly progress reports to the CM.

- ◇ Residential agencies must submit annual assessment summaries that specify an individual's preferences, likes, dislikes, skills, challenges, supports and services in both the community and home environment, and progress towards the desired outcomes in the ISP.

## Day Service Providers

Assessments must be reviewed and updated annually, be signed and dated. Providers must also submit quarterly progress reports to the CM.

- ◇ Day service agencies must submit annual assessment summaries that specify the individual's preferences, likes, dislikes, skills, challenges, supports and

services in both the community and service environments, and progress towards the desired outcomes in the ISP.

- ◇ Diagnostic evaluations completed every three years by certified Local Education Agency (LEA) personnel or a neuropsychologist, support the development of the Individual Education Plan (IEP) for school age children, and are also helpful for ISP planning.

## Vocational Providers

Assessments must be reviewed and updated annually, be signed and dated. Providers must also submit quarterly progress reports to the CM.

- ◇ Specialized assessments, related to the individual's skills and interests are completed by supported employment agencies (work evaluations, situational work site assessments, etc.); individual work plans are completed by the Division of Vocational Rehabilitation (DVR).
- ◇ Informal assessments of vocational interest must be updated annually by the team and results documented in the ISP.

## Case Manager Responsibilities

### Annual Level of Care (LOC) Process

1. Complete agency training related to completion of all elements of the Long Term Care Abstract packet.
2. The ABS, Vineland, and LOC abstract are completed with input from the individual, family and/or agency staff.
3. The CM completes the ABS (Vineland may be used for children under age 16).
4. The CM then scores the LOC abstract, using information from the ABS/Vineland.

5. The CM prepares his/her agency's History and Physical (H/PH) form with the individual's name and pertinent data.
6. The CM gives the LOC abstract and H/PH form to a family or agency representative to give to the PCP to document findings and recommendations from the annual physical.
7. While the CM is waiting for return of the LOC abstract and physical form from the PCP, he/she completes the CIA.
8. Upon completion of the initial Long Term Care Abstract packet, and every third year thereafter, the CM submits this packet to NMMUR, with all required supporting documentation (LOC abstract signed by PCP or certified nurse practitioner (CNP), completed ABS/Vineland, a current history and physical form signed by PCP or CNP, and a completed CIA).
9. During the middle two years, the CM's supervisor must review and approve the LOC packet. The agency then sends a copy of the approved LOC packet to the appropriate ISD office; the original is filed in the primary record. During these two years, the CM has authority to review the current ABS; he/she will sign and date the document if there are no changes in the individual's capacity. A new ABS must be scored if there have been changes.
10. An individual also needs to be financially eligible to receive DD Waiver services. Although it is the responsibility of the family or representative payee to submit the required financial documentation to the local ISD office for this determination, it is **IMPERATIVE** that the CM assures this happens.

⇒ **Chapter I: How Individuals Become Eligible DD Waiver Services**

## Challenges and Solutions

The CM may experience conflicts when completing LOC responsibilities.

- ◇ The LOC abstract is a deficit-based document, which conflicts with training received by the team, to focus on the person's strengths.
- ◇ An individual or a family member (especially with new allocations) may see the LOC abstract and ABS as a "test" and quite naturally want to score the individual much higher than his/her actual capacities.
- ◇ An individual/family member may conversely be afraid they will not be eligible for the waiver unless a much lower score is received.
- ◇ Once an individual is receiving services, the CM may continue to experience conflicts as the LOC score is directly related to the amount of funding for residential, day, vocational and/or ancillary therapy services.

When faced with such dilemmas, the CM has different options:

- ◇ The CM can actually observe the individual to verify if she/he can perform a certain skill.
- ◇ The CM can review the finding of the abstract with medical, psychological, or educational (teachers/diagnosticians) professionals.
- ◇ Finally, if the CM feels strong pressure to "modify" the LOC score he/she should request technical assistance from the DDS Regional Office.

## **Preparation and Completion of the ISP**

1. Ensure the team has considered all assessments relevant to planning.
2. Ensure all required assessments, and others identified by the team, are completed in a timely manner, are current and accurate, contain findings and recommendations relevant to planning, and are signed and dated.

3. Review team assessments in order to identify implications for team discussion and planning. ISP Regulations require that assessments be submitted to CM ten working days prior to the annual meeting.

⇒ **7 NMAC 26.5; DD Waiver Standards 2.3 ISP Development Process**  
<http://www.nmcpr.state.nm.us/nmac/title07/T07C026.htm>

4. Support the individual and his/her family or guardian to provide input into the comprehensive assessment.
5. Review findings and recommendations with the individual and his/her family or guardian prior to the planning meeting.
6. Assist the team to discuss, analyze and synthesize information from completed assessments in order to identify the individual's level of care for funding, desired outcomes, skills, challenges, and necessary supports.
7. Integrate relevant information into the ISP.
8. Ensure minimal discrepancy between ISP and assessment findings and recommendations.
9. Complete and submit the DDSD Decision Justification Form to document consensus and rationale if the team determines one or more assessment recommendations are not appropriate
10. Ensure that new assessments are completed in a timely manner, when need is identified by the team. Note: When new assessments are completed after the annual ISP meeting, the CM must reconvene the team to review any new implications for planning and recommendations and revise the ISP to incorporate the new information.
11. Maintain current assessments in the primary record.

⇒ **Chapter VII: Record Keeping on the Behalf of the Individual**

12. Ensure re-assessment is completed on an annual basis or sooner, if a significant change occurs in the individual's life.

## Challenges and Solutions

The CM may face challenges and/or conflicts when completing the ISP:

- ◇ Assessment results may not be received in a timely manner.
- ◇ Assessments may be of lacking in quality, e.g., recommendations are unclear, deficit-based, unrelated to what the individual wants, etc.
- ◇ The team may not agree with recommendations from one or more assessments.
- ◇ When the team recommends new assessments they may not be scheduled or completed in a timely manner.

When faced with such dilemmas, the CM has different options:

- ◇ The CM should document in his/her case notes: failure to complete and/or submit assessments in a timely manner, receipt of inadequate assessments and/or team disagreement with recommendations.
- ◇ The CM should then submit a written request for the assessment and/or revision to the assessment; the request should be sent to the provider, with a copy to the agency director and include a reference to the ISP Regulations.
- ◇ The CM may contact the DDSD Regional Office for assistance.
- ◇ If the team does not agree with one or more assessment recommendations the CM should complete and submit the DDSD Decision Justification Form with attached ISP document; input from the team should be included.
- ◇ If problems persist, the CM may request technical assistance, mediation and /or conflict resolution services from DDSD.

⇒ [Chapter VI: Resolution of Concerns Flowchart \(page 144\)](#)

## Ongoing Assessment

Assessment of the individual's strengths, interests and continued needs is ongoing throughout the year. The CM will collect update information through medical reviews, site

visits and review of quarterly and semi-annual reports submitted by providers. If major changes are noted (i.e. mastery of specific action plans, need for additional supports, major change in the individual's life situation, etc.), the CM must convene the team and revise the ISP.

Particular care must be taken to identify the need for the team to conduct a risk assessment to determine underlying causes whenever there is a pattern, or series of negative events. Such patterns may be evidenced by multiple incidents reports, but may also be shown through data collected by providers, individual and/or family complaints, quarterly reports, etc. The purpose of the risk assessment is to analyze the factors contributing to a pattern of negative events in order to determine root causes, so that effective problem solving can then be undertaken.

⇒ **Chapter III: Making the Most of Meetings, Problem Solving Process**

*Bob has been falling much more than usual lately. This last time, he scraped his arms and legs in the parking lot quite badly and subsequently developed cellulites. The team decided they better find out why Bob has become so unsteady. They first asked the nurse if any of his medication had been changed, but that was not the case. However, given that Bob is now nearing 65 years old, they decided to check with the pharmacist to see if any of his medication could be explaining the problem. Someone else thought maybe they should also get his vision checked again. It turned out that Bob has developed cataracts requiring surgery. The CM noted on the Health & Safety page of the ISP that the house lead will work with the eye surgeon's office to arrange the surgery.*

Additional CM responsibilities are specified in **Chapter VIII** of this manual.

## Assessment Matrix

	Area to Assess	Procedures to Prepare for Planning	Annual Waiver Requirements
<b>Health</b>	<ul style="list-style-type: none"> <li>◆ History</li> <li>◆ Chronic/current conditions, treatments &amp; follow-up</li> <li>◆ Health practitioners</li> <li>◆ Symptoms</li> <li>◆ Medications</li> <li>◆ Nutrition (inc. weight issues)</li> <li>◆ Effect on daily functioning</li> <li>◆ Medication errors</li> <li>◆ Admissions (ER or hospital)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Review history</li> <li>◆ Individual &amp; family Interviews</li> <li>◆ Review History &amp; Physical form</li> <li>◆ Observation</li> <li>◆ Record Review</li> <li>◆ Identify implications for planning</li> </ul>	<ul style="list-style-type: none"> <li>◆ Health Assessment Tool (HAT)</li> <li>◆ Adaptive Behavior Scale (ABS)</li> <li>◆ Vineland may be optional for children under age 16</li> <li>◆ Aspiration Review* (quarterly)</li> <li>◆ Therapy Evaluations*</li> <li>◆ Maintain in primary record</li> <li>◆ History &amp; Physical</li> </ul> <p>* As appropriate to the individual</p>
<b>Ancillary Medical</b>	<ul style="list-style-type: none"> <li>◆ Dental conditions</li> <li>◆ Visual acuity</li> <li>◆ Auditory acuity</li> <li>◆ Lab results (if applicable)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Review history</li> <li>◆ Review chronic and current conditions &amp; treatments</li> <li>◆ Identify planning implications</li> </ul>	<ul style="list-style-type: none"> <li>◆ Dental exam</li> <li>◆ Visual exam</li> <li>◆ Auditory exam per audiologist</li> <li>◆ Lab results</li> <li>◆ Maintain in primary record</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>◆ Psychiatric issues</li> <li>◆ Behavior supports</li> <li>◆ Cognitive functioning</li> <li>◆ Affective functioning</li> <li>◆ Dual-diagnosis issues</li> </ul>	<ul style="list-style-type: none"> <li>◆ Review history &amp; Evaluations</li> <li>◆ Observation</li> <li>◆ Record Review</li> <li>◆ Interviews</li> <li>◆ Identify planning implications</li> </ul>	<ul style="list-style-type: none"> <li>◆ Psychiatry evaluation (as appropriate)</li> <li>◆ Positive Supports Assessment</li> <li>◆ Movement screening (as appropriate)</li> <li>◆ Others as requested by team</li> <li>◆ Maintain in primary record</li> </ul>

	Area to Assess	Procedures to Prepare for Planning	Annual Waiver Requirements
<b>Social &amp; Personal</b>	<ul style="list-style-type: none"> <li>◆ Family connections</li> <li>◆ Friendships</li> <li>◆ Community connections</li> <li>◆ Stress level &amp; coping mechanisms</li> <li>◆ Interests, preferences, values, dreams, desires</li> </ul>	<ul style="list-style-type: none"> <li>◆ Interviews with individual, family &amp; friends</li> <li>◆ Annual provider agency assessment summaries</li> <li>◆ Review history</li> <li>◆ Observations</li> <li>◆ Identify planning implications</li> </ul>	<ul style="list-style-type: none"> <li>◆ Annual Strengths, Needs &amp; Preferences Summary</li> <li>◆ ABS</li> <li>◆ Vineland is optional for children under age 16</li> <li>◆ Client Individual Assessment (CIA)</li> <li>◆ Maintain in primary CM record</li> <li>◆ Positive Supports Assessment</li> <li>*As appropriate to the individual</li> </ul>
<b>Adaptive</b>	<ul style="list-style-type: none"> <li>◆ Money management</li> <li>◆ Daily living skills</li> <li>◆ Independent living skills</li> <li>◆ Personal care</li> <li>◆ Formal/informal supports</li> <li>◆ Community</li> </ul>	<ul style="list-style-type: none"> <li>◆ Standardized testing</li> <li>◆ Informal assessment</li> <li>◆ Observation</li> <li>◆ Interview with individual, family, friends and/or staff</li> </ul>	<ul style="list-style-type: none"> <li>◆ ABS/Vineland</li> <li>◆ CIA</li> <li>◆ Annual Strengths, Needs &amp; Preferences Summary</li> <li>◆ Maintain in primary CM record</li> </ul>
<b>Vocational</b>	<ul style="list-style-type: none"> <li>◆ Skills/interests</li> <li>◆ Job development &amp; coaching support needs</li> <li>◆ Transportation</li> </ul>	<ul style="list-style-type: none"> <li>◆ Interview with the individual</li> <li>◆ Observation</li> <li>◆ Informal assessment of relevant outcomes, needed supports &amp; accommodations</li> <li>◆ Standardized assessments</li> </ul>	<ul style="list-style-type: none"> <li>◆ DVR Individual Work Plan</li> <li>◆ Formal vocational assessments</li> <li>◆ Informal assessment of interest</li> <li>◆ Annual Strengths, Needs &amp; Preferences Summary</li> <li>◆ Maintain in primary CM record</li> </ul>
<b>Educational</b>	<ul style="list-style-type: none"> <li>◆ Cognitive</li> <li>◆ Academic</li> <li>◆ Social/Emotional</li> <li>◆ Daily Living/Personal Care</li> <li>◆ Community Awareness</li> </ul>	<ul style="list-style-type: none"> <li>◆ Standardized testing</li> <li>◆ Informal testing</li> <li>◆ Observation</li> </ul>	<ul style="list-style-type: none"> <li>◆ Diagnostic evaluation reports</li> <li>◆ Individual Educational Plan (IEP) developed by the Public Schools</li> <li>◆ Transition Plan (as appropriate)</li> <li>◆ Maintain in primary CM record</li> </ul>

Area to Assess		Procedures to Prepare for Planning	Annual Waiver Requirements
<b>Financial</b>	<ul style="list-style-type: none"> <li>◆ Amount of Income</li> <li>◆ Sources of Income</li> <li>◆ Trust Funds/Inheritances</li> <li>◆ Assets</li> </ul>	<ul style="list-style-type: none"> <li>◆ Asset reporting submitted to ISD</li> <li>◆ Bank statements submitted to ISD</li> <li>◆ Verification of income to ISD</li> </ul>	<ul style="list-style-type: none"> <li>◆ ISD 381 Determination form</li> <li>◆ MAW (MAD060)</li> <li>◆ CIA</li> <li>◆ Guardianship, Conservatorship &amp; Representative Payee documents</li> <li>◆ Maintain in primary CM record</li> </ul>
<b>Environment</b>	<ul style="list-style-type: none"> <li>◆ Architectural barriers</li> <li>◆ Physical &amp; health hazards</li> <li>◆ Functional structure, design &amp; need for modifications</li> <li>◆ Transportation</li> <li>◆ Neighborhood safety</li> </ul>	<ul style="list-style-type: none"> <li>◆ Observation of individual in home, work &amp; other community environments</li> <li>◆ Interview with individual</li> </ul>	<p>This area is assessed when need is indicated</p> <ul style="list-style-type: none"> <li>◆ Physical Therapy evaluation</li> <li>◆ Occupational Therapy evaluation</li> <li>◆ Assistive Technology evaluation</li> <li>◆ Environmental Modification evaluation</li> <li>◆ CIA</li> <li>◆ Maintain in primary CM record</li> </ul>
<b>Risk Factors</b>	<ul style="list-style-type: none"> <li>◆ Medical</li> <li>◆ Mealtimes</li> <li>◆ Environmental</li> <li>◆ Life-style</li> </ul>	<ul style="list-style-type: none"> <li>◆ Observation</li> <li>◆ Interviews</li> <li>◆ Therapy/provider reports</li> <li>◆ Incident reports</li> <li>◆ Trend data for negative events</li> </ul>	<ul style="list-style-type: none"> <li>◆ MAD 378/ ICFMR LTC Abstract</li> <li>◆ Medical reports and documentation</li> <li>◆ Swallow Study/SAFE evaluation</li> <li>◆ Incident reports</li> <li>◆ Quarterly Aspiration reports</li> <li>◆ Quarterly reports</li> <li>◆ Site visit findings</li> </ul>
<b>Eligibility</b>	<ul style="list-style-type: none"> <li>◆ Medical</li> <li>◆ Financial</li> </ul>	<ul style="list-style-type: none"> <li>◆ Initial eligibility</li> <li>◆ Re-assessment</li> <li>◆ Re-admit LOC abstract (upon discharge from medical facility)</li> </ul>	<ul style="list-style-type: none"> <li>◆ MAD 378/ICFMR LTC Abstract</li> <li>◆ CIA</li> <li>◆ ABS</li> <li>◆ Vineland optional for children under age 16</li> </ul>

Area to Assess		Procedures to Prepare for Planning	Annual Waiver Requirements
<b>Eligibility</b>		<ul style="list-style-type: none"> <li>◆ Annual completion of the Waiver Re-determination (ISD 381)</li> </ul>	<ul style="list-style-type: none"> <li>◆ MAW Letter (MAD060)</li> </ul>
<b>Therapy Needs</b>	<ul style="list-style-type: none"> <li>◆ Sensorimotor</li> <li>◆ Comprehension</li> <li>◆ Communication</li> <li>◆ Mobility</li> <li>◆ Seating/positioning</li> <li>◆ Assistive Technology</li> <li>◆ Environmental Access</li> </ul>	<ul style="list-style-type: none"> <li>◆ Review therapy assessments</li> <li>◆ Discuss potential issues with team and assure informed decisions and appropriate prevention strategies are developed</li> </ul>	<ul style="list-style-type: none"> <li>◆ MAD378 ICFMR LTC Abstract</li> <li>◆ CIA</li> <li>◆ HAT</li> <li>◆ ABS</li> <li>◆ VINELAND optional for children under age 16</li> <li>◆ Therapy evaluations</li> <li>◆ Medical evaluations/reports</li> <li>◆ Quarterly/Semi-annual reports</li> <li>◆ Complete environmental adaptation assessment and cost proposal</li> </ul>

# Chapter III

## Making the Most of Meetings



- ◆ Meetings that Enhance the Individual's Life
- ◆ Preparing for an Effective Meeting
- ◆ Meaningful Participation & Self-Advocacy
- ◆ Starting off on the Right Track
- ◆ Giving & Receiving Feedback
- ◆ Facilitating Focused Discussions
- ◆ The Problem Solving Process
- ◆ Dealing with Disagreement
- ◆ Reaching Consensus
- ◆ Co-Facilitating Meetings
- ◆ Understanding & Working with Guardians
- ◆ Resources on Guardianship

# Chapter III

## Making the Most of Meetings

### Meetings that Enhance the Individual's Life

A primary case management function is the facilitation of formal (team meetings) and informal (discussions with guardians or resolving issues with providers) meetings. To ensure effective and outcome oriented meetings for the individual and the team, the case manager (CM) must be a skilled facilitator. **Remember:** *Effective, outcome-based meetings are critical to ensuring health, safety, and quality of life.* The following information will help the CM:

- ◇ utilize effective advocacy skills;
- ◇ promote self-advocacy;
- ◇ ensure relevant issues are addressed in a positive manner;
- ◇ promote creative thinking and problem solving that produce desired outcomes;
- ◇ clarify the role of legal guardians and others who assist with decisions;
- ◇ utilize conflict resolution techniques to resolve disagreements; and
- ◇ assist the team to achieve consensus on decisions.

#### Training Resources

Information on facilitation is provided in the Developmental Disabilities Supports Division (DDSD) Level 1 course: **Promoting Effective Teamwork.**

**Remember:** *The process should be as person-centered as the intended outcomes.*

The following checklists can be duplicated for use when preparation and facilitation of meetings become difficult.

## Preparing for an Effective Meeting

A well-run meeting requires thoughtful and thorough preparation on the part of the facilitator, the individual and other team members.

<b>Tips for Preparing for an Effective Meeting</b>	
□	Determine the purpose and desired outcome(s) of the meeting.
□	Develop an agenda in collaboration with other stakeholders. Word topics clearly and sequence issues in a logical flow. Include appropriate timeframes for each agenda item, including some “flex” time.
□	Select location and meeting time appropriate to the individual and guardian. If considering a meeting at the person’s home: <ul style="list-style-type: none"> <li>□ Ensure others living in the home will feel comfortable. If not, find another location.</li> <li>□ Determine how to respect privacy and confidentiality if other individuals and their staff will be present.</li> <li>□ Ask for permission to use wall/flip charts and re-arrange furniture.</li> </ul>
□	Review files to identify information you need before and at the meeting.
□	Send written notification and agenda in advance of the meeting. ⇒ <b><i>Pre-Service Manual Sample</i></b>
□	Ensure participants are ready for the meeting, especially the individual.
□	Prepare visual aids and a tentative list of ground rules.

## Meaningful Participation & Self-Advocacy

Individuals may require assistance to prepare for and participate in meetings, in order to demonstrate self-determination. As the primary advocate for the person, it is the responsibility of the CM to speak up and take action to ensure the individual's rights are honored and that his/her desires, needs, and point of view are heard, seriously considered, and supported by the team.

<b>Tips to Support Individuals' Participation &amp; Self-Advocacy</b>	
<input type="checkbox"/>	During regular visits, talk with the individual to determine interests, preferences, dreams, issues, fears, concerns, etc.
<input type="checkbox"/>	Provide supports that assist the person to learn his/her rights.
<input type="checkbox"/>	Encourage the individual to join a self-advocacy group.
<input type="checkbox"/>	Talk to the individual about the purpose and desired outcome(s) of the meeting and obtain his or her input on the agenda items (staff may assist as needed).
<input type="checkbox"/>	Make sure the scheduled time and location of the meeting are convenient for the individual and that any needed accommodations are in place.
<input type="checkbox"/>	For ISP meetings, assist the individual to draft his dreams, aspirations and long-term outcomes for all life areas, prior to the meeting.
<input type="checkbox"/>	Assist the individual and staff to creatively express desires and concerns, at the meeting; staff should help prepare charts, collages, photos, etc.
<input type="checkbox"/>	Make sure the individual has sufficient time to express opinions.
<input type="checkbox"/>	Require team members to direct all comments and questions to the individual; staff may assist with answers when necessary.
<input type="checkbox"/>	Encourage the individual to assist in the facilitation of the meeting.
<input type="checkbox"/>	Include communication and choice-making strategies and supports in the Individual Service Plan (ISP).
<input type="checkbox"/>	At the meeting, <b>ADVOCATE</b> for what the person has shared with you.

<b>Starting off on the Right Track</b>	
<input type="checkbox"/>	Arrive early to set up the room and eliminate environmental distractions.
<input type="checkbox"/>	Start on time; welcome others and lead introductions that set a person-centered tone for the meeting (personal connections with the individual, his/her accomplishments, gifts, successes, etc.).
<input type="checkbox"/>	The individual should be seated in a manner to promote direct communication with team members.
<input type="checkbox"/>	Explain the purpose, desired outcomes, agenda items and how the meeting will be facilitated; obtain commitment from the team to adhere to the agenda.
<input type="checkbox"/>	Explain why all members must participate in the full meeting; ask for commitment.
<input type="checkbox"/>	Assist team members to develop, agree upon, and adhere to ground rules.
<input type="checkbox"/>	Assign roles (timekeeper, scribe, etc.) to ensure all relevant information is available for planning and the team's time is spent effectively.

The CM is responsible for capturing detailed and thorough notes that reflect the issues the team has addressed, deliberated and resolved. The information must be integrated into the ISP as appropriate, along with any CM notes that accompany the ISP. All meetings to discuss expert/clinical recommendations require documentation of team decisions on the DDSD Decision Justification Form.

⇒ **Appendix: *DDSD Decision Justification Form***

<b>Tips for Accurate Note-Taking</b>	
<input type="checkbox"/>	Use flip charts or other visual aids.
<input type="checkbox"/>	Post main ideas where all team members can see them. This helps the team maintain focus, be aware of issues, and reach consensus.
<input type="checkbox"/>	Use exact quotes whenever possible and clarify what team members offer prior to writing them.
<input type="checkbox"/>	Print legibly and large enough for all team members to see. Leave adequate space between written thoughts, opinions, issues, etc.

## Giving & Receiving Feedback

Facilitators must be able to provide and receive constructive feedback to keep the team focused, ensure a respectful team process, resolve conflicts, and achieve consensus.

<b>Tips for Providing Constructive Feedback</b>	
<input type="checkbox"/>	Share your feedback as soon as possible.
<input type="checkbox"/>	Describe what you have seen and heard; keep comments concise.
<input type="checkbox"/>	Share positive outcome(s) associated with the person's actions.
<input type="checkbox"/>	If corrective feedback is needed, focus on the situation or behavior; state what should be occurring, what is occurring, and ask what must be done to correct the situation (provide input as needed). Do not blame; provide feedback in private when appropriate.
<input type="checkbox"/>	Let others know about the excellent performance of any team member.

<b>Tips for Receiving Constructive Feedback</b>	
<input type="checkbox"/>	Keep an open mind; strive to understand others' perspectives.
<input type="checkbox"/>	Take notes to help you process what you are hearing.
<input type="checkbox"/>	Withhold your opinions until you clearly understand the feedback.
<input type="checkbox"/>	Summarize differences and commonalities.
<input type="checkbox"/>	Gain consensus on a mutually desired outcome.
<input type="checkbox"/>	Collaborate with the person in order to determine next steps.

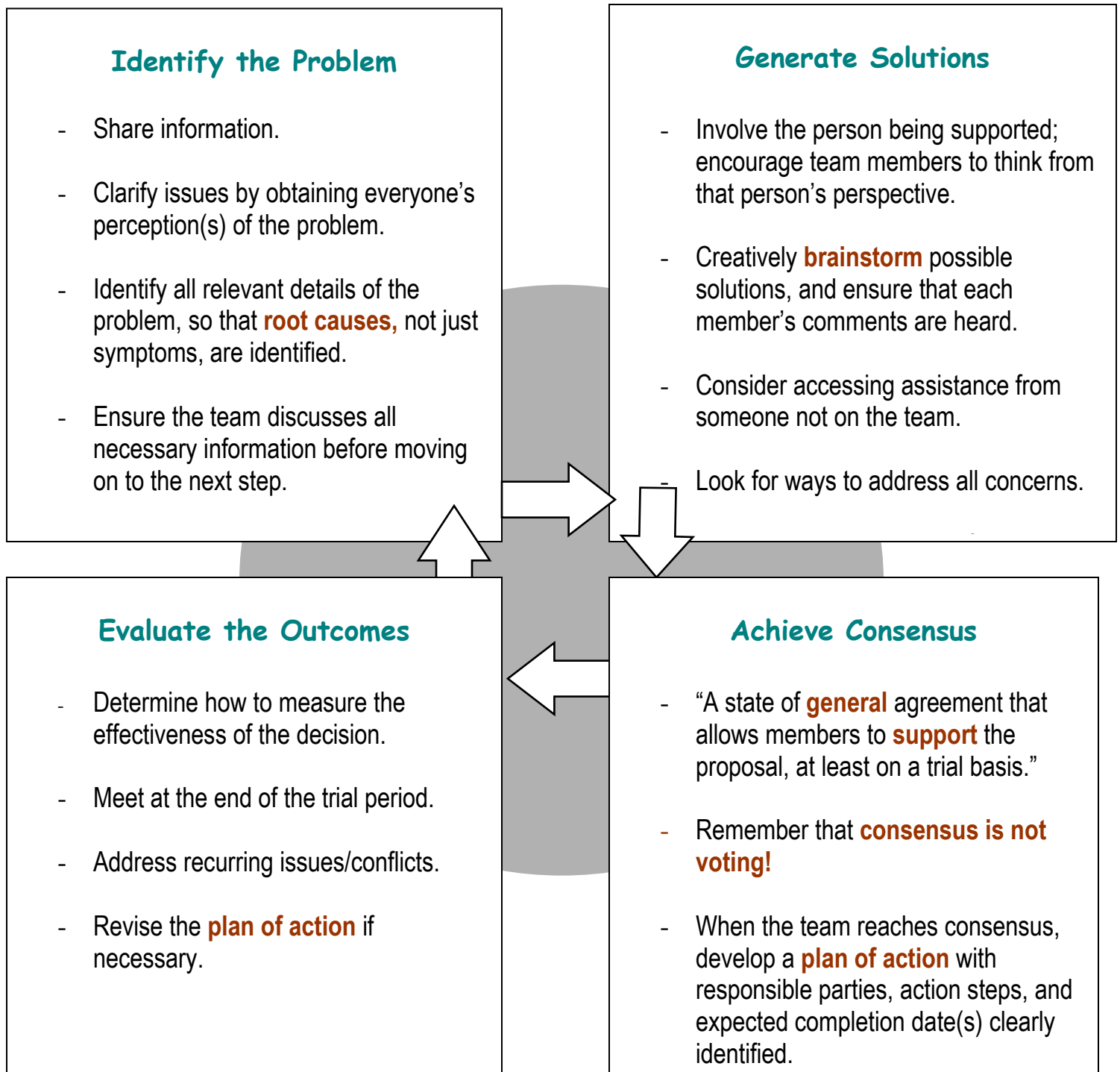
## Facilitating Focused Discussions

Meetings that produce effective outcomes for the individual require focused discussions. These tips respect participants' needs and emotions, and keep the discussion on track.

<b>Tips for Facilitating Focused Discussions</b>	
<input type="checkbox"/>	State context of discussion, ask team to focus on facts, monitor vibes, and intervene as necessary.
<input type="checkbox"/>	Provide sincere encouragement and constructive feedback.
<input type="checkbox"/>	If team members help as scribe/timekeeper, check in to ensure comments are recorded and team is adhering to the established agenda.
<input type="checkbox"/>	Assist team to address conflict openly and appropriately; use constructive feedback.
<input type="checkbox"/>	Actively work on resolving challenges, using techniques for brainstorming and consensus that promote effective participation of all team members. When decisions are made, ensure the scribe has made accurate notes and provide a brief but inclusive summary of the agreement.
<input type="checkbox"/>	Actively model effective communication, problem solving and respect.
<input type="checkbox"/>	Ensure roles and responsibilities are clearly established and summarized prior to the end of the meeting.

## The Problem Solving Process

Teams must be skilled in problem solving in order to effectively plan and provide services to individuals with complex issues and/or desires. This diagram displays the sequence and substance of the problem solving process.



## Dealing with Disagreement

It is common for disagreements to arise during problem solving. **Remember:** *Disagreement can be beneficial; it is not a threat to group process or a personal attack. Appropriately facilitated, it may help the team plan and prevent “false consensus”.* If issues are communicated and negotiated effectively, conflict is less likely to occur, outcomes will be created, and relationships maintained.

<b>Tips for Dealing with Disagreement</b>	
□	<p>Use active listening</p> <ul style="list-style-type: none"> <li>□ Use 'I' statements rather than 'you' statements.</li> <li>□ Ask open-ended questions.</li> <li>□ Identify critical content in each participant's dialogue.</li> <li>□ Respect the person even if you do not agree with his/her idea.</li> <li>□ Summarize statements both verbally and in writing.</li> </ul>
□	<p>Don't react to inappropriate behavior; try to view the situation objectively and respond rationally. Be aware of your own values and emotions.</p>
□	<p>Ensure that concerns are:</p> <ul style="list-style-type: none"> <li>□ Identified,</li> <li>□ Expressed,</li> <li>□ Addressed, and</li> <li>□ Negotiated before conflict occurs.</li> </ul>
□	<p>Refer team to agenda and re-direct comments to a more appropriate time.</p>
□	<p>If a topic is not on the agenda, ask if the issue should be added, placed on a 'parking lot' until later in the meeting, or scheduled for a separate meeting.</p>
□	<p>Enforce ground rules when necessary to ensure a civil discussion.</p>
□	<p>If disagreement results in confusion or frustration and stifles group process, take a break to help participants keep an open mind. Use the time to speak to participant(s) who need clarification or constructive feedback</p>
□	<p>If disagreement is moving toward conflict:</p> <ul style="list-style-type: none"> <li>□ Attempt to contain and de-escalate the conflict.</li> <li>□ Negotiate varied views to handle conflict in a safe and neutral forum.</li> <li>□ Determine needs for technical assistance and set a time to discuss the issue with additional support</li> </ul>

## Reaching Consensus

The team is required to plan and resolve conflicts in a manner that promotes health, safety and quality of life, through consensus. The individual does not require team agreement/approval regarding his/her dreams, aspirations and desired long-term outcomes, only the team's willingness and commitment to help him or her to get there.

<b>Tips for Reaching Consensus</b>	
<input type="checkbox"/>	Remind the team of the individual's desired outcomes.
<input type="checkbox"/>	Ask people to state their views (including their underlying concerns/fears); protect their perceptions and re-frame in context with the individual's outcomes.
<input type="checkbox"/>	Ask questions to clarify or address non-verbal signs of concern.
<input type="checkbox"/>	All concerns should be listed on a visual aid.
<input type="checkbox"/>	Do not permit blame or ego to sabotage the process.
<input type="checkbox"/>	Allow all members time to process.
<input type="checkbox"/>	Facilitate solution-focused brainstorming sessions. <ul style="list-style-type: none"> <li><input type="checkbox"/> Brainstorming session should be time limited; 15 minutes at most.</li> <li><input type="checkbox"/> Don't evaluate ideas until time is up, just keep listing more ideas.</li> <li><input type="checkbox"/> To assure everyone's ideas are heard and accepted for consideration, consider having members write their ideas down individually (one idea per index card) and then share with the group. If the team has "turf" issues, collect all ideas, read them out loud and list them on a flip chart so ideas are not ruled out on the basis of personalities or agency affiliation.</li> <li><input type="checkbox"/> Evaluate <b>after</b> brainstorming time is up.</li> </ul>
<input type="checkbox"/>	When all concerns have been addressed, ask the group to identify the most appropriate course(s) of action, and create an action plan that all members are willing to try.
<input type="checkbox"/>	If the group cannot reach consensus, continue with solution-focused brainstorming until either the team achieves consensus or time is up.
<input type="checkbox"/>	Consider the need for technical assistance if team cannot reach consensus.

### ⇒ Chapter IV: *Planning with the Individual*

## Co-Facilitating Meetings

There are times when the CM will co-facilitate a meeting with the individual or other team members. Successful co-facilitation requires thought and preparation but benefits facilitators and participants in the following manner:

- ◆ Increases ownership of the team process.
- ◆ Provides benefit of different perspectives.
- ◆ Helps monitor group process, problem-solving and conflict resolution.
- ◆ Supports shift from role of a facilitator into the role of an advocate
- ◆ Enhances meeting effectiveness through additional checks on perceptions, interpretations and agreements; models collaboration.

<b>Tips for Effective Co-Facilitation</b>	
<input type="checkbox"/>	Clearly determine roles and responsibilities in advance and prepare.
<input type="checkbox"/>	Discuss how to mesh facilitation styles and identify how each of you would like to be supported before, during, and after the meeting.
<input type="checkbox"/>	Be consistent in instructions to the team.
<input type="checkbox"/>	Adhere to agreed upon timelines.
<input type="checkbox"/>	Advise the group when you are changing roles.
<input type="checkbox"/>	Be involved and positive when not actively facilitating: <b>stay in the room</b> , monitor process and assist with conflict/content. Agree on a “help” signal.
<input type="checkbox"/>	Share preparation and clean up; both facilitators should have a complete agenda, notes and set of facilitation materials.
<input type="checkbox"/>	Have a back-up plan in case one facilitator is late or cancels at the last minute.
<input type="checkbox"/>	Use each other’s strengths.
<input type="checkbox"/>	Do not interrupt or disagree in a negative manner. <ul style="list-style-type: none"> <li>▣ If a difference of opinion arises, take a break to debrief.</li> <li>▣ If the other person hasn’t fully addressed something or you want to contribute, wait until they finish and ask if you may contribute.</li> <li>▣ Work out a system to cue or prompt each other to maintain the current facilitator’s role and limit disruption.</li> </ul>
<input type="checkbox"/>	Debrief and provide each other constructive feedback.

## Understanding & Working with the Guardian

Individuals naturally become legal adults at the age of eighteen; the Courts, however, can legally appoint others to assist the individual with decision-making. The Probate Code governs most appointed guardians; the Mental Health and Developmental Disabilities Code governs treatment guardians. The CM, in conjunction with the team must ensure that the level of guardianship is appropriate, when needed. The DDSD Individual Assistance and Advocacy (IAA) Unit (505-841-5528/800-283-5548) and Continuum of Care [www.unmcoc.org](http://www.unmcoc.org) are sources of additional information. **Note:** *A copy of the Court Order appointing guardianship must be kept in the primary file at the Case Management agency.*

### Types of Guardianship

Be aware of the levels of guardianship, the timelines for appointment and the parameters of authority for each to ensure decisions are made appropriately. **Note:** *Incapacity must be proven for any type of guardianship to be appointed to someone.*

**Guardian Ad Litem:** Court appointed attorney who protects and ensures the rights of individuals (including minors) in Court proceedings. A “guardian ad litem” is always appointed to represent the individual in a guardianship proceeding.

**Treatment Guardian:** Person temporarily appointed by the Court to assist with decisions for specific **mental health treatment** (i.e. medication) of an individual in a mental health facility; responsibilities are **limited** to these decisions. Treatment guardians should not be confused with other types of guardians.

**Temporary Guardian:** Person temporarily appointed (60 days) by the Court when physical health is in jeopardy. A process is available for quick appointment so emergency health and safety decisions can be made in a timely manner.

**Testamentary Guardian:** Person appointed by, and named in the will of, a parent and/or other legal guardian; the appointment becomes effective after the guardian's death. **Note:** *The CM should work with aging guardians to ensure a testamentary guardian has been named or other measures to transfer guardianship are in place. The testamentary guardian should be encouraged to begin their involvement in the individual's life, before his/her guardianship is in place.*

**Limited Guardian:** Person appointed by the Court if the individual is able to make some, but not all, personal decisions and can manage some, but not all, aspects of personal care. A Court Order for limited guardianship will specify responsibilities and powers of this guardian. The individual will retain all other decision-making authority.

**Plenary or Full Guardian:** Person appointed by the Court as responsible for all major decisions on behalf of the individual. An Order for Plenary Guardianship notes only decisions the guardian is **excluded** from making (i.e. decisions regarding sterilization and marriage). All other authority and responsibilities are vested in the guardian. Effective guardians work with the individual and team to ensure desires are identified and considered; if the guardian and individual disagree, conflicts must be resolved in a manner that supports the individual to the maximum degree possible. If not, then the team must intervene. Refer to "Tips for Ensuring Guardianship is Adequate" and "Tips for Promoting Consensus between Legal Guardians and Individuals" found later in this chapter.

## Supports for Decision Making & Communication

The CM is responsible for ensuring other types of supports are accessed should the individual need help with making decisions. Copies of documentation regarding the use of the supports listed below must be maintained in the primary case management file.

**Surrogate Health Care Decision-Maker:** An individual with decisional capacity can appoint a surrogate health care decision-maker. If the appointment is made orally, the individual must personally inform the health care provider with primary responsibility for health care, of the appointment. The surrogate informs health care providers of treatment to provide or withhold, in accordance with the individual's wishes should the individual become unable to make his/her own decisions. If the individual does not have a guardian or appointed decision maker, the hospital's policy for designating a surrogate should be followed.

**Conservatorship:** Person appointed by the Court to manage the property and/or financial affairs of an individual deemed incapable of doing so (adult or minor child).

**Durable Power of Attorney:** Legal instrument empowering a designated person to act on another's behalf; the "durable" power does not lapse if the individual who executed it becomes incapable of making informed decisions. This support was originally intended to permit financial or property transactions; however, durable powers of attorney are also used to delegate authority for medical decisions.

**Representative Payee:** Person appointed as a representative payee to receive and manage financial benefits of the individual. The Social Security Administration, Veteran's Administration and other government agencies have specific procedures to appoint a

representative payee; the appointment only applies to the specific program(s) for which it is granted.

**Trust:** Legal relationship created by a person (settlor), in which another (trustee) manages assets for the benefit of a third party (beneficiary). A trust can help to ensure a higher quality of life for an individual, including funds to support additional education, assistance, recreation, vacations, gifts or personal amenities.

**Advanced Medical Directives:** The CM should encourage individuals with complex medical issues and/or who are aging to consider an advanced medical directive that will identify and communicate personal desires for extreme medical measures. When supporting a person considering advanced medical directives, please remember:

- 1) Everyone has the right to be informed about advanced medical directives.
- 2) People must have decisional capacity to make advanced medical directives.
- 3) Advanced directives can be made either in writing or orally.
- 4) No one can make advanced medical directives for another person.
- 5) The individual can change advanced medical directives at any time.
- 6) It is preferred that the individual, his or her family, and his or her physician be in agreement on decisions. The parties involved can be referred to an ethics committee or mediation services in the event of conflict; however, this is not required.
- 7) It is recommended that the CM initiate the discussion of advanced medical directives with the individual at the time of his/her annual assessment. This discussion should be held privately due to its sensitive nature. The team needs to be aware of whether or not advanced medical directives are in place and the directives need to be described in the ISP. The basic health and safety related supports section may be used to document these decisions, which must also be referenced on the individual specific training section.

⇒ **Guidelines regarding Advanced Directives**  
<http://www.unmoc.org/training/advance.htm>

One type of advanced directive indicates the individual's desire regarding resuscitation. If a Do Not Resuscitate Order (DNR) is desired, this must be identified and documented in the ISP and primary case file at the Case Management agency. When supporting a person during emergency situations, remember the following:

- ◆ Do Not Resuscitate (DNR) orders only apply to cardiac or respiratory arrest
- ◆ If an individual has a DNR order the EMS/DNR form must be completed, as it is the only form legally recognized by Emergency Medical Services (EMS).
- ◆ If an individual has a DNR, staff should call 911 and give the form to EMS.
- ◆ Emergency medical staff **cannot** assume that DNR orders are in place, based on a person's disability or health status; if a DNR order is not in place, medical staff must implement all possible life saving measures.
- ◆ If the individual does not have a guardian or appointed decision maker, the hospital's policy for designating a surrogate should be followed.

### **Ensuring the Adequacy of Guardianship**

If the team believes an individual's guardian is ineffective, it is the responsibility of the CM and team to ensure issues are resolved or a change of guardianship is initiated in a timely, yet sensitive manner.

<b>Tips for Ensuring Guardianship is Adequate</b>	
□	Try to resolve issue(s) with the guardian.
□	Facilitate a meeting to discuss and document why the team perceives the guardian is not acting in the best interests of the individual. Depending on the situation, this may need to involve a separate meeting with just the CM and guardian after collecting concerns from the team.
□	Attempt to locate a family member, advocate, or other interested party who may be interested in assuming guardianship or helping the guardian to be more effective.
□	If the current guardian does not agree to the change in guardianship, the Office of General Counsel/Department of Health (DOH) should be consulted.
□	Once a change of guardianship is agreed to, the team must seek the services of an attorney to ensure legal channels are followed.

*Ken is a 63-year-old man receiving services through the DD Waiver. Approximately 10 years ago, his mother, who also served as his guardian, passed away and no one petitioned to continue the guardianship.*

*Over the years, Ken has become more stubborn and has engaged in behaviors or incidents that are harmful to him. His finances are a major trigger to him. He refuses to pay rent or allow anyone to handle his money. Ken says they are trying to steal his money. However, he will go to the bank and withdraw all of his money to spend. The team is not sure where the money goes and this leaves Ken with no money to pay his bills. He is on psychotropic medications due to a diagnosis of depression but gets very angry if staff does not take him to the casino where he can gamble and drink alcohol. Although team members, including his psychiatrist, have tried to explain to him the dangers of combining alcohol and medications, Ken refuses to stop and reminds everyone that he is his own guardian.*

*The team invited a state advocate to meet Ken and attend his meetings, if Ken approved. Ken turned out to be very receptive to this situation. The team continued to feel uncomfortable that Ken is still not making informed decisions in many areas of his life. The team recommended a referral to the Guardianship Unit of the Developmental Disabilities Planning Council to begin the process of guardianship.*

*The CM completed the referral packet to DDPC and then ensured that a neuro-psychological evaluation was scheduled and completed. Ken's residential staff obtained the needed medical information from Ken's primary care physician pertaining to the need for guardianship. Prior to the court proceedings, Ken had the opportunity to meet with the court appointed guardian ad-litem and the lawyer. Ken was very resistant to having a guardian. His behavioral support consultant worked closely with Ken and his team during this potentially volatile time. Ken worked closely in preparing what he wanted to tell the judge when the proceedings began.*

*Ken's CM and invited team members accompanied him to court. He did have the opportunity to speak to the judge, which made him feel both respected and empowered. The result of the petition was that Ken would have limited guardianship to oversee his financial and medical decisions.*

## Consensus between Individuals & Legal Guardians

The CM must ensure the relationship between the individual and legal guardian is protected should conflict arise; facilitation of consensus to resolve disagreements is the first step. The tips on the following page reflect respect for both parties and their values.

### Tips for Promoting Consensus between Legal Guardians & Individuals

<input type="checkbox"/>	Gather information from both parties regarding how and why their opinions/desires differ. Encourage each to share the issues/concerns behind his/her opinions; seek to understand all viewpoints (past experiences, lack of trust, inadequate supports, etc.).
<input type="checkbox"/>	Ask the guardian what must be put in place to support the individual's desire(s) and the action plan(s) identified by the team.
<input type="checkbox"/>	With permission from both parties, facilitate a discussion of their viewpoints to ensure a full perspective of the situation is considered.
<input type="checkbox"/>	Help the parties agree upon similar elements of their different views.
<input type="checkbox"/>	Design an ISP to include the individual's desires and actions plans the guardian will support.
<input type="checkbox"/>	The team must <b>always</b> request technical assistance from DDSD if consensus cannot be reached that will preserve the relationships between the individual and guardian.

### Resources on Guardianship

Developmental Disabilities Planning Council (DDPC)	<b>(505) 827-7596</b>
Adult Protective Services (APS)	<b>(505) 841-7984</b>
The Arc of New Mexico (the Arc)	<b>(505) 883-4630</b>
Lawyer Referral for the Elderly Program	<b>(505) 797-6005</b>
State Bar of New Mexico	<b>(505) 797-6000</b>
Protection and Advocacy (P&A)	<b>(505) 256-3100</b>
Individual Assistance and Advocacy Unit (DDSD)	<b>(505) 841-5528 &amp; (800) 283-5548</b>

## Sources Used for this Chapter

*Pre-service Self-Study Manual for Case Managers & Service Coordinators, 2005 edition, DDS*

*Advocacy Strategies for Case Managers and Service Coordinators, 2003, The Cutting Edge Consulting Services & NM DOH/DDS, Barbra Portzline & Noelia McNew.*

*Guidelines for Community Programs & Case Managers & Interdisciplinary Team Members Regarding Advance Directives and Health Care Decisions, Continuum of Care Project, 2001*

# Chapter IV

## Planning with the Individual



- ◆ The Individual's Team
- ◆ Team Meetings
- ◆ Guidelines for the Team
- ◆ Case Management Responsibilities
- ◆ The Planning Process
- ◆ Completion of the Individual Service Plan
- ◆ Ongoing Roles and Responsibilities
- ◆ Quality Assurance
- ◆ Collecting Data on the Individuals' Progress
- ◆ Guidelines for Progress Reporting
- ◆ Review/Reassessment/Revision
- ◆ Guidelines for Reviewing Action Plans
- ◆ The Dispute Resolution Process
- ◆ Team Facilitation Process
- ◆ Special Planning Considerations

## Chapter IV

# Planning with the Individual

Service Planning is an essential component of case management focusing on the process of assisting an individual to develop the Individual Service Plan (ISP). The ISP is an individualized and person-centered plan, based on the individual's dreams, aspirations, and desired outcomes that includes services and supports necessary for the achievement of the individual's stated desires.

### The Individual's Team

The individual is provided assistance in the development of the plan by his/her team. Teams assist individuals in achieving their outcomes by 1) developing relevant action and support plans; and 2) identifying and providing supports adequate to maintain the individual's health, safety and quality of life. In order for a team to function effectively, all team members must clearly understand the individual and actively work together. Teams are generally comprised of the individual, CM, family members, specialized providers and close friends. ISP regulations require at least the following participants:

- ◆ Individual Receiving Services and Supports (Most important member of the team)
- ◆ Court Appointed Guardian or parent of a minor (as applicable)
- ◆ Independent Case Manager
- ◆ Friends (as requested by individual)
- ◆ Family Member(s) and/or Significant Others (as appropriate)
- ◆ Community Service Provider Staff (support staff who are directly involved in the ongoing, regular support to the individual in his or her home, work or other

activities) **must** participate in planning. The agency service coordinator must also attend.

- ◇ Ancillary Service Providers such as an occupational therapist (OT), physical therapist (PT), speech/language pathologist (SLP), Behavioral Support Consultant (BSC), nurse and/or nutritionist will participate as appropriate to the individual's specific challenges.

Others the individual may want to invite include:

- ◇ Advocate (personal, legal or corporate)
- ◇ Community Representatives (including employers)
- ◇ Interpreter
- ◇ Cultural Liaison
- ◇ Public School Representatives
- ◇ Minister, Priest, Rabbi, or other Spiritual/Cultural Advisor
- ◇ Co-worker
- ◇ Healthcare Practitioner
- ◇ DDSD Representative

## Team Meetings

The team must meet annually to develop the ISP, as requested by the individual or guardian at any other time for a review of the ISP, and may need to convene at other times, as necessary, to review and revise the ISP as specified by the *ISP Regulations*.

⇒ **Chapter IV: *Planning with the Individual, Review/Re-assess/Revise***

## Guidelines for the Team

The CM should assist the team to plan in accordance with the Guiding Principles of the ISP Regulations and the DD Waiver Service Standards:

1. Individuals can live in, and be a part of, the community in the same manner as would any other person of like age and interests.
2. All working age adults with developmental disabilities are capable of working given the appropriate supports.
3. There are no starting assumptions based on models of service; rather, supports are tailored to meet the needs of the individual and/or family.
4. Supports and services are provided **only** to the extent there is a demonstrated individual need.
5. All persons have strengths and interests and are capable of growth and development at their own individual pace.
6. Successful individualized planning starts from and builds on individual and family strengths and interests, not deficits.
7. Individualized planning must be flexible and responsive to changing circumstances and environments.
8. Families and individuals have choices in, and ownership of, the planning process.
9. Planning protects and maintains the self-esteem and dignity of families and individuals.
10. Planning focuses on the desired outcomes the individual or family wishes to achieve.
11. Community and natural supports are preferred over specialized services in assisting individuals and families in attaining their goals and desired outcomes.

In addition, the following guidelines are in place so that all team members are able to actively support the individual to participate meaningfully in planning:

1. Team members who are employed by a paid service agency (directly/through contract) must be trained in the ISP process. CMs and provider agency staff receive this training as part of the DDSD-mandated training curriculum. CMs

should inform friends and family members that they may request training through the local DDS regional office or the Statewide Training Coordinator: **(505) 841-5500**.

2. A team in the process of developing an ISP must be able to analyze information, problem-solve and achieve consensus to resolve issues and/or conflict.
3. It is recognized that on occasion, despite good faith efforts and multiple attempts, consensus cannot be achieved; at that time voting becomes the last resort. The CM must submit documentation of completion of the steps to reach consensus and the voting record to the Regional Office. Only identified team members may vote. The individual, parent/guardian, CM, and a single representative from each involved provider may have one vote each. Persons providing natural supports and others chosen by the individual may participate but are not entitled to a vote.
4. Exempt from the voting process are 1) the individual's decisions regarding his or her own long term vision and desired outcomes and 2) the individual and guardian's choices as provided for under **Freedom of Choice of Providers**.
5. Team members are responsible for contributing their expertise to the development of the ISP. Therapists should discuss with the team, strategies/recommendations that are working, what needs to be re-examined and what follow-up needs to occur.
6. Team members must respect the different opinions each member contributes.
7. Each team member is responsible for the success of the ISP. Team members must clearly understand who will be responsible for plan components and timelines for implementation. Therefore it is important to document this information in the action plan section of the ISP.
8. Each team member is aware of and willing to access the mediation processes available to ensure an adequate plan is developed and implemented. The

- Dispute Resolution Process applies to Jackson Class Members and the Team Facilitation Process applies to all other DD Waiver recipients.
9. The team must ensure that both the planning process and the ISP are respectful of the culture and language of the individual and/or family, including the use of an interpreter and translation of relevant documents, when necessary.

- ⇒ **DDD/DOH Guidelines Governing the IDT Process**  
<http://www.nmcpr.state.nm.us/nmac/parts/title07/07.026.0005.htm>
- ⇒ **Dispute Resolution Process (DRP) and Team Facilitation Process**  
<http://www.nmcpr.state.nm.us/nmac/parts/title07/07.026.0008.htm>
- ⇒ **Chapter III: Making the Most of Meetings**

*Maria is very proud of her Hispanic background. She is close to her extended family and likes to have them at her meetings. Some family members only speak Spanish. Her aunt speaks some English. When her aunt comes to Maria's meetings she understands only part of what is being said. She is embarrassed to ask for clarification. The CM notices her puzzled looks and realizes they have been using jargon and technical terms the aunt doesn't understand.*

*The CM asks the therapist to repeat what he/she said so Maria can better understand. The CM reminds team members to be clear in what they are saying. Since Maria is bilingual the CM enlists Maria's aunt to repeat some key points for Maria in Spanish. This ensures everyone understands what is being discussed.*

*The CM makes a point of talking to Maria and her aunt privately about whether they would like to have an interpreter there. Maria's aunt is impressed with the CM's concern. The CM asks Maria and her aunt if they would like to invite either Maria's cousin, who is bilingual and gets along well with Maria, or a professional interpreter, to the next meeting.*

## Case Management Responsibilities

- ◇ It is the CM's responsibility to advocate and role model Person-First language (written and oral) as language and attitude can reflect either respect or marginalization, and in turn, affect the attitude brought to and reflected in planning.
- ◇ Although the CM may only co-facilitate the planning meeting and may not develop all components of the ISP document, it remains the responsibility of the CM to ensure both the process and document(s) meet DDS expectations and requirements.
- ◇ The CM completing the ISP should have a full understanding of the person's desires, strengths and challenges. This occurs through visits with the individual by CM and team members, as well as through the formal assessment process. Assessment should include successes, strengths, challenges, what is and is not working for the individual, desires for changes and potential risk factors.

⇒ **Appendix: Risk Assessment, Evaluation & Planning Worksheet**

- ◇ The CM must ensure the person is given the opportunity and support necessary to participate in the development of the service plan to the fullest extent possible. If the person is unwilling or unable, the CM should document the reasons why the person was unable to participate directly in the planning process. **Remember:** *The CM should provide information to the individual prior to the ISP meeting so that the individual can become oriented to the process and his or her role within the team.*
- ◇ At the ISP meeting, the CM facilitates the team to identify the individual's long-term vision and desired outcomes, ensure action plans are completed, including the identification and/or development of needed supports, and assign follow-up responsibilities for development of strategies and/or support plans as appropriate.
- ◇ The CM is responsible for promoting the development of an ISP that is based on informed choice. Informed choice occurs when a person is provided all necessary

information to consider options, consequences of the choice(s), and his or her responsibilities to self and others in a manner that balances personal right to choice with the rights and safety of others. For example, if an individual wishes to have a pet, but lives with a housemate who has allergies the CM should help the individual explore the consequences of his/her choice and viable options.

- ◇ Although individuals are entitled to the dignity of risk, a personal opportunity to learn and grow by experiencing the natural consequences (positive and negative) of a personal decision, it is the team's responsibility to assess risk and develop supports that minimize significant risks. The CM is responsible for ensuring the ISP contains a "safety net" when choices or desired outcomes involve significant risk. CMs should carefully discuss, and document discussions, with the individual and/or legal guardian, all concerns regarding reasonable care, alternatives, and risks associated with their decisions.

⇒ **Appendix: *DDSD Decision Justification Form***

- ◇ The CM will facilitate a review of current/needed medical and therapy information, ensure that all relevant medical and therapy issues are planned for, assign follow-up responsibilities as needed, and ensure that the status of guardianship and placement are reviewed and addressed as needed.
- ◇ The CM ensures that the team identifies who on the team will take primary responsibility for coordination of healthcare.

### ***Training Resources***

DDSD provides training in healthcare related topics in the ***Pre-Service Manual*** and in ***Level One Health for Case Managers and Service Coordinators***.

- ◇ The CM shall work with the individual and guardian to identify the specialized and natural supports related to the individual's desired outcomes. The CM will then work with the team to identify services and supports and create a budget to support them.

### ⇒ **Chapter VIII: *Creating the Individual's Budget and Billing for Services***

- ◇ CMs and teams sometimes disagree about the individual's plan and decisions involving health and safety. CMs must have conflict resolution skills or request mediation from another source when 1) the disagreement involves them or 2) the disagreement cannot be resolved within the team process.
- ◇ The CM is responsible for ensuring the ISP describes meaningful roles in the community, in accordance with the meaningful day initiatives of the DDS. These roles are developed from the identified preferences and interests of the individual and would be valued by other members of the community; this helps ensure the individual has opportunities to promote freedom and equality. Teams may request assistance from the DDS meaningful day coordinators, as needed.
- ◇ The CM is responsible to ensure that employment decisions are based on informed choice and that the ISP reflects the discussion on employment options and issues.

#### ⇒ ***DOH Policy on Access to Employment*** <http://www.health.state.nm.us/dds/polproc.htm>

- ◇ The CM is responsible to ensure that specialized assessments and services are provided by appropriate agencies (DVR, supported employment agencies, etc.) for individuals who express an interest in employment. It is the CM's responsibility to ensure the information is reviewed by the team and incorporated into planning.
- ◇ The CM is responsible to ensure that the ISP is developed annually, revised as needed, reflects growth and progress towards the person's dreams and aspirations (long term vision), and lists the services and supports the person needs to achieve desired outcomes.
- ◇ The CM, with the support and assistance of the team, must be diligent in helping the individual access generic resources and natural supports from his/her community.

### ⇒ **Chapter V: *Community Resources & Supports***

- ◇ The CM is responsible to ensure the person and his or her guardian should be aware of their rights, responsibilities, and applicable grievance processes, including the right to change service providers; these should be reviewed with the individual and guardian prior to each annual ISP meeting. The CM must actively support the individual to exercise his/her rights on an ongoing basis.

<b>Training Resources</b>
Training related to the above CM functions can be found in the <b><i>Pre-Service Manual, Two-Day ISP Training, and ISP Critique</i></b> . In addition, <b><i>Promoting Effective Teamwork</i></b> is designed to help the CM be an effective facilitator and team member. <b><i>Advocacy Strategies for Case Managers</i></b> is designed to promote individuals' rights and advocacy strategies for teams.

## The Planning Process

The following table outlines the roles and responsibilities of all team members throughout the ISP process.

⇒ **ISP Regulations 7 NMAC 26.5**  
<http://www.nmcpr.state.nm.us/nmac/parts/title07/07.026.0005.htm>

1. **Preparation for ISP meetings:** In order for planning to be timely and effective, all team members must complete pre-meeting responsibilities in accordance with the ISP Regulations.

<b>Step</b>	<b>Responsible Parties</b>	<b>Tasks</b>	<b>Time Lines</b>
1	CM	Set date of annual ISP meeting	60 days prior to expiration of current ISP
2	CM	Distribute written notice of annual and interim meetings	21 days prior to annual ISP meeting, in a timely manner for interim meetings

Step	Responsible Parties	Tasks	Time Lines
3	All Paid Service Providers, including Therapists, Nurses and Nutritionists, as applicable	Submit written assessment summaries to CM. <i>For Nurses, this must include the HAT.</i>	2 weeks prior to annual ISP meeting
4	CM	Provide overview of process to individual and/or guardian.	Prior to meeting
5	CM	Update and complete: <ul style="list-style-type: none"> <li>◆ Strengths, Needs &amp; Preferences Summary</li> <li>◆ Input from team members unable to attend</li> <li>◆ Arrangement for any accommodations needed by the individual during the meeting.</li> </ul>	Prior to meeting
6	CM Other team members	Prepare individual to: <ul style="list-style-type: none"> <li>◆ Identify desired outcomes, goals, and supports</li> <li>◆ Present information</li> <li>◆ Ask questions</li> <li>◆ Facilitate/participate in his/her meetings.</li> </ul>	Prior to and during the ISP meeting
7	Providers, Therapists, Nurses & Nutritionists, as applicable	Identify training members will need.	Prior to meeting

*When the CM contacts team members she lets them know they will be required to stay longer than usual because Greg wants the team to revisit the strengths, preferences and needs section. She lets them know he has not felt supported in the past and wants the team to be sure to have submitted all supporting documentation, evaluations and/or assessments in plenty of time for review before the meeting. The new co-worker is not able to attend so the CM makes sure to interview him over the phone and gets some great information to share with the team.*

**2. Development:** The team is responsible to (1) annually review and update the strengths, needs, and preferences summary section of the ISP, (2) identify and reach consensus on the individual's desired outcomes, (3) assist the individual to co-facilitate the meeting as desired, (4) identify and resolve problems and obstacles, (5) identify action plans, medical, nutritional and/or therapy support plans, and other supports (specialized, personal and community) that must be developed to assist the individual in the accomplishment of the long-term vision and desired outcomes. The CM must assure that all individuals are given the opportunity to consider paid and volunteer employment options and that this discussion is documented in accordance with the DDSD Employment First Policy. The action plans will be completed at the meeting, with input from the team. Providers and therapists must submit detailed strategies to support each action plan.

Step	Responsible Parties	Tasks	Time Lines
8	CM	CM facilitates the meeting, supporting the individual to co-facilitate the meeting as desired.	At the ISP meeting
9	Team	Determine need for additional assessments.	At the ISP meeting
10	Team	Identify dreams, aspirations, long-term vision and desired outcomes, including paid and volunteer employment. Analyze outcomes using annual assessment information to identify: <ul style="list-style-type: none"> <li>◆ Action plans</li> <li>◆ Support plans</li> <li>◆ Natural, generic &amp; agency supports</li> <li>◆ Assistive technology &amp; environmental adaptations.</li> </ul>	At the ISP meeting

Step	Responsible Parties	Tasks	Time Lines
11	Team	Discuss medical, behavioral and mental health status and issues and identify a healthcare coordinator.	At the ISP meeting
12	Team	Identify arrangements for medical appointments, medications, therapy appointments, and crisis prevention plans (medical and behavioral).	At the ISP meeting
13	Team	Arrive at consensus on training for team members who will implement the ISP.	At the ISP meeting
14	Team	Identify desired outcomes.	At the ISP meeting
15	Providers, therapists, nurses and/or nutritionists as appropriate to the individual	Develop action plans that include: <ul style="list-style-type: none"> <li>◆ Criteria for success</li> <li>◆ Timelines for completion</li> <li>◆ Detailed strategies including integration of applicable therapy recommendations for staff implementation.</li> </ul>	At the ISP meeting  Within 2 weeks of the ISP meeting
16	CM	Monitor completion of needed assessments identified at ISP meeting.	After ISP meeting
17	CM	Ensure all sections of the ISP form are completed (including medical page), submit for quality assurance by CM agency and DDSD and ensure utilization review is completed per DDSD requirements.	After ISP meeting

Step	Responsible Parties	Tasks	Time Lines
18	CM	Perform final review of action plans, support plans and strategies for: <ul style="list-style-type: none"> <li>◆ Relevance</li> <li>◆ Sufficient detail to implement</li> <li>◆ Clarity for staff comprehension</li> <li>◆ Integration of applicable therapy recommendations.</li> </ul>	Prior to submission of the plan for quality assurance and for utilization review
19	CM	Distribute ISP to the individual & all team members.	No later than 5 working days prior to expiration date of the previous ISP.

## Completion of the Individual Support Plan

The ISP document must be completed in accordance with state regulations, be based on the person's desires, values, preferences, and strengths and contain the following:

- ◆ An updated written "picture" of the individual that includes life experiences, strengths, gifts, preferences, relationships, work/volunteer history, and challenges;
- ◆ Depiction of the individual's life at the present time;
- ◆ The individual's dreams and aspirations, long-term vision and desired outcomes;
- ◆ Supports and action plans sufficient to assist the individual to achieve desired outcomes;
- ◆ Medical, therapy and crisis plans needed to support not only desired outcomes, but also existing health, behavioral health, and therapy needs identified by the team to promote health, safety, and quality of life; and
- ◆ Training for team members to ensure the individual receives services from qualified staff.

**Note:** *Medical, therapy and crisis plans are incorporated into the ISP by reference.*

⇒ ***DDSD Regulations Governing the Development of the Individualized Service Plan, New Mexico Administrative Code, 7 NMAC 26.5***  
<http://www.nmcpr.state.nm.us/nmac/parts/title07/07.026.0005.htm>

### **Appendix: *ISP form***

The CM is responsible for completing the following sections of the ISP:

1. Face Page
2. Narrative Section
  - ◇ Strengths, Preferences & Needs
  - ◇ School, Work and/or Volunteer History
  - ◇ Relationships
  - ◇ Gifts, Talents, & Hobbies
3. Long Term Vision
4. What Life is Like Now
5. Desired Outcomes
6. Action Plans
7. Basic Health & Safety Related Supports
8. Individual-Specific Training Requirements
9. Signature Sheet

The CM is also responsible to review the strategies and support plans completed by provider agencies and therapists for integration with the ISP.

**Note:** *The CM is responsible for quality assurance of portions completed by other team members.*

## Providers and Therapists

Action and support plans must 1) relate to the individual's desired outcomes and 2) should be written to facilitate consistent implementation of therapy recommendations and strategies by team members.

- ◇ Strategies to Support Action Plans
- ◇ Support Plans
- ◇ Medical and/or Behavioral Crisis Prevention Plans
- ◇ Health Care Plans

Action and support plans to achieve the individual's desired outcomes are developed by the appropriate therapists, provider agency staff, or nurses and submitted to the CM for inclusion in the ISP. Submission should occur as soon as possible after the meeting, but no later than fourteen (14) days, preferably via e-mail so that content can more easily be integrated. Therapists must ensure relevant therapy recommendations are integrated with the steps of corresponding action plans.

*Sam has a health care plan that indicates he needs more exercise to keep his blood pressure under control. Sam loves animals but his housemate is allergic to animal fur thus precluding him from having pets in their home. Sam's CM schedules a team meeting to discuss options for Sam to have more exercise and reduce health risks. A Direct Support Professional from Sam's home mentions that one of Sam's neighbors has a good-natured dog and lives just down the street. Sam has spent time visiting and playing with the dog from time to time. Sam would like to take the dog for walks if that is OK with the dog's owner. The staff member accompanies Sam to meet with the neighbor and works out a schedule for Sam's daily dog walks. The neighbor also offers Sam a reasonable fee for the service he will provide.*

## Procedure for Distributing the ISP

The CM provides copies of the completed ISP no later than five (5) working days prior to the expiration date (of the previous ISP) to the following:

- ◇ Individual
- ◇ Guardian (if one is appointed)
- ◇ Service Providers
- ◇ Individual's Attorney (if applicable)
- ◇ Others (if identified by the individual)
- ◇ DDSD Regional Office

Current copies of the ISP must be kept in the individual's primary record at the Case Management agency. At least quarterly, the CM must make sure that the current ISP is available to the individual and to his or her direct support staff in the home and day program. If the CM, with assistance from agency support staff, cannot locate the ISP, case management documentation should indicate that the service coordinator was contacted by the CM and asked to place a new copy in an accessible location at the site(s).

**3. Implementation:** All team members hold joint responsibility to implement the ISP. Data is collected as stated in the ISP and summarized to the CM in formal progress reports. Most providers submit quarterly reports. At the ISP meeting it is the responsibility of the CM to have the team reach consensus to determine if therapy reports will be submitted on a quarterly or semi-annual basis. The CM monitors to ensure that the plan is implemented as written and identifies any issues that may require the team to reconvene and/or revise the ISP, as defined in the Monitoring section of this manual.

### Training Resources

Information on Behavior Support Plans can be found in training material on **Positive Team Approach to Behavioral Supports**. Communication plans and Aspiration/Mealtime plans are covered in both **Participatory Communication and Choice Making** and **Level One Health**.

Step	Responsible Parties	Tasks	Time Lines
20	Providers, Therapists	Provide & document training for team members as agreed upon by the team.	As specified
21	Providers, Therapists	Locate, procure, and/or develop: <ul style="list-style-type: none"> <li>◆ Services</li> <li>◆ Supports</li> <li>◆ Equipment &amp; materials</li> </ul>	Within timelines established by the team
22	Provider Agencies	Provide ISP in home and all program areas.	Upon receipt
23	CM	Monitor availability of plan, services, and equipment.	Ongoing
24	Providers, Therapists	Implement ISP in all program areas and collect data.	Ongoing as specified in ISP
25	Providers, Therapists	Provide progress reports to CM.	Quarterly or as specified by the team
26	Providers, Therapists, Nurses and/or Nutritionists	Provide documentation of team training for all individuals working with the individual.	Ongoing
27	Providers, Therapists, Nurses and/or Nutritionists	Provide copies of Incident Reports to CM.	Ongoing

Step	Responsible Parties	Tasks	Time Lines
28	CM	Review progress via: <ul style="list-style-type: none"> <li>◆ Data collection;</li> <li>◆ Progress reports;</li> <li>◆ Incident reports;</li> <li>◆ Documentation of team training and</li> <li>◆ Site visits.</li> </ul>	Ongoing
29	CM	<ul style="list-style-type: none"> <li>◆ Monitor integration, coordination, and implementation of services;</li> <li>◆ Review progress reports, data collection, training documentation, incident reports, condition/ availability of special equipment &amp; assistive devices; and</li> <li>◆ Maintain primary record file.</li> </ul>	Ongoing
30	CM Team	Identify: <ul style="list-style-type: none"> <li>◆ Who the individual is and what she/he wants; and</li> <li>◆ Service support needs.</li> </ul>	Ongoing

## Ongoing Roles and Responsibilities

The following information is provided to clarify the ongoing roles and responsibilities of team members.

### Quality Assurance

1. Quality assurance is imperative to ensure that the ISP is thorough, addresses all issues, and meets the expectations of DDSD. The following steps reflect DDSD's expectations for quality assurance of all annual ISPs.

- a) The CM should use the **Quality Assurance Guideline Questions** to develop and review the ISP and make any necessary revisions. The CM will obtain these Guidelines from his/her supervisor.
  - b) The ISP should be submitted to the quality assurance staff person at the case management agency, who will also use the *Guideline* questions to review the ISP and give feedback (positive and constructive) on the Quality Assurance (QA) form.
  - c) For Jackson Class Members, the ISP and the completed QA form will be submitted to the DDS regional office for review and additional comment. The DDS reviewer will return the completed QA form to the Case Management Agency and the relevant service provider or therapist. A sample of other DDS Waiver ISPS and QA forms may also be reviewed by the RO.
  - d) For all plans reviewed by the Regional Office, the CM will review the comments and make necessary revisions, convening the team as needed, and return the revised ISP and QA form to the regional office for review; the plan will either be approved at that time, or returned for additional action within timelines specified by DDS. At this juncture, additional technical assistance may be requested from the Regional Office.
2. Failure to comply with this process, at any step, may result in sanctions imposed on the provider.

*A very good plan was developed for Tim at the Tip Top case management agency. The CM who developed it left to take a job in Alaska. Since the plan had been written by a competent CM and looked pretty good on the surface, the new CM didn't do a thorough QA check before turning it in. The QA person at the case management office was swamped and asked the CM if they had 'QA'd the plan. They took the "yes" to be good enough.*

*A DDS Regional Office staff member also QA'd the plan and did a very thorough job. The ISP had identified some issues that were crucial to the*

*health and safety of the individual. However, therapy support plans that were attached had not included those issues. Tim was having problems at work directly related to the issues to be covered in therapy support plans.. The DDS staff informed the CM and the plans were returned to the therapists immediately for revision. Tim received the supports he needed to keep his job.*

## Collecting Data on the Individual's Progress

Data **does not** need to be collected every time the person practices the skill; the skill should be practiced more often than data is taken. Data **does** need to be taken as stated in the action plan to ensure consistent evaluation of progress.

- ◇ How often data is collected depends on:
  - ◇ the individual;
  - ◇ the “newness” of the skill;
  - ◇ the difficulty of the skill; and/or
  - ◇ the critical nature of the skill.
- ◇ Method of data collection and type of data recording depend on the task and the individual.

**Remember:** *Keep it simple and non-invasive.*

Use natural measurement systems when possible.

The reporting samples on the following pages provide guidance to the CM in fulfilling his/her role in monitoring the individual's progress.

# Sample Monthly Report Form

Month of \_\_\_\_\_ Year \_\_\_\_\_

VES \_\_\_\_\_ DAY HAB \_\_\_\_\_

Consumer \_\_\_\_\_ Address \_\_\_\_\_

Provider \_\_\_\_\_ Date Report Completed \_\_\_\_\_

Primary Activity Location \_\_\_\_\_ Job Site \_\_\_\_\_

Case Manager \_\_\_\_\_

1. Briefly identify current employment and/or day program objectives: (Please refer to the ISP or ask a supervisor if you need assistance with this. Do not leave this section empty).

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2. Please identify the day habilitation or employment activities this month that contributed to meeting the objectives in number 1 above:

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3. Any significant or positive changes or accomplishments this month:

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4. Please identify problems encountered this month (health, behavior, transportation, etc.):

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5. Comments:

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- 6. A. Were there any Health issues this month? YES \_\_\_\_\_ NO \_\_\_\_\_
- B. Were there any serious INCIDENTS this month? YES \_\_\_\_\_ NO \_\_\_\_\_
- C. Were there any staff or provider changes this month? YES \_\_\_\_\_ NO \_\_\_\_\_

If 6 A, B or C was answered yes, please briefly explain:

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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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Cc: file/adpmonth

## Sample Objective Report

Provider Agency Name

Life Area: \_\_\_\_\_

**Objective:** \_\_\_\_\_ sill attend at least one outing per week in which she will have opportunities to explore her interest in animals, old churches and old houses. Document once a week: date, activity, location of activity and comments regarding \_\_\_\_\_ participation.

Date	Activity	Location of Activity	Comments
3-1-05	Nature Ride	Belen Tome Hill	Pointed out calf, cows, ponies. GW (staff initials)
3-3-05	Nature Ride	Peralta, Isleta, Los Chavez, Belen	Socialized throughout ride, pointed animals independently. In Isleta, commented how much water was in river. Thanked staff for ride. GW
3-4-05	Nature Ride	Belen, Pueblitos, Jarales	Saw lots of cows, sheep. Enjoyed the ride. BT (staff initials)
3-6-05	Nature Ride	Tome Hills, Los Lunas area	Pointed out lambs, goats, horses, a few cranes. She socialized throughout the ride. PG (staff initials)
3-11-05	Nature Ride	Los Lunas	Socialized throughout the ride. Pointed out cows, horses, birds. In Los Lentos, commented on Catholic Church. PG
03-15-05	Nature Ride	Tome/Belen	Pointed out horses, cows, sheep. GW
03-25-05	Nature Ride/Church Good Friday	Tome-Los Lunas-Bosque Farms-Isleta	Went to Tome hill to see pilgrimage. Later on went to church at Tome Church. She said Lent reminded her of her mom and the past. PT (staff initials)
3-26-05	Nature Ride to Belen	Belen-Tome	Went on nature ride. Socializes during ride. Pointed out animals along the way. Horses, cows, birds. PT
3-31-05	Nature Ride	Los Lunas/Belen	Socialized throughout ride. Pointed out animals—cows, horses. Thanked staff for ride. PT

## Sample Provider Agency Monthly Summary

**SERVICE COORDINATOR MONTHLY SUMMARY FOR:** November

**Consumer:** \_\_\_\_\_ **Date:** November 30, 2004

**HEALTH & MEDICAL (Including Physician or special visits):**

11/02/04—Podiatry  
 11/04/04—Psychiatrist

**SEIZURES:** N/A **SEVERITY:** N/A

**WEIGHT:** 153 LBS.

**SPECIAL DIET:** Low Sugar

**CURRENT MEDICATIONS:** (see attached Doctors orders)

NAME	DOSAGE	SCHEDULE	PURPOSE

**COMMUNITY ACCESS/SOCIALIZATION:**

\_\_\_\_\_ continues to be very active in her community. She attends church services every Sunday. She also enjoys going out to eat and to the movies. \_\_\_\_\_ also enjoys shopping for puzzles, and she also helps staff with grocery shopping. She enjoys her nature drives that she takes weekly. This month \_\_\_\_\_ attended Merry Makers and the Belen Christmas light parade.

**FAMILY CONTACT/VISITS:**

\_\_\_\_\_ talks with her brothers and sisters by phone monthly. In November all of her brothers and sisters came to visit and take her out to eat. She was very excited and happy they all came to visit.

**PROGRESS ON GOALS & OBJECTIVES:**

1. Collecting House Mail: \_\_\_\_\_ continues to do very well with this goal. This is something that she enjoys doing because she can also visit with her friends while she is at the Los Lunas Community Program. \_\_\_\_\_ collects her mail daily with no problems. \_\_\_\_\_ continues to meet this goal at this time.
2. Movies: \_\_\_\_\_ attended 2 movies this month. She enjoyed Spiderman 2 and Cellular. She was unable to attend two other times due to behaviors and therefore the movie outing was cancelled.
3. Dinner/Lunch with Friends/Family: \_\_\_\_\_ had one friend/staff over for dinner this month. After dinner \_\_\_\_\_ was very rude to her guest and left her alone while she went to watch TV.

**BEHAVIORAL—SIGNIFICANT INCIDENTS:**

None

**PERSONAL NEEDS/FINANCIAL STATUS:**

\_\_\_\_\_ continues to collect Social Security to meet all of her needs. Her checking account status is doing well.

**MONTHLY NOTES:**

I did not visit \_\_\_\_\_ in her home this month. Due to audit requirements, I was unable to attend. Audit requirements did recommend that service coordinators, nursing and house managers meet to discuss any medical concerns and to update books. Nursing and I did meet, discussed medical concerns and talked about how to maintain health. There were no major concerns at this time.

**SERVICE COORDINATOR:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\_\_\_\_\_ **HOME VISIT** \_\_\_\_\_ **OTHER:** \_\_\_\_\_

## Guidelines for Progress Reporting

The following information should be reflected in the Progress Reports completed by providers:

- ◇ Quantitative Summary statement to describe progress or regression on outcomes and action plans within the quarter. Include any changes to criteria or strategies.
- ◇ Qualitative description of the person's life including joys and challenges within the quarter and details of naturally occurring opportunities and community integration.
- ◇ Summary of incidents and steps to prevent future occurrence.
- ◇ Problems with durable medical equipment, environment, employment, etc. and strategies to rectify situations.
- ◇ Reports submitted by therapists should reflect adherence to standards established for their respective disciplines, which can be obtained from the DDSD therapy unit at **(505) 841-2948**.

## Progress Reports: Timelines & Responsible Parties

Quarterly Reports are due from providers of the following services:

- ◇ Day Habilitation
- ◇ Residential
- ◇ Vocational
- ◇ Therapists, nutritionists and others as determined by team (if quarterly or semi-annually)

These reports are due to the CM no later than fourteen (14) working days after completion of each ISP quarter.

Record information needs to be maintained as follows:

## Provider Agency

- ◇ Data sheets
- ◇ Provider progress notes
- ◇ Documentation of staff training

## Primary File at Case Management Agency

- ◇ CM progress notes
- ◇ Provider quarterly reports

## Review/Reassessment/Revision

The CM is responsible for reviewing all formal progress reports, information collected during site visits, incident reports, reports of ongoing medical or mental health treatment/issues and/or any other information provided by team members. Based on this review, the CM must convene the team to address any emerging issues and completion of desired outcomes.

The following information from the ISP Regulations provides guidance on when the team must convene to review, re-assess and revise the ISP. In the following circumstances, the team must convene to review and make any necessary changes:

1. Annual ISP
2. Medical change affecting health, behavior and/or emotional status
3. Team must meet within one (1) day of allegation(s) of abuse, neglect or exploitation *and* if the issue is not resolved satisfactorily; another team meeting must be called within two (2) days of substantiation of abuse, neglect or exploitation.

4. In situations where an individual is at risk of significant harm, the team shall convene within one working day, or in person or by teleconference. If necessary the ISP shall be modified accordingly within 72 hours.
5. Serious accident, injury, illness, and patterns of incidents (i.e. multiple incidents that have a similar cause/nature, increase or decrease in use of emergency services, etc.)
6. Criminal justice system involvement or risk of involvement
7. Serious and/or sudden change in behavior
8. Change in long-term vision or desired outcomes and/or need to revise action plans
9. Loss or death of significant person in the individual's life
10. Loss of job
11. Change of living situation
12. Individual, guardian, or ANY other team member requests a meeting (within 10 days of request)
13. Proposed change in services
14. Medicaid Utilization Review contractor, DDSD regional office, and/or annual community practice review recommendations

The flow chart on the following page illustrates the progression of review and revision of action plans. During each review, CMs need to evaluate progress, or lack thereof, and intervene to ensure that the individual's plan stays on track.

## Guidelines for Reviewing Action Plans



### **PROGRESS**



#### **Fast Success:**

- Increase difficulty
- Decrease support



**Move to next action plan**



### **NO PROGRESS**



#### **Investigate:**

- Degree of difficulty
- Level of assistance
- Motivation and meaning
- Materials
- Staff actions
- Personalities
- Lack of therapy support
- Verbal directions
- Task analysis
- Alertness/Time of day



**Revise strategy or action plan, modifying above**

## The Dispute Resolution Process/Team Facilitation Process

The Dispute Resolution Process (DRP) was created out of the Jackson Lawsuit to provide due process for the resolution of disputes. Disputes may be based on either the content or substantial failure to carry out an Individual Habilitation Plan (IHP) in an ICFMR facility, Individual Transition Plan (ITP) or an Individual Service Plan (ISP) for individuals with developmental disabilities who are Jackson Class Members.

- ⇒ **New Mexico Administrative Code (NMAC) Regulation (7.26.8)**  
<http://www.nmcpr.state.nm.us/nmac/parts/title07/07.026.0008.htm>

### Who can file a dispute?

1. Individual
2. Parent and/or guardian
3. Department of Health (DOH)

### How can a dispute be filed?

1. In person
2. By telephone
3. In writing
4. Through representation of legal counsel or other parties

### What can be disputed?

1. Content of Plan:
  - ◇ What is written in the plan needs to be **specific** as to the individual's needs.
  - ◇ When the plan is not specific or does not address the specific needs of the individual, a dispute may be filed.
2. Substantial Failure to Implement a Plan:

- ◇ Plan needs to contain step-by-step instructions indicating who, what, when, where and how supports to meet the individual's need(s) will be carried out.
- ◇ When something written in the plan is not being provided or acted upon by the provider(s), a dispute may be filed.

## Timelines for Filing a Dispute

1. Dispute on Content of the Plan: DRP needs to be filed within thirty (30) days from mailing of completed plan by the CM.
2. Dispute on Substantial Failure: DRP needs to be filed within thirty (30) days of a team meeting that has been held to discuss the issues in dispute.

## How to File a Dispute

**Please call the DDSD Individual Assistance and Advocacy/Dispute Resolution Process (IAA/DRP) Unit at 1-800-283-5548 or (505) 841-5528 for more information.**

## Team Facilitation through the DDSD IAA/DRP Unit

The team facilitation process is a means of opening communication among all participants at a team meeting in an effort to resolve issues specific to the individual. It is a voluntary process that can be used for any individual receiving services and/or supports from the DOH/DDSD. This process can be initiated by any team member or DDSD staff who identifies unresolved issues. A mediator will guide the meeting to ensure that members' opinions are heard and that issues and concerns are fully discussed.

⇒ **Appendix: *DDSD Guidelines for the Team Facilitation Process***

## At the Meeting

1. Mediator shall request introductions of all participants and their roles /titles;
2. Ground rules are set;
3. Mediator explains the process;
4. Mediator requests all participants to sign the Agreement To Mediate;
5. Discussion ensues;
6. Mediator facilitates discussion;
7. Mediator summarizes or paraphrases statements for clarity;
8. Mediator fills out Team Facilitation Agreement form;

## At the End of the Meeting

9. Mediator gives each participant the opportunity to review and change the Team Facilitation Agreement in accordance with earlier discussion (only additional changes that have been discussed are to be included);
10. Mediator reviews and states final agreements;
11. Participants sign the Team Facilitation Agreement, which amends the ISP; and Mediator gives each participant a signed copy of the Team Facilitation Agreement.

## Special Planning Considerations

Some individuals require special assistance, planning, monitoring and support from the team due to the serious nature of the issues they experience (aging, criminal justice involvement, serious aspiration risk, etc.). The following considerations are provided for CMs serving individuals with these personal circumstances.

## Special Considerations for Children & Youth

- ◇ Coordinated planning with IEP team at the school as the individual reaches adolescence to assure smooth transition to adult supports and services.
- ◇ Coordination with EPSDT funded services.
- ◇ Supports for the child within the context of family life (e.g., behavioral support consultation within context of family routines)
- ◇ Linking families with other parents and/or advocacy groups
- ◇ Consideration/exploration of supports to enable the child to participate in activities with typically developing peers (e.g., Boy/Girl Scouts, sports, clubs)
- ◇ Mentoring parents to coordinate and monitor their child's services for the months they don't receive case management services.

## Special Considerations for Individuals who are Aging

As with all planning functions, the team should be respectful of the individual's cultural and spiritual values regarding the aging process and end of life decisions. The CM should review the following with the individual and/or guardian, to identify priority issues and include these in team discussions for planning, as approved by the individual and guardian.

- ◇ Implementation of a financial plan
- ◇ Changing interests due to loss of physical, mental, or functional capacities
- ◇ Changes to social networks and personal circles
- ◇ Retirement from work
- ◇ Screening and treatment for conditions associated with aging, such as Dementia or Alzheimer's disease. For more information, refer to the Continuum of Care (COC) and Transdisciplinary Evaluation and Support Clinic (TEASC) programs:

◇ COC: <http://www.unmcoc.org/manual/dementia/index.htm>

**(877) 684-5259 (toll free)**

- ◇ TEASC: (505) 272-5158
- ◇ The Center for Development and Disability (CDD): (505) 277-0281
- ◇ Additional medical supports (e.g., medical alert bracelet, personal emergency response systems)
- ◇ Creation of a living will, trust, and/or last will and testament
- ◇ Identification of burial preferences
- ◇ Creation of advanced medical directives
  - ⇒ **Chapter III: Making the Most of Meetings, Advanced Medical Directives**
- ◇ Estate planning options
- ◇ For more information on estate planning, you can contact:
  - ◇ New Mexico Legal Assistance
  - ◇ A Private Attorney
  - ◇ New Mexico Protection and Advocacy
  - ◇ The Arc of New Mexico
  - ◇ The Self-Advocate's Bank

*Tony is 79 years old and is known for wearing overalls, flannel shirts and carrying a pipe from his large collection. Friends and family describe him as nurturing, caring, and having a very strong work ethic. Tony thrives on his Italian culture. He especially loves Italian food.*

*Tony's family owned a farm where Tony helped take care of the cattle and tend the crops. Tony frequently shares his wonderful memories growing up on a farm. To this day, Tony farms on a small scale, growing tomatoes. He keeps in touch with cousins through letters, cards and phone calls.*

*Today, Tony enjoys good health, but has a tendency to put on weight, so the team needs to oversee his diet and support Tony to remain active. Tony spends time visiting his favorite cousin Michael, collecting cans, working four days a week, helping his roommates, growing tomatoes and*

*collecting pipes. Michael is now Tony's legal guardian. Tony has willed his collection of pipes to his local parish.*

*When Tony reflects on his life of 79 years, he feels that he has had a productive and full life. Tony says, "I have lived my life well and the way I wanted to."*

*Tony's accomplishments with assistance from his CM:*

- ◆ *Tony's team and CM have provided Tony with a stable, secure life that maintains his close family ties.*
- ◆ *He has obtained a Guardian and been assisted to prepare a will.*
- ◆ *He has received medical screenings for Alzheimer's, Dementia, rheumatoid arthritis, and prostate cancer, and has had surgery for cataracts.*
- ◆ *He has received comprehensive dental care, including a comfortable set of well-fitting dentures that help him thoroughly enjoy his food.*
- ◆ *He has felt supported in continuing to work 4 days a week as is his preference.*

## Assisting Individuals in the Criminal Justice System

The fact is once a consumer has entered the justice system the rules change. The ISP team and CM are no longer the main players in the individual's team. There is a whole new set of players and new rules by which the team needs to adhere to. It is at this time that the team needs to request assistance from Office of Behavioral Services (OBS) and/or the Justice Advocate from the ARC.

**Example:** A CM contacted OBS regarding a crisis situation for a young male consumer in a family living placement. At a team meeting, the CM requested assistance from OBS' crisis team to address the situation.

*A 17 year old boy who attended a local high school. He has experienced instability within his family setting for a long time. His parents are divorced and his father lives out of state. His mother is unable to meet his needs as well as the needs of her other children. His parents share guardianship but his mother gave Power of Attorney to the assistant director of the family living provider agency because she was not able to be available for her son. The single female provider was beginning to feel unsafe in her home because he challenged her authority, intimidated her and began to hit and shove her. (He was following a pattern of behavior he had engaged in for years. When he was in a positive living arrangement he would ensure its failure by aggressing towards the people he lived with to terminate the placement).*

*The crisis team was able to locate a safe placement for the boy with another agency. After six months with the new provider in a supported living home he continued to progress and had fewer behavioral problems. During this time however, the team became aware of a court hearing that he missed and that the juvenile justice probation officer was about to file for a bench warrant to arrest him. The CM requested the warrant not be issued and arranged for the team to meet with the probation officer to discuss the problems. The probation officer honored the CM's request.*

*However, the issues surrounding his legal problems were not cleared up. The meeting with the probation officer included the CM, the BSC, his father, his grandmother, the Power of Attorney, two representatives from the new provider, and OBS. The probation officer explained to the team that she was required to send her report to the District Attorney with recommendations.*

*(The young man had two counts of misdemeanor assault from two years ago and two more recent counts of felony assault, all from his local high school.) After the probation officer left the room the team continued to discuss what could be done for the boy to prevent the court from following the probation officer's recommendations which were to send him to a residential treatment center in Albuquerque, as is a short term placement and to then send him to Utah to live with his father. The IDT agreed that this would only prolong his instability and would present a hardship for his father.*

*The team agreed that what would serve his best interest would be to remain in his current living arrangement. He is doing well there, he is able to continue to attend his local school and he has other family in the area. The Power of Attorney could be changed from the assistant director of an agency he was no longer a part of to his grandmother. The relationship with his father could be strengthened with the intent of a transition to live with him sometime in the future. His grandmother and father's presence and involvement in his life is part of the stability he needs to succeed.*

*The team agreed to make contact with the Public Defender as soon as one was named and request a competency evaluation. The competency evaluation could result in a new hearing in front of a judge to address competency. At that point the Public Defender will meet with the District Attorney and hopefully come to an agreement to allow the boy to continue receiving services from the DD Waiver to be supported in his current living arrangements as recommended by the team, since it has provided him a stable environment. He likely will be found incompetent to stand trial and charges dropped because he has a developmental disability and necessary supports are in place.*

## **Procedures for Assisting Individuals Involved with the Criminal Justice System**

### **Incidents Involving Law Enforcement**

1. Report all incidents in which law enforcement is involved, to the Division of Health Improvement (DHI); use established incident report (IR) form and procedures. Involvement of law enforcement includes but is not limited to:
  - ◇ Any time a law enforcement entity (e.g. any agent, officer or legal representative of an organization empowered by local, state, or federal to have stated or implied power to take an individual into custody) and individual have direct contact in which the officer or agent is acting in his/her official capacity (e.g. individual is the cause or reason law enforcement is present).

- ◇ When there is direct contact between a law enforcement entity and others who have a relationship with the individual (e.g. family, staff, friends, acquaintances, team members, etc.) that has a direct impact on the individual.
  - ◇ The individual is affected, directly or indirectly, due to the presence of a law enforcement entity.
2. Notify the local DDSD Regional Office (either verbally or in writing), within twenty-four hours of knowledge of incident(s).
  3. Request an emergency team meeting to discuss:
    - a. The circumstances surrounding the incident.
    - b. Resource availability.
    - c. An action plan to immediately address health/safety issues resulting from the incident(s). The plan must be detailed and address the following: 1) required actions, 2) priority of actions, 3) responsible party for implementation of each action, 4) timelines for each action, 5) responsible party for monitoring timely and appropriate completion of each action, and 6) party responsible for scheduling the follow up meeting.
    - d. Assurance that all individuals who require notification have been contacted.
    - e. Need for technical assistance from DDSD.

## Incidents Involving the Court System

1. Report to DHI all incidents in which an individual legally interfaces with the court system; use the established IR form and procedures. Such instances include, but are not limited to:
  - ◇ An individual is summoned to appear in court (local, district, or federal).
  - ◇ An individual is the focus of court (criminal or civil) activity.

- ◇ The outcome of court activity has or has a high potential for directly affecting the individual's health, safety, well being and/or quality of life.
- ◇ Any and all incidents whereby the individual is cognitively aware of and/or physically present in, any type of court proceedings (local, district, or federal) that have immediate or eventual impact on the individual's health, safety, well-being and/or quality of life.

2. Repeat steps 2 & 3 cited above.

### Incidents Involving the Department of Corrections

1. Report to DHI all incidents in which the individual is formally involved with the Department of Corrections; use established IR form and procedures. One example of such Involvement is when an individual becomes a ward of the Department of Corrections regardless of the length of time.
2. Repeat steps 2 and 3 cited above.

The follow community resources provide additional information and/or assistance:

- ◇ Southern New Mexico Legal Services  
Clovis: **(505) 769-2326**  
Las Cruces: **(505) 541-4800**
- ◇ San Juan County Legal Services  
**(505) 325-8886**
- ◇ The Arc of New Mexico  
**(505) 883-4630** or **1-800-358-6493**
- ◇ Statewide Lawyer Referral  
**(505) 797-6010** or **1-800-357-0777**
- ◇ Protection and Advocacy  
**(505) 256-3100** or **1-800-432-4682**

## Special Considerations for Individuals with Serious Aspiration Risks

DDSD has adopted a comprehensive approach to addressing the needs of individuals who have serious risks of aspiration. Tools that assist the CM with the special planning considerations posed by aspiration risk are included in this Manual.

- ⇒ **Chapter VI: Keeping Things on Track, Aspiration Monitoring Responsibilities**
- ⇒ **Appendix: DDSD, Identifying Individuals at Risk for Aspiration & What to do about it**

*John is a 42-year old man with mild mental retardation, GERD, pulmonary hypertension, osteoporosis and spastic quadriplegia. John has a history of severe aspiration, documented on video fluoroscopic swallow study. He has had a gastrostomy tube since 2004. He has a doctor's order for NPO (nothing by mouth). He has audible reflux multiple times an hour according to his staff, therapists and family. John states that he has heartburn but he does not like to complain. He has a history of frequent pneumonia, and was hospitalized 3 times in 2004. Since his G-tube was placed, he has not been hospitalized. He has had 2 recent respiratory illnesses with pneumonia in December 2005 and bronchitis 2 weeks ago. He has just recently finished his antibiotics for this bronchitis. He currently is on daytime bolus feedings. He refluxes if too much volume is given or if the feeds are given too quickly. His weight has been stable at 105 pounds.*

*John is his own guardian and is competent to make his own decisions. He realizes that he should not eat orally, and understands the risk of aspiration. However, he has requested that he be allowed to eat on special occasions and he wants to eat at a restaurant once a week with his family. He would really like to eat regular food such as hamburgers, Cheeto's and Dr. Pepper when he feels like it. His mom agrees with his choice to eat by mouth and when he visits her, she feeds him if he asks for it. His team has been informed that they cannot feed him by mouth due to liability issues. John is very angry about this and feels his civil rights are being violated.*

*John then spoke with his new PCP who is willing to discontinue his NPO order to improve his quality of life. The Speech Therapist then worked with John to develop strategies for John to eat as safely as possible. John agrees to have his food chopped into very small bites and to sip from a straw.*

## Special Considerations for Individuals with End of Life Issues

Supports provided at the end of life should improve the quality of life of the individual dying and of the people who have a direct connection to that individual by offering comfort, dignity, education and comfort measures. This includes offering emotional, social, spiritual, and medical help for the individual, the family and direct support staff.

The core decision makers on an end of life support team are the individual, the family/guardian, and the staff. The support team can also include doctors, nurses, aides, social workers, spiritual caregivers, counselors, therapists, volunteers and friends of the individual.

*Arno has lived the majority of his adult life in a Supported Living arrangement with his best friend, Tomas. Hospice services have been provided for the past couple of months and the hospice provider has notified the CM that Arno's condition has worsened and that death is near. The CM reviews material from End of Life training she has received before going to see Arno for what may be the last time. The CM has, in fact, reviewed suggestions on how to be helpful from Arno's perspective that she learned in End of Life training when Arno's hospice services were first being considered. The CM acknowledges her own grief and sadness as she enters Arno's home.*

*The CM spends time with Arno at his bedside. Arno's eyes are closed; he looks like he is sleeping soundly. The case manager speaks softly to him while touching his arm. The CM is respectful of Arno's family who are also in the room. She is aware that Arno can hear what is being said so she is careful about what she says to the family about comfort measures, DNR orders and funeral arrangements.*

*Before the case manager leaves the house, she speaks to the staff and Tomas. Hospice services are providing grief counseling to Tomas, staff and the family, and nursing and comfort measures to Arno.*

*Although the CM is very sad, she is mindful of the work that must be completed following Arno's passing. These include the following:*

- ◆ Filing an incident report with Division of Health Improvement (DHI) and Adult Protective Services (APS).*
- ◆ DHI will place the calls to the provider and CM to discuss the individual's death. DHI will request the last 6 months of records to do a mortality review. The CM will prepare the file for the mortality review.*
- ◆ APS may also make contact with those supporting the individual up through the time of death.*

## How to be Helpful: The Perspective of an Individual Receiving Hospice Services

**Don't feel sorry for me.**

*When you understand I am dying, you respect me and help me have dignity and pride.*

**Touch me.**

*I am still the same person, and no matter how I look, I still wish to be accepted. I am still the same person you always knew. Look deeper than my appearances.*

**Laugh with me, cry with me.**

*I am feeling lots of intense emotions, allow me to feel them. Be there with me when I feel my feelings. You don't have to fix me.*

**Let me talk about my illness if I want to.**

*Help me work through my feelings by listening to me.*

**Let me be silent if I want to.**

*Just sitting with me while I am quiet and you are quiet feels good to me. Quiet support lets me know that I am not alone.*

**Continue to be my friend.**

*Don't let my illness overshadow the good times we have had together. I know that my dying is hard for you too.*

**Offer to help me with the simple chores.**

*Because I am often tired, routine chores are often hard to do. So you help me greatly when you offer to help do chores.*

**Support my family, friends, and animal companions.**

*I am the one who is sick, but they are going through intense feelings of suffering too. Let them express their grief. Please make sure that they have support also and make sure you take good care of my animals. Be there if I want to talk about my dying, and what it's like for me and you.*

**I understand that someone will ask me about my preferences for my arrangements including funeral, burial, cremation, power of attorney, living wills, wills, etc.**

*At first I may not be ready to talk about this stuff, please find a time to ask me again about these important decisions, so that I may have some say in the outcome.*

**Listening may be the most important thing you may do for me as I am dying.**

*Usually when I ask questions about what life means, I really don't want an answer, I want someone to listen to my concerns, fears, and thoughts.*

**Be kind to other people while in my presence, and within my earshot.**

*I may be more sensitive to other people's feelings and emotions, so stay calm around me, and close enough for me to hear you.*

**Talk to me directly.**

*I am dying but that doesn't mean I don't want to be talked to directly. Ask me questions, and tell me when you are about to do something that involves me.*

## Special Considerations for Individuals with Co-Occurring Conditions

Individuals with co-occurring developmental disabilities and mental illness are particularly vulnerable and, in some situations, underserved by social service organizations. While these individuals represent a relatively small number of service recipients, their unique challenges impact team planning and service delivery. Most of these individuals require a coordinated array of support and treatment options that may not typically be found solely within either the developmental disability or mental health service systems. Services are usually organized to address either condition but not both.

Teams focusing on the needs of individuals with co-occurring conditions should focus on the following aspects of planning:

- ◇ The plan should be person-centered and driven by the strengths, needs, and preferences of the individual, regardless of which diagnosis is considered primary and also regardless of traditional service system divisions.
- ◇ Community integration, social competence, individual capacity building, and meaningful community contribution should be emphasized.
- ◇ Accountability, personal responsibility, and responsiveness to community concerns regarding health and safety issues should all be considered in planning.
- ◇ Coordination of services across both the DD system and mental health system is vital.

For more information on planning and program options, contact the DDSD Office of Behavioral Services.

## Special Team Considerations for Individuals Regarding Sexuality

*Jenny, 38, and Eddie, 43, have been dating for almost a year. Both are diagnosed with mild mental retardation and receive residential services from the same agency. Jenny's mother has plenary guardianship, while Eddie is his own guardian. Over the last six months, their relationship has progressed from going out to a few hours together in their homes, having dinner, watching movies and cuddling on the couch. Jenny and Eddie are able to state their desires and needs; the couple has recently expressed a desire to spend time alone in the bedroom. Jenny told her mother, June. June became extremely concerned and contacted Sarah, Jenny's CM (CM). Members of both Jenny and Eddie's teams felt a joint meeting was needed to discuss this issue.*

*Sarah has been a CM for five years and worked with Jenny for the past three. She understands the teams' concerns, but also recognized that sexuality issues for people with developmental disabilities must be handled sensitively. She was also concerned that not everyone on the team was aware of Jenny and Eddie's rights, as stated in the DD Waiver standards and guidelines. Sarah believed this was an opportunity to help educate team members about sexuality issues. In order to advocate for Jenny in a productive manner, she initially met with Jenny's mother and behavior support consultant (BSC). June's fears and concerns were addressed in this small, private setting. During the meeting, Sarah shared information she received from the Sexuality course provided by the DDS Office of Behavioral Services (OBS) and encouraged June and the BSC to enroll in the next available course. June and the BSC agreed the Sexuality course would help them make informed decisions and allow them to view the situation from a new perspective. June said after the training she would like to meet with only Jenny and the BSC, as this would be the most appropriate venue to discuss Jenny's wants and feelings. Sarah spoke to the agency about training for the staff and contacted the local DDS OBS representative to identify resources for additional training and information should it be requested.*

*Eddie's CM received his permission to talk with Jenny's mother and CM. Jenny agreed to participate should the teams feel that a meeting with a few team members and the couple would be helpful and supportive.*

## Special Team Considerations for Individuals Who are Nonverbal

*Mary is a 29-year-old Hispanic woman living in Taos. Mary is a very shy yet curious individual. She has been receiving services through the DD Waiver for almost a year. The team usually struggles in developing a long-term vision in meetings with Mary due to her limited ability to communicate. The team generally develops her "Vision" by observing her actions and following through with what they perceive as her interests. Over the last several months the team has noticed Mary attempting to communicate more through simple gestures such as pointing to and grabbing items she appears to desire. The team has expressed a wish to help Mary increase her means of communication. The team decided to have a Speech Therapy assessment completed to obtain information and recommendations focused on helping Mary communicate more effectively. In the interim, the team began documenting Mary's actions and what each expression might mean.*

<b><i>ACTION</i></b>	<b><i>POSSIBLE MEANING</i></b>
<i>Grabbing a cup</i>	<i>Wanting something to drink</i>
<i>Pulling on her waistband</i>	<i>Wanting to use the bathroom</i>
<i>Pointing at the lamp by her bed</i>	<i>Wanting it turned on/off</i>

*The information was compiled and given to the Speech-Language Therapist (SLP) for planning. Once the therapy assessment was completed the team began developing Communication Supports for Mary. The SLP assisted the team in developing a "Communication Dictionary" using the information provided by the team to support Mary. This will help the team understand Mary's way of communicating. The team also began using objects to help Mary express her desires. Since these supports were put in place the team has noticed Mary interacting more with individuals and expressing her desires in meetings through gestures and objects. The team members are able to understand what her actions and messages mean.*

### ***IMPORTANT CLUES TO ALWAYS REMEMBER:***

- ◆ *Take the time to LISTEN, STOP AND WAIT*
- ◆ *WATCH for actions*
- ◆ *FOLLOW THROUGH with Mary's choices. Following through with the choice is Mary's reward for making the choice.*
- ◆ *AVOID LEADING Mary to choose any particular option*

# Chapter V

## Community Resources & Supports



- ◇ Community Resources & Supports
- ◇ Networking
- ◇ Natural Supports
- ◇ Generic Supports

## Community Resources & Supports

**Individuals should have the opportunity to participate in their community and culture, as we all do, without regard to abilities or limitations.** Team members must come to know the individual's values, beliefs, goals, cognitive and physical abilities, and resources.

The team should brainstorm ways to identify and include activities that utilize natural or generic resources that support an individual's friendships, needs and quality of life, and *may also reduce his/her dependence on the formal services system.*

The case manager's (CM) role is to have familiarity with local community resources so he/she can suggest logical links between the individual's interests and opportunities in the community. If the CM is not aware of a resource that connects to an individual's interest, he/she should ask other team members what ideas they have. The CM, as well as other team members, may need to research new resources if needed.

## Networking

It is important for the CM and team members to "network" with a variety of local resources in order to link the individual with natural and generic supports within his/her community.

- ◇ The team should first try to identify and arrange natural and generic supports within the community.
- ◇ The team should always ask what natural and/or generic supports the person already has available to him; the CM should be sure these are integrated into the Individual Service Plan (ISP).
- ◇ Assist the individual and family in using neighborhood and community supports, services and resources as the primary means of meeting the individual's needs and preferences as identified in the action plans of the ISP.

- ◇ Recruit and involve community members, associations, family, neighbors, co-workers, support groups and other interested persons (i.e. the waitress at the coffee shop) to increase community connections and inclusion.

## Natural Supports

Natural supports are defined as personal relationships and associations developed through an individual's natural environment or community. These supports or individual associations enhance and sustain a person's life, helping them feel included and secure in his/her chosen roles in the community. **Natural supports are people in an individual's life** that are neighbors, fellow employees, family, associations developed through mutual interests and hobbies, community clubs, organizations and civic activities. Natural supports come from diverse populations that reflect a wide range of cultures, neighborhoods and communities. Relationships with these people are natural supports.

As in any relationship, natural supports change through the years. As we grow and our interests expand, some relationships fall away and others are nurtured. These relationships are reciprocal in nature; there is no one method to develop these relationships or supports. Each natural support will be unique as to what it has to offer and how it is developed.\*

*“Friendships and relationships are at the core of ongoing personal satisfaction...Activities by themselves are usually not as rewarding or fulfilling...when you do plan for community activities/outings/events, design them with a purpose—so that connections can happen”. \*\**

*Susan is a 25-year-old Hispanic woman who lives in her own apartment and receives assisted living services through the DD Waiver. Susan has worked at a local nursery for two years. Her co-workers and customers value her*

*willingness and dedication to helping others. Susan has obtained a driver's license and has her own car. Susan expressed to her team that she wants to be more independent in getting to and from work on her own. She told them that she was having car trouble and needed help to get it fixed. Susan did state that she wanted to start saving some of her earnings from work to get the car fixed. Susan voiced concern about not being able to get to work if her transportation wasn't dependable. Susan stated that her job was very important to her and she did not want to lose it.*

*The team suggested that Susan make a list of close friends, co-workers, and family members she could contact to help her if she was having trouble getting to work. Susan contacted those people she thought could give her a ride to work and made arrangements with them in case her car was not available. The team also assisted Susan in obtaining a bus pass and a bus schedule in case she needs to take the bus to work. Susan put the phone list and bus schedule on her refrigerator where she could find it whenever she needed alternate transportation. Car trouble was no longer a source of anxiety for Susan and she felt confident that it would not interfere with the job she valued.*

**Remember:** *Relationships are reciprocal.* The CM should help identify what the person can give back to the relationship (i.e., baking cookies with a staff person for a club meeting or church group). “Assist a person to do a community activity and he will do a community activity. Assist a person to build a friendship and he will have a friend and they will probably spend lots of time in the community doing a variety of community activities.”\*\* The CM and team should brainstorm these ideas and integrate them into the steps of action plans so that direct support staff can implement them consistently and successfully.

Natural supports can help the person with some of the following activities they might choose to do:

- ◆ *Researching, accessing and learning to use* Public Transportation
- ◆ *Participating* in Civic groups

- ◇ *Getting to know* Neighbors
- ◇ *Using* Public Libraries
- ◇ *Attending* Churches & religious organizations
- ◇ *Joining* Volunteer organizations
- ◇ *Helping* with medical or other appointments.

*Morgan is 37 and lives with two other men. Morgan LOVES to eat out at a particular Italian place. He can afford to do it 2-3 times a week. The challenge was that others in the home HATED Italian food. No problem. The weekend staff had a friend who LOVES Italian. He introduced him to Morgan. The two hit it off and 'did Italian', not just every weekend but also once or twice during the week. The staff person moved on to another job after a couple years. Morgan and the staff person's friend kept 'doing Italian'...until that friend also moved on. The staff Morgan had then seemed not to have the time to help him find a new way to eat Italian. The plan was dropped and not picked up again. About two weeks later Morgan began picking fights with one of the other guys in the house. He had never done that before. No one had a clue as to why. Six weeks later Morgan was taken to a psychiatrist who prescribed a medication designed to reduce Morgan's aggressive behavior. \*\* This outcome might have been avoided if a team meeting was called to discuss the issues and "discovered" the Italian meal was dropped. The team could then develop strategies to restore this desired activity to Morgan's life.*

An excellent strategy for helping people find places to belong in their communities is a team meeting for the sole purpose of identifying and setting up natural supports. At this meeting the CM can:

- ◇ With the team and person, identify his/her strengths and abilities as well as the things he/she would be interested in doing.
- ◇ Help the person create a "community road map" which identifies the things he/she can walk to, will need to take a bus to or will need to take a car to.

- ◇ Help the person create a relationship map of his/her various friends and family members and people he/she knows and likes. This will be a foundation for expanding relationships.
- ◇ Invite someone from the community who is very well connected, a *true community networker!* This might be a person who belongs to a civic group, neighborhood association, church or volunteer organization. Ask them for ideas on how to connect the person to the interests he/she may have. They surely will know the right person to call. The CM may need to coordinate with the individual and/or the staff to identify these new team members.
- ◇ If the person is not able to communicate well, the CM might sit with the individual (perhaps before this meeting) and look at magazine pictures together and talk about things the person may like to do. Often a person will react more clearly to pictures, showing likes or dislikes, which can then begin the process of identifying something the person may like to do or participate in.\*\*

## Importance of Natural Supports

The importance of natural supports being in place is highlighted when family members are no longer able to assist with informal respite, recreation, errands and appointments due to some change in their life circumstances. A natural support system involving non-relatives could help with running errands, picking up groceries, visiting, or even dropping off a meal. However, help from friends and neighbors vary widely by individual family and cultural groups. Some families may actively seek help from churches, social, and service organizations. Other families do not seek or accept help from such resources. Keep in mind that not all caregivers and their families provide care in the same way. The CM can expect to see some differences in caring style by gender, cultural group and age. Do not assume that all women, men, older people, or families of a specific cultural heritage, will hold similar

attitudes about the caring role, disability, social activities and the use of community services.\*

## Generic Supports

Generic Supports are generally known and available to the public. Generic supports are any support that can be purchased or arranged for by any individual or family in the community.

An individual needs to be prepared to pay for these services on his/her own or an agency can assist in arranging to pay for the support in the community. Generic Supports are community supports that are not usually paid for through the Waiver.

These include but are not limited to:

1. Dr. Appointments
2. Mental Health Facilities
3. Health clubs
4. A taxi or bus pass
5. Division of Vocational Rehabilitation
6. Department of Labor
7. Psychologist/Psychiatrist
8. Joining an association for some sport or hobby
9. Tax filing assistance
10. Food bank

## Examples of Generic Supports

- ◆ *How can an individual obtain treatment for depression? The team needs to identify local resources (Mental Health Facilities, Hospitals, etc.) to determine if the individual qualifies for outpatient behavioral health services. Then the team may need to identify a source to fund this service. Many civic clubs will donate money for specific services or purchases for people with disabilities who cannot afford the services themselves.*
  
- ◆ *Emma lives in Ireland and loves bird watching. She often goes on long walks by herself and comes back home with stories of the birds she has seen, their names, colors and habits. She also loves to draw pictures of the birds she knows. Emma does not like to be called "disabled" and would really like to have non-disabled friends to spend time with. One of the staff in her home finally called the RSPB (Royal Society for the Protection of Birds) and asked if she could attend their monthly bird watching outing. Emma was warmly invited to join the outing and a staff went along with her to help her make friends with the other members. Emma came home very happy to at last have some friends who didn't see her as a person with a disability, but as a person who loves birds. She was also able to help identify some of the birds they saw and share her knowledge with the other members. The local RSPB had quarterly meetings with speakers and they charged \$5.00 for participants. Emma had to save enough of her own spending money to pay for the meetings. The staff that went with Emma paid their way from the house budget. Interestingly, paying her own way was very important to Emma and a source of pride that she could do that.*

\* **How to Develop Natural Supports: A Quick Look**, based, in part, on The Lanterman Developmental Disabilities Services Act, Section 4512 of the California Welfare and Institutions Code, Part (e).

\*\***Doing It Right, A "How to" Guide for Independent Support Coordinators**, developed for the State of Tennessee Division of Mental Retardation Services, Rucker, Powell and Associates, 2000.

# Chapter VI

## Keeping Things on Track



- ◆ Spending Time with the Individual
- ◆ Telephone & Quarterly Report Monitoring
- ◆ Special Issues to Keep an Eye On
- ◆ Incident Management
- ◆ Request for DDSD Regional Office Intervention

## Chapter VI

# Keeping Things on Track

The Case Manager (CM) is responsible for monitoring services individuals receive through the Developmental Disabilities Waiver (DD Waiver), including:

- ◇ health and safety,
- ◇ finances,
- ◇ services,
- ◇ quality of life,
- ◇ environments,
- ◇ guardianship, and
- ◇ implementation of the Individual Service Plan (ISP).

Monitoring must include:

- ◇ visits with the individual,
- ◇ review of incident reports,
- ◇ telephone contacts, and
- ◇ review of reports from therapists and providers.

### Spending Time with the Individual

When visiting with an individual at a location where he/she is receiving waiver services, the CM is obligated to monitor not only the substance of ISP implementation but also the individual's health and safety. It is important to realize why site visits are conducted. The main reason behind the funding of services through the Waiver is to provide the individual with the supports needed to achieve his/her dreams and aspirations. Sitting in an office all

the time, it is difficult to know if this is happening. Visiting with the individual in his/her environment also helps the CM build rapport which is integral to becoming a strong advocate. When the CM visits the person in the home, day program or community, it offers him/her the opportunity to observe direct support staff and often gain their valuable input concerning the effectiveness of the program. Site visits also provide the CM with the opportunity to personally see if the program is working, or if the team needs to re-convene to review and/or revise the program to make it more effective or more in line with who the individual really is.

- 1) Face-to-face visits with individuals, other than children, are to be conducted a minimum of one time per month for individuals who are not members of the Jackson Class and two times per month for Jackson Class Members.
- 2) For Jackson Class Members, one visit must occur in the individual's home and the second in day services or his/her job in the community.
- 3) For individuals who are not class members, but do receive community living services, a visit in the individual's home must occur at least every other month.
- 4) For individuals who are not class members and do not receive community living services, a visit to the home at least quarterly is adequate.
- 5) For children under the age of 18, the parent/guardian may determine that the CM visit less than the required 12 visits per year, but at a minimum of four times per year.
- 6) Site visits for all other services may occur at the service site (day habilitation program, community employment site, in the school, during medical appointments or during therapy sessions) or in the individual's home.
- 7) If a visit is to occur at the work site, during medical appointments, or at school, the CM must be sensitive to the dynamics of meeting with an individual in these environments. Permission from the individual, the school, the doctor, or job coach

should be obtained first so that the visit does not interfere with the individual's performance of his/her school/job duties, influence the perception of the individual by co-workers, employer, or other students or interfere with medical treatment. If it is necessary to cancel a scheduled site visit, the visit must be re-scheduled within the same month of service.

Health and safety issues to monitor include, but may not be limited to: medical issues; availability and usage of designated augmentative or assistive technology devices; adequacy and appropriateness of clothing, food and financial status; structural state of the site; and presence of trained, qualified staff. Safety issues may also include an individual at risk of exploitation (misappropriation of property or money), injury, unreasonable confinement, or situations that may cause physical harm, emotional distress, or mental illness.

### **Training Resources**

Information regarding health and safety is presented in ***Level One Health Training for Case Managers and Service Coordinators***; dignity of risk is covered in ***ISP Two Day Training, A Positive Team Approach to Development of Behavioral Supports***, and ***Advocacy Strategies for Case Managers***.

Monitoring the substance of ISP implementation entails assuring that action plans, strategies and the medical, therapy and community integration supports are being implemented in accordance with the ISP.

⇒ **Appendix: *DDSD Site Visit Form***

## Visiting the Individual

### Residential & Day Habilitation or Work Settings

- 1) Conduct a face-to-face visit with the individual. Spend time conversing and simply being with the person.
- 2) Conduct part of the visit with family (if the individual is not in residential supports or day program supports) or current staff in order to observe and determine if the program is being implemented in accordance with the ISP.
- 3) Conduct a review of medical and program files if the individual is in residential or day program services.
- 4) Assure that the setting (home, day habilitation, etc) is in safe condition, appropriately staffed, and there are no outstanding health and safety issues.
- 5) Pay attention to the individual's appearance regarding mood, satisfaction with environment and activity, dress, cleanliness and obvious indicators of health.
- 6) When a CM identifies everything he/she is responsible to review during a visit with the individual, it may, at first, appear overwhelming. However, part of the site review process is up to you! The CM needs to use common sense. If an individual is considered to be medically fragile or has quite a few chronic medical needs (e.g. has a seizure disorder and diabetes) it would be important to check the medical files and information every visit. If there has been an ongoing issue that has not been resolved, status should be checked. If the individual is in good health, with no ongoing medical issues, the CM may review the medical information every third visit. It is also acceptable to review the outcomes, action plans, and data every other month if the CM feels the provider has presented accurate and current data.

## Medical Issues to Review

- 1) Review the Medication Administration Record (MAR) and update your list of medications if needed, noting any changes in medications, dosages, administration times, etc. **Review monthly.**
- 2) Note if the individual has taken his medication regularly or has missed any dosages. **Review monthly.**
- 3) During the review of the MAR, note any errors in medication administration. If there have been several medication errors, contact the agency nurse and/or program coordinator no later than the next working day. Request that a plan of action be developed (to prevent these errors from occurring again) and sent to both the DDSD Regional Office and CM. **Review monthly.**
- 4) Check for documentation of occurrences if the individual has a seizure disorder. Note seizures occurring during that month and identify if there has been an increase or decrease in frequency, duration or intensity of seizure activity. **Review monthly.**
- 5) Check documentation regarding medical appointments, emergency room visits, incident reports, or any other health or safety issue. When returning to the CM agency, compare to the primary record to ensure provider(s) have submitted all necessary documentation (i.e. reports from physicians/specialists, incident reports, etc.). **Review at least every other month.**
- 6) For each appointment, document in a progress note the date, physician seen, purpose of appointment or Emergency Room visit and evaluate provider record to ensure instructions from the medical provider are being followed by the responsible team members. **Review at least every other month.**
- 7) Document in a progress note the date of last blood work completed and date next lab work is due if appropriate; and ensure that proof of completion of lab work has been submitted for the CM record. **Review at least quarterly.**

- 8) If the individual is medically involved (e.g. has a seizure disorder, diabetes, is at risk for aspiration, etc.) review medical documentation and assure that the health care plans and crisis plans are current and available to staff and verify staff have been trained according to the ISP. **Review quarterly.**
- 9) If the individual is prescribed psychotropic medications that may cause movement disorders, it is the responsibility of the CM to ensure that regular movement screenings are conducted by a nurse, psychiatrist, or medical doctor (in compliance with the frequency determined by the prescribing practitioner). Documentation of completion must be in both the medical file at the provider agency and the primary file at the Case Management agency. **Review according to the frequency determined by the prescribing practitioner.**
- 10) Assure pertinent training or instruction sheets for staff are readily available, with due regard for individuals' privacy. **Review quarterly.**

## Reviewing Other Program Files

- 1) For any individual receiving residential services (Supported, Independent, or Family Living) supported employment, or adult habilitation services, the CM will review the program or data book located on site.
- 2) **Note:** *If the individual is employed in the community this information may be requested from the job coach; if the job coach is unavailable, request the documentation at a later date and/or time.*
- 3) Ensure that a current copy of the ISP is available to the individual and staff. The best way to ensure this is available is to request that the staff on duty show you where the plan is located (i.e. in the house file, posted in the staff room, on the data clipboard, etc). **Review quarterly.**
- 4) If the ISP and/or data file is not available, contact the program coordinator of the specified agency and ask them to place a current copy of the ISP and/or data file on

site within forty-eight hours, note this interaction in case notes; the CM must then check to assure the needed documentation is on site and staff are aware of the location of the document(s).

- 5) Note if the program being implemented is current. **Review quarterly.**
- 6) Document if data is being taken on a regular basis, in accordance with the ISP. Determine if the data is explanatory, presents a clear picture of the individual's current skill level (what portion of the skill the individual is completing and how much assistance they actually require from staff). The CM must also document whether the skill level increased, decreased or has been maintained and/or if the individual has met the criteria for the outcome/action plan. If the data reveals a decrease in skill area, check the documentation for possible reasons and potential solutions; consider convening the team to problem solve. **Review every other month.**
- 7) **Remember:** *When a desired outcome in the ISP has been attained, the team must reconvene and determine the next step(s) to ensure the individual continues towards accomplishment of his/her long-term vision.*
- 8) Document any notation of behavioral incidents and how the incident was resolved. **Review monthly, as applicable.**

⇒ **Appendix: DDSD Site Visit Form**

## Telephone/Quarterly Report Monitoring

- ◇ The CM may monitor services and complete follow up items by using the phone. Phone calls must be entered into his/her progress notes.
- ◇ The CM is able to monitor services and program implementation through the use of quarterly and semi-annual reports provided by the residential, adult habilitation, supported employment, therapy providers. The only DD Waiver services that do not

require a quarterly or semi-annual report are Respite services and Environmental Modifications.

## Re-evaluation

This section addresses the requirement to re-evaluate/revise the individual's program, as the need is determined through ongoing monitoring and observation/notification of changes in the person's life.

## Guidelines for Emergency Meetings

Although any team member may request an emergency meeting for any of the reasons noted under the next part of the monitoring section *When to Call a Team Meeting*, the CM is responsible for convening the team.

## Case Manager Responsibilities

- ◇ Depending on the nature of the meeting, it is recommended that the CM ask the individual/guardian whom they wish to attend.
- ◇ It is the responsibility of the CM to provide information or resources the individual/guardian needs to prepare for and/or follow-up with the meeting, when requested.
- ◇ The CM is responsible for preparing typed minutes of any interim team meetings (other than the annual ISP) and distributing them to team members. In some cases the meeting may also result in revisions to the ISP.
- ◇ Some team meetings result in a change of services, a change of providers, or a variance in specific hours requested (this usually pertains to therapies). It is the responsibility of the CM to submit such changes to the authorized agent for New Mexico Medicaid Utilization Review (NMMUR) on a revised MAD 046 Budget form

for approval have the secondary Freedom of Choice (FOC) signed and distribute copies to the selected provider agencies.

## When to Call a Team Meeting

Team meetings must be scheduled for a variety of reasons as urgent situations arise. The CM is the person designated to convene a team meeting, but other team members may request that the team convene to discuss issues relevant to the individual's services and supports, including health and safety.

⇒ **Chapter IV: *Planning with the Individual***

The professional judgment of the CM should take into account if the meeting can be held on the telephone, with the CM contacting the involved team members individually, or by informal meeting where a specific issue may get resolved. An example of this would be if the guardian does not feel the residential provider is communicating with them. The CM would schedule a meeting with only the guardian and service coordinator from the agency to resolve the issue. The CM must document that this meeting occurred, and the agreed upon resolution of the issue, in the case notes section of the primary file.

## Special Issues to Keep an Eye On

### Aspiration

The Developmental Disabilities Supports Division (DDSD) is committed to providing support for people on the DD Waiver who have dysphasia or other risks for aspiration. DDSD has developed a policy to clarify expectations for the DD Waiver CM, therapist/eating specialist, agency nurse and dietician/nutritionist.

⇒ **Appendix:**      ***DDSD Identifying Individuals at Risk for Aspiration & What to do About it***

### **Summary of Case Manager Expectations**

1. Assure that the individual is referred for further evaluation if he/she displays any of the warning signs. These include, but are not limited to, the following: coughing, gagging, or excessive throat clearing during or after meals, gurgling sounds in the throat, weak or absent cough, and/or poor head control during the meal.
2. Evaluations may include, but are not limited to: assessment by Primary Care Physician (PCP), video fluoroscopy, or an evaluation by a speech therapist specializing in swallowing disorders.
3. An excellent resource for teams is the Supports and Assessment for Feeding and Eating clinic (**SAFE**) at **(505) 272-0285**.
4. If an individual is found to be at risk for aspiration, the CM convenes a team meeting to identify and develop plans and procedures necessary to minimize that risk.
5. The CM will notify the Aspiration Review Coordinator (ARC) and/or designated DDSD Regional Office staff person to add the individual to the aspiration-monitoring list.
6. If an individual has been determined to be at risk, the CM is to assure that a Meal Time Procedures Packet and/or Feeding Tube Protocol is developed and distributed, and that appropriate staff are trained to competency. If efforts to obtain this information prove unsuccessful, the CM should notify the DDSD Regional Office.
7. Assure implementation of the timelines as described in the Aspiration Procedures document.

8. Complete quarterly review forms and send to designated staff at the DDSD Regional Office (RO).
9. Observe the individual's meal/snack a minimum of every six months.
10. Complete "Quarterly Review for Persons with Dysphasia/Risk for Aspiration" (both residential form and day program form) and send to the designated staff at the DDSD Regional Office.

⇒ **Appendix: DDSD Decision Justification Form**

### **Training Resources**

Aspiration is included in ***Participatory Communication and Choice Making*** as well as ***Level One Health Training for Case Managers***.

## **Incident Management**

Often individuals with developmental disabilities are at a higher risk of being abused, neglected or exploited by others. It is the responsibility of the CM, as well as other individuals, to monitor the individual's health and safety. This occurs during visits and from feedback and reports from team members. This includes assuring that the person is in a safe environment, provided with adequate shelter, food, and clothing. Other areas of concern may include, but not be limited to: inappropriate use of the individual's money or property, discovery of cuts or bruises on the body, inappropriate verbalizations toward individuals, and inappropriate sexual conduct toward others.

It is important to realize that **YOU** and all other team members are obligated by law to report any suspicions of abuse, neglect or exploitation whether you observe the incident or the incident has been reported to you. As a CM you are responsible to report issues as a result of ongoing monitoring of records, visits, services and supports. Teams can request

information on providers or individuals for patterns of alleged abuse, neglect and misappropriation of individual's belongings or money from DHI.

The Incident Management System (IMS) provides a consistent means of reporting incidents regarding alleged abuse, neglect and exploitation of individuals receiving services through the DD Waiver. The IMS is managed collaboratively by DHI/DOH and the Children, Youth, and Families Department (CYFD)/Adult Protective Services (APS).

⇒ **Appendix: *DHI Incident Management System Manual, 2006***  
[http://dhi.health.state.nm.us/elibrary/imbdocs/IMS\\_Booklet\\_SFY2006.pdf](http://dhi.health.state.nm.us/elibrary/imbdocs/IMS_Booklet_SFY2006.pdf)

- 1) All CMs must be trained in the IMS to assure appropriate and timely response when incidents occur.
- 2) The most current Incident Report (IR) form must be used to report and document incidents alleging abuse, neglect, exploitation and to report deaths and other reportable incidents.
- 3) **IT IS IMPERATIVE THAT PRIOR TO FILING A REPORT, THE SAFETY OF THE INDIVIDUAL IS SECURED** (i.e. providing first aid, medical care and/or removal from the immediate environment).
- 4) The staff person with the most direct knowledge of the incident is the individual who reports the incident (this may not be the CM).
- 5) If someone other than the CM files the report, it is his/her responsibility to inform the CM within one (1) working day of the incident and to provide a copy of the report to the CM as soon as possible after it is completed.
- 6) **ANY** suspected abuse, neglect, or exploitation must be reported immediately to CYFD's Adult Protective Services Statewide Centralized Intake, either by faxing the form to **(505) 841-6691** or by phoning **1-800-797-3260**.

- 7) The IR form must be faxed to DHI/DOH at **1-800-584-6057** within 24 hours of the knowledge of an incident or the following business day in the event of a weekend or holiday occurrence, by the person/agency reporting the incident.
- 8) Fax a copy of the report to the local DDS Regional Office.
- 9) Fax a copy of the report to the agency being reported.
- 10) Reportable incidents include alleged abuse, neglect, and misappropriation of an individual's belongings or money.
- 11) It is also mandatory to report incidents involving environmental hazards (i.e. unsafe conditions in the home or community that create a threat to life or health), law enforcement intervention, and emergency services.
- 12) Emergency services are defined as admission to a hospital or psychiatric facility, or the provision of emergency services that results in medical care which is unanticipated and/or unscheduled and would not routinely be provided by a Primary Care Provider. This would not apply to most circumstances when a Primary Care Physician is contacted and the individual is sent, upon the physician's orders, to be seen in the Emergency Room.

If the incident occurred when the individual was not under the direct care or supervision of a DOH-funded or ICFMR provider or if the alleged perpetrator is not a paid employee of the provider agency it does not need to be reported to DHI/DOH. The CM and the team retain the responsibility to report the incident to CYFD/APS if abuse, neglect, or exploitation is suspected.

*Greg was working at the State Fairgrounds. He took the bus to and from work to his home in the North Valley. He started talking to a woman he often saw on the same bus route. She was very friendly and Greg grew to trust her. Soon after they met the woman asked Greg if she could borrow some money. He first loaned her \$5.00 then \$10.00 and soon every week he was loaning her money, which she never paid back.*

*The job coach started noticing Greg didn't have any money for drinks or food like he used to. He asked Greg about it and he told the job coach about the friend he had on the bus who was always borrowing money but never paying him back.*

*The job coach thought this was exploitation so filed an incident report stating that by this time he had loaned out around \$75.00. This was quite a bit for Greg. The job coach also called the CM and asked her to let the people who needed to be aware of it on the team know. The CM talked to Greg who said he was embarrassed and didn't know what to do. Since she was not an employee of any agency connected to Greg and Greg and his family did not want to press charges, the CM decided to get involved.*

*The CM called the residential supervisor and explained the situation. She said she would have her staff talk to Greg about how to make friends without loaning them money. They also coached him on how to ask for the money to be repaid. With the help of the job coach, CM and residential staff he was able to confront the woman and she paid back some of the money. She stopped asking Greg for money and he learned a valuable lesson.*

*The CM talked to Greg and told him how well he had done confronting the woman. She also talked with him about how potentially dangerous it is to make friends with people who you just meet on the bus. She wanted to make sure he understood that it is great to make friends, but also important to be safe. He felt supported by the team and thanked the CM for helping.*

## **Request for DDS Regional Office Intervention**

The **Request for Regional Office Intervention** form was developed by DDS to support the CM (or any team member) to report persistent issues to the regional offices and to be able to know what steps have been taken by the state to help resolve the issue.

⇒ **Appendix: Request for Regional Office Intervention Form**

This form is to be used when a member of the team has identified a continuing issue in residential, day habilitation or community environments. These issues may include but not be limited to:

1. Continued lack of appropriate staffing;
2. Lack of community access;
3. Insufficient food;
4. Family dynamics that may affect the individual;
5. Lack of implementation of parts of the ISP program;
6. Continuous medical errors;
7. Lack of medical follow-up;
8. Assistive/augmentative devices not purchased or in worn condition;
9. Poor condition of durable medical equipment;
10. Unsafe conditions within the home environment; and/or
11. Failure of agencies to provide reports as required per regulation.

When the CM submits this form, it is expected that he/she will have attempted to resolve the issue with everyone involved (i.e. direct support staff, service coordinators, home managers, therapists, agency directors, etc.) prior to contacting the regional office. The CM must follow the directions attached to the form. Time lines are to be followed by all parties. It is recommended that the CM call the Regional Office if he/she has not heard from them within the initial timelines. In conclusion, please report ongoing issues that you have attempted to resolve to no avail.

**IT IS IMPERATIVE THAT THE CASE MANAGER REALIZES THAT THE REQUEST FOR REGIONAL OFFICE INTERVENTION FORM DOES NOT SUBSTITUTE FOR THE INCIDENT REPORT FORM.**

**When you suspect an individual is at risk for abuse, neglect, or exploitation, YOU MUST complete and fax the appropriate forms to Division of Health Improvement and Adult or Child Protective Services**

## **Resolution of Concerns**

In summary, it is the CM's responsibility to continue to monitor all identified concerns, through resolution. The flowchart lists steps the CM must complete to successfully resolve concerns. Common categories, with examples, are listed below.

### **1. Team Conflict**

- ◇ Individual served is dissatisfied with supports/planning
- ◇ Team concerned the individual's decisions put his/her at risk
- ◇ Team disagrees with guardian decisions
- ◇ Team can't reach consensus on an issue
- ◇ Blaming or accusation occur between team members

### **2. Difficult Healthcare Decisions**

- ◇ Decision is complex and hard for individual or healthcare decision maker to understand
- ◇ Individual refuses recommended treatment; team not completely sure of consequences
- ◇ Team members reluctant or refusing to implement decisions made by individual or healthcare decision maker

### **3. Lack of ISP Implementation**

- ◇ Direct support staff not trained on strategies (or other relevant areas of the ISP)
- ◇ Assistive Technology equipment not available or in poor repair
- ◇ Action plans and/or support plans not implemented
- ◇ ISP document and/or support plans not available on site
- ◇ Services not delivered according to plan (e.g. therapists are missing appointments)
- ◇ Choices not offered or honored
- ◇ Identified assessments not completed

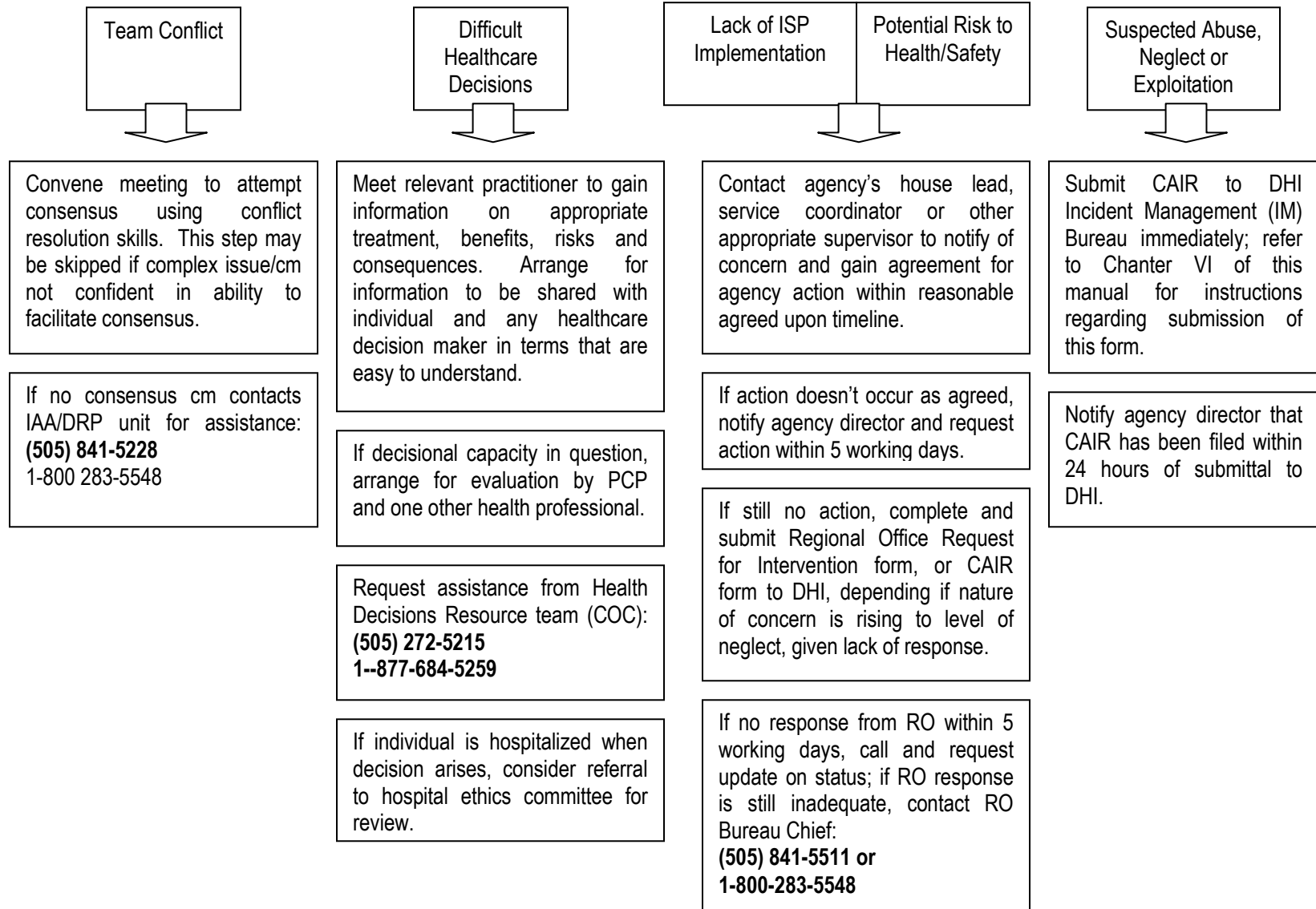
### **4. Potential Health/Safety Risk**

- ◇ Torn carpet creates risk for tripping
- ◇ Air conditioner not operational during summer
- ◇ Broken window fixed with cardboard and tape
- ◇ Environment not consistently clean
- ◇ Food is running low
- ◇ Smoke detector(s) not present
- ◇ Lack of alternative emergency exit route
- ◇ Broken handrails in bathroom

### **5. Suspected Abuse, Neglect or Exploitation**

- ◇ Individual pays for items for staff
- ◇ Staff takes individual's property
- ◇ Medical supports not implemented
- ◇ Staff demean the individual
- ◇ Staff touch individual inappropriately
- ◇ Sexual assault
- ◇ Staff hit, kick or otherwise cause physical harm to individual
- ◇ Staff leave individual unattended (other than as specified in the ISP)

## RESOLUTION OF CONCERNS



# Chapter VII

## Record Keeping on Behalf of the Individual



- ◇ Primary Record Contents
- ◇ Required Information Maintained in the Case Management File
- ◇ Documentation Procedures and Standards
- ◇ Documentation Guidelines
- ◇ Accountable Documentation Practices

## Chapter VII

# Record Keeping on Behalf of the Individual

### Primary Record Contents

Record keeping is an essential part of case management. Personal information is critical for evaluating the effectiveness and efficiency of services, for providing accountability to funding sources (DOH, CMS, etc.), and for reimbursement purposes. The case manager (CM) is required to comply with agency, state and federal requirements regarding documentation. The primary case management record is a unified, confidential collection of documents. This record is to be considered the master file for all information pertaining to assessment, evaluation, finances, service planning, medical information, incident management, case notes, progress reports, meeting minutes and all other collateral information regarding the individual. Although providers should also maintain agency files regarding the individual, essential information identified above must be submitted to the CM in a timely manner for inclusion in the primary file. When information is not submitted in a timely manner, the CM should document all requests in his or her notes and submit the Developmental Disabilities Support Division (DDSD) Request for Regional Office Intervention form.

⇒ ***DOH Policy Governing Primary Record Requirements, Section IV.9***

DDSD and members of the team are “covered entities” according to the Health Insurance Portability & Accountability Act (HIPAA) and therefore releases are NOT needed to share documents between these entities. This applies as well when individuals select new providers through the Freedom of Choice (FOC) process.

Information about an individual must be kept confidential and secure at all times, in compliance with HIPAA Requirements. The CM may use a working file when in the field.

However, the working file must be kept in a secure place such as a locked briefcase or a file box to ensure that only the CM has access to that information when in the field.

HIPAA Regulations must always be followed. Contact the HIPAA officer at your local DDSD Regional Office for more information.

## Guidelines for Primary Record Contents

- 1) The CM must maintain a separate file or record at the CM agency for each individual
- 2) The CM must maintain privacy and confidentiality of individual records.
- 3) Primary Records must be made available to representatives of the State for auditing purposes and upon request.
- 4) The CM must ensure the record contains complete and up-to-date documentation of the individual's care and services.
- 5) The CM must maintain and archive records according to all appropriate laws and regulations.
- 6) The primary record must include sufficient information to demonstrate CM monitoring of team roles and responsibilities. When issues are identified, the case record must contain documentation to support monitoring and action by the CM and other team members through resolution of the issue(s).

The CM must comply with all DDSD record requirements available from his/her supervisor. These include ***DOH Policy on Primary Record and Documentation Requirements*** (February 8, 1998) and ***DDSD Memorandum, Records Retention Period*** (January 15, 1998).

## Required Information Maintained in the Case Management File

- 1) Individual Service Plan (ISP), amendments, revisions
- 2) MAD 046
- 3) Team meeting minutes
- 4) Progress notes from therapists and/or provider agencies
- 5) Quarterly reports from provider agencies and therapists
- 6) Assessments/evaluations from medical providers, therapists, and/or community provider agencies.
- 7) Adaptive Behavior Scale (ABS) (individuals over 16 years of age)
- 8) Vineland Adaptive Behavior Scales (children under 16 years of age)
- 9) CIA (Comprehensive Individual Assessment)
- 10) Support plans (e.g. behavior support plan, career development plan)
- 11) Medical information (i.e. annual exam, level of care, physician notes, and other relevant medical reports)
- 12) Medication documentation, incident reports and follow-up
- 13) Guardianship information
- 14) MAW (Medical Assistance Worker) letters and approval for Medicaid
- 15) Standard case notes written by CMs
- 16) Documentation of orientation provided to the individual and parent/guardian regarding client rights regulations, client complaint procedures, regulations, and dispute resolution process
- 17) Signed primary and secondary freedom of choice (FOC) forms
- 18) Programmatic correspondence applicable to services received by the individual
- 19) Site visit forms

⇒ **Appendix: *DDSD Site Visit Form***

## Documentation Procedures & Standards

As stated above, the CM is responsible for maintaining adequate records to document all CM activities. The CM utilizes documentation practices in accordance with DDS expectations, to capture pertinent and legal information clearly and concisely, as outlined below.

⇒ **Appendix: *DOH/DDS DD Waiver Program Technical Assistance Document Recommended Practices: Service Delivery Documentation***

### Documentation Guidelines

- 1) The CM must document in chronological narrative, each contact with the individual and service providers.
- 2) The CM must document that the individual's health and safety is monitored and ensured on a monthly basis.
- 3) The CM must maintain records in a standard format and sequence.
- 4) The CM must use clear and legible writing. Typing contacts or notes is preferred.
- 5) The CM must record facts only; in the case of information communicated directly/indirectly by any team member, including the individual receiving services, the CM should make a notation that identifies the source of the information.
- 6) The CM must sign his/her name after each record entry.
- 7) The CM will refrain from using correction fluid or erasures, written critical comments or judgments about the individual and leaving blank spaces in the case notes.
- 8) If an individual is physically unable to sign a document and does not have a legal representative, the CM documents verbal discussion with the individual.
- 9) When an individual changes CMs, the existing CM must provide the complete individual record to the new CM at the transition meeting. Documentation of the record transfer must be indicated in the record.

## What Should the CM Document?

- 1) Status on outcomes and action plans
- 2) Quality of services
- 3) If the ISP is being implemented appropriately
- 4) Coordination of services, including referrals and access of services
- 5) Status of assessments
- 6) Any follow-up that is occurring regarding the ISP or general services
- 7) Medical/health update or medication information (e.g. changes in medications)
- 8) All visits and telephone contacts with individual, guardian and providers

## Documentation Must Include:

- 1) Description and purpose of case management activity
- 2) Result or intended result
- 3) Continued service planning need
- 4) Content of contact/conversation and parties
- 5) Date and time of contact or call
- 6) Type of contact (e.g. phone, home, office, other)
- 7) Length of contact or call

## Sample Contact/Progress Note

*9-1-05/10:45 am: The CM received a call from a Leaders Service Coordinator (SC) to address placing Margaret H. on a PRN psychotropic medication, recommended by her psychiatrist to assist with aggressive behaviors. CM explained to SC that per DOH policy dated 3-1-03, there are requirements for the use of PRN psychotropic medications, e.g., Human Rights Committee review, BSP components, integration into ISP, etc. CM told SC that a team meeting will be scheduled ASAP to address the psychiatrist's recommendation and assess the appropriateness of the medication as related to Margaret's needs and circumstances. CM will contact all team members to set up the meeting.*

## Accountable Documentation Practices

- ☒ “If you didn’t document it, you didn’t do it!” Remembering this important statement may 1) help you preserve an individual’s personal history and record of services and supports and 2) save you a lot of grief or legal repercussions.
- ☒ Chronological sequence is important.
- ☒ Ambiguity in wording can lead to misinterpretations. Be Clear!
- ☒ Use black ink and write legibly.
- ☒ Do not erase or use white out. Instead, draw a single straight line through the mistake. Then, write the word “error” and place your initials above the mistake.

### **Example:**

#### **Error JTL**

I fix my ~~mystakes~~ mistakes this way.

## Chapter VIII

### Creating the Individual's Budget and Billing for Services



- ◆ **Annual Resource Allotments (ARA)**
- ◆ **Services in Excess of the ARA**
- ◆ **Authority and Responsibilities of the Case Manager**
- ◆ **Completing the DD Waiver Individual ARA Budget Plan**
- ◆ **Additional Services outside the ARA**
- ◆ **Completing the Waiver Review Form (MAD 046)**
- ◆ **Process for Changing Units**
- ◆ **Approval or Denial of the MAD 046**
- ◆ **DD Waiver and Basic Medicaid Benefits**
- ◆ **Billable & Non-Billable Activities**

## **Chapter VIII**

# **Creating the Individual's Budget & Billing for Services**

The Medicaid Waiver for individuals with Developmental Disabilities (DD Waiver) was made possible by Title XIX: Home and Community-Based Services Act of 1981. This act made an exception to or 'waived' traditional Medicaid requirements by making Medicaid funds available for home and community-based services as an alternative to institutional care for people with developmental disabilities.

The following information is provided to support the case manager (CM) in completing budgets and billing for services provided through the DD Waiver. The new CM must complete training and/or mentorship, as specified by the Developmental Disabilities Supports Division (DDSD) prior to completing Annual Resource Allotments, MAD 046 forms and/or billing for services.

### **Annual Resource Allotments (ARA)**

#### **History**

The state of New Mexico must assure the federal government that services delivered to individuals under the DD Waiver program are less expensive than serving those same individuals if they were in institutional settings such as an ICFMR. Historically, DDSD established a maximum amount for each type of service that Individual Service Plans (ISP) were allowed to include, in order to assure this cost effectiveness. In other words, only a

certain number of therapy units were allowed, a certain number of respite hours, a certain number of nursing hours and so forth; each service had its own cap.

Beginning July 1, 2002 DDSD changed this budgeting process to a system of Annual Resource Allotments (ARA), within which teams can select any amount of particular services, as long as the total cost of services does not exceed the amount of the individual's allotment. In other words, an ARA is a maximum budget amount, within which specific services must fit. This is intended to give individuals and their teams more flexibility in meeting individuals' unique needs, while still assuring the cost effectiveness of the overall program.

### Parameters for Annual Resource Allotments (ARA)

Individual ARA amounts are based upon the individual's age, Level of Care (LOC) score and residential service status. Service menus are slightly different for children versus young adults and adults. Parameters for each category are outlined below. Children whose 18<sup>th</sup> birthday occurs part way through their ISP "year", and are not in school, may choose to continue with services under the children's category until their annual ISP date, or they may choose to transition to the young adult category immediately.

The ARA does not include residential services, called Community Living Supports. The ARA amount is somewhat lower for individuals receiving Community Living Supports because the residential provider is required to provide certain supports as part of that service, such as transportation, personal care and nursing. If an individual moves into Community Living Supports during the ISP year, the ARA will be prorated based upon the percentage of funding used up to the date Community Living Supports began. Children are not eligible for Community Living Supports, unless an exception is granted by DDSD.

The ARA amounts are lower for adults age 18-21, than for those 22 and over, because young adults continue to be eligible for special education services through the public schools until their 22<sup>nd</sup> birthday, and therefore should not need to purchase as many day program services through their ARA. However, if a young adult receiving Community Living Supports is not enrolled in public school, he/she may access the Adult 22 and older level of ARA funding. Please be aware that the ARA amounts may be adjusted periodically, so check current limits with your supervisor. The following tables are current as of July 1, 2006.

### Allotments for Individuals Not Receiving

#### Community Living Supports

Age Range	Level of Care	ARA amount
Children up to age 18	1	\$32,495
	2	\$26,975
	3	\$21,453
Young Adults age 18-21	1	\$43,958
	2	\$41,434
	3	\$38,910
Adults age 22 and older	1	\$45,956
	2	\$40,803
	3	\$36,527

#### Allotments for Adults Who Also Receive Community Living Supports

Age Range	Level of Care	ARA amount
Young Adults age 18-21	1	\$23,577
	2	\$19,771
	3	\$16,300
Adults age 22 and older	1	\$36,436
	2	\$27,847
	3	\$24,055

#### Services Children may obtain through their ARA

**Note:** Please review the current DD Waiver Service Standards for definitions and requirements of each service.

- ◇ Case Management (children require a minimum of 4 monthly units, maximum of 12)
- ◇ Behavioral Support Consultation\*
- ◇ Community Access
- ◇ Occupational Therapy \*
- ◇ Physical Therapy \*
- ◇ Respite
- ◇ Speech Therapy \*
- ◇ Environmental Modifications
- ◇ Goods and Services
- ◇ Personal Care

\* Only to the extent not covered through Early Periodic Screening Diagnosis and Treatment (EPSDT).

## Services Young Adults and Adults age 22 and older, may obtain through their ARA

Young adults, and adults age 22 and older, who **do not** receive Community Living Supports, may select from the following menu of services:

- 1) Case Management (12 monthly units required)
- 2) Adult Habilitation
- 3) Behavioral Support Consultation
- 4) Community Access (supports to increase individuals' independence, participation in their community, and self-advocacy skills)
- 5) Individual Supported Employment

- 6) Intensive Supported Employment
- 7) Group Supported Employment
- 8) Occupational Therapy
- 9) Physical Therapy
- 10) Personal Care
- 11) Private Duty Nursing
- 12) Respite
- 13) Speech Therapy
- 14) Environmental Modification
- 15) Goods and Services
- 16) Nutritional Counseling
- 17) Substitute Care (Similar to Respite, but only for Family Living providers)

Young adults and adults who receive Community Living Supports may also choose from the above menu with the exception of the following services, which are provided as part of Community Living Supports. The residential provider is obligated to provide the following three (3) services:

- ◇ Personal Care
- ◇ Private Duty Nursing
- ◇ Nutritional Counseling

If an individual does not receive residential services, Personal Care, Private Duty Nursing, Nutritional Counseling may be added to the budget.

**Respite** is available for children and adults who live at home and have unpaid caregivers. Substitute Care is available only for Family Living providers. Family Living providers do not have Respite.

**Community Access** may be provided anytime. Community Access services do not include activities that would normally be part of an individual's residential life. Community Access services are designed to support active engagement in community life through participation in community cultural, social, civic, political, religious and/or recreational groups that include individuals who do not have disabilities who share a common interest.

For individuals with Community Living Supports, Non-Medical Transportation services can be purchased from **Goods and Services** through the ARA and are available only under the following conditions:

- ◇ Travel in excess of 100 miles round trip, which is required to meet ISP outcomes;
- ◇ Travel to and from the individual's employment; even if the individual is traveling from the site of another DD Waiver Service, e.g. Community Living or Adult Habilitation Services; and
- ◇ Non-medical transportation services are not used during the hours the individual receives Adult Habilitation services.

## Services in Excess of the ARA

There are three (3) services not included in the ARA but purchased in addition to services included in the ARA:

- ◇ Community Living Services which include Supported Living, Family Living, and Independent Living;

- ◇ Outlier Services which are one-to-one staff support for individuals with very high medical or behavioral needs. Outlier services are added on to existing residential and/or day services; and
- ◇ Environmental Modifications

## Exception Process

In some circumstances, DDS may authorize additional therapies and/or supported employment beyond the ARA through the **Exception Process**. These requests may be made, even if the individual has not utilized the full amount of his/her ARA. However, if there are funds available within the ARA, DDS advises that the team use the ARA to obtain additional needed therapies. The CM can authorize therapies within the ARA ceiling directly rather than having to go through the approval process with the DDS Regional Office. The Exception Process is as follows for therapies:

- ◇ CM submits a packet to the Regional Office with the current ISP and Provider Request form.
- ◇ The need for additional therapy services must be clinically justified with supporting documentation.
- ◇ The individual has already used at least \$6,000 worth of his/her ARA to obtain any combination of therapy services.
- ◇ The specific therapy requested must have already been funded at some amount under the individual's ARA.
- ◇ The additional therapy will not exceed: 72 hours each of OT, PT, SLP if it is the first year for the given therapy or 58 hours for subsequent years unless an approved clinical justification is granted, and 104 units of Behavior Consultation.
- ◇ Supported Employment: For all Adult and Young Adult Categories, additional funding outside the ARA may be requested to meet the needs of individuals who are

employed, or want to be employed, but resources within the ARA are insufficient to provide needed supports and services. The additional funds will be used for Supported Employment Services to assist the individual to gain or maintain employment or to maximize the number of hours they are able to work.

Environmental Modification Services are also available, but not included in the ARA amount. Providers of these services may be selected from the Freedom of Choice (FOC) list available from each DDS Regional Office, in the same manner that the individual or their guardian selects other service providers. Environmental Modification Services involve purchase and/or installation of equipment and/or modifications to the individual's residence necessary to ensure or to enhance the individual's level of independence and/or accessibility in the home environment. Funding for adaptations is capped at \$8,500 every five (5) years, inclusive of the provider's administrative cost. Examples include ramps, lifts, roll-in showers, doorway widening, alarm or signaling systems, voice activated devices, etc. Environmental Accessibility Adaptations may not be used for the individual's employment site or for vehicles. Division of Vocational Rehabilitation (DVR) may be a possible funding source for these needs.

### **Authority and Responsibilities of the Case Manager with Respect to Billing and Budgets**

- 1) After the Action Plan section of the ISP is completed, the CM should conduct a 'budget caucus' with the individual and family/guardian to discuss which services are priorities and which they might choose to forgo if there is not enough funding in the ARA for everything. This caucus can be as short as 20 minutes or as long as necessary. The CM, with the individual and family/guardian, reconvene with representatives from all provider agencies (with authority to sign the budget) and discuss allocation of ARA resources and finalize the budget. ***These supports must***

***directly relate to supports necessary for the individual to reach his/her desired outcomes, participate in the community, and assure his/her health and safety.***

This meeting may be separate from the annual meeting held to develop the ISP, or may just follow a break for the caucus on the same day as the ISP meeting.

- 2) Explore alternatives to DD Waiver services that could support the individual so that ARA funds are only used for supports that are not otherwise available (e.g. maximize natural supports).
- 3) Based upon team decisions made at the ISP meeting, the CM completes the ISP document and Waiver Services Review Form (MAD 046).

⇒ **Appendix: Sample MAD 046**

- 4) The CM has five (5) working days from the ISP meeting to obtain signatures to verify supports that are agreed upon by the providers. If providers fail to sign the MAD 046 in a timely manner, they are ineligible to bill for services; however providers remain responsible for provision of all services identified in the ISP developed by the team.
- 5) The CM has sole authority to approve the MAD 046, unless one of the criteria below, which requires New Mexico Medicaid Utilization Review (NMMUR) approval, is met:
  - a. The individual will be accessing a Community Living Support for the first time,
  - b. The individual is changing from a less restrictive Community Living to a more restrictive Community Living Service (e.g., moving from Independent Living to Family Living or from Family Living to Supported Living),
  - c. Awake at Night Staff is requested for a Community Living Support, for the first time,
  - d. Outlier funding is being requested for the first time or to be continued for an additional six (6) months, or
  - e. Department of Health (DOH) requests a third party review.
- 6) Even though NMMUR approval of the budget is not needed according to the above criteria, the CM must submit the MAD 046 to NMMUR for data entry. The MAD 046

must be submitted at least 30 calendar days before the expiration date of the current ISP.

- 7) If NMMUR approval is needed, relevant justification and supporting documents must be submitted with the MAD 046 at least 30 days prior to ISP expiration, but not sooner than 45 days prior to ISP expiration.
- 8) Monitor utilization of the ARA budget. ***This is very important, as funding for services will terminate until the beginning of the next ISP year if the individual uses all the funding in the ARA prior to the end of the ISP year.*** When this information is requested, DDSD Regional Office case management coordinators can provide technical assistance to the CM.
- 9) Prepare and submit revisions to the ARA budget as needed. The CM has two (2) weeks to submit budget revisions requested by providers.
- 10) Prepare and submit requests for exceptions to the ARA.
- 11) Monitor quality, effectiveness and appropriateness of services and supports delivered. As part of this monitoring, a face-to-face visit with the individual must occur at least once each month (twice each month, if the individual is a Jackson Class Member).

Although there is no specific training in this area, DDSD Regional Office staff are available for any needed clarifications and other technical assistance.

## Completing the DD Waiver Individual ARA Budget Plan

### Background

The ARA budget plan is used to determine how much money is being spent for the individual. The team needs to budget funds so that they stay within the allotted ARA. The DD Waiver Individual ARA budget plan is to be reviewed by the team during any meeting

that requires the team to address the budget in ensuring all relevant services are included in the ARA budget plan.

All services included in the ARA budget plan must be transferred to the MAD 046, including needed services that are outside the ARA (i.e. residential services). The CM will complete the ARA budget form and the MAD 046. The ARA form is generally addressed and reviewed by the team at the ISP meeting; however, the CM can insert the basic information and then, back at his/her office, enter the units and amounts on the computer in order to determine how much money is being spent within the ARA and make sure the ARA budget is not exceeded. If correct, the services are transferred to the MAD 046.

⇒ **Appendix: ARA Budget Forms  
MAD 046**

Keep in mind that there are **5** different ARA categories of budget plans as follows:

- 1) **Children's ARA:** Children up to the age 18
- 2) **Young Adult ARA:** Age 18-21 (for individuals not receiving Community Living Supports)
- 3) **Young Adult ARA Community Supports:** Age 18-21 for individuals receiving Community Living Supports
- 4) **Adult ARA Supports:** Age 22 and older for individuals not receiving Community Living Supports
- 5) **Adult ARA Community Supports:** Age 22 and older for individuals receiving Community Living Supports

## Additional Services Outside of the Annual Resource Allotment

### Adult Community Supports, Adult ARA, Young Adult Community Supports and Young Adult ARA

1. Environmental Accessibility
2. Adaptation Consultant
3. Supported Living
4. Independent Living
5. Additional Therapy hours (exceptions as per criteria noted in *Services in Excess of the ARA*, Paragraph # 2)
6. Outlier – These services are outside the ARA budget, do not impact or change the ARA, and do not use any of the ARA funds. Residential and Day Habilitation services are outliers.
7. Additional Supported Employment (Exception Process)

*Bob's annual ISP meeting has just been held, as his plan will expire later this month (November). Bob celebrated his 21<sup>st</sup> birthday in October and will continue to attend high school until graduation this coming May. He lives at home with his two parents. Due to cerebral palsy, Bob uses a wheelchair and a computerized augmentative communication device.*

*During the strengths, preferences and needs portion of the ISP, the team discovered that Bob loves to spend time cruising the internet on his computer; he especially enjoys trading for comics over sites such as E-Bay and participating in chat rooms related to his interest in comic books. He also stated his desire to move to a place of his own and to have a girlfriend - these desires were incorporated into Bob's long-term vision. He also wishes his laptop had wireless internet capacity so that he isn't limited to use of the PC in his bedroom when accessing the internet.*

*The team was also reminded of the importance of supporting Bob to prevent pressure sores. Last year he suffered greatly with a pressure sore. Luckily this was successfully treated and the physical therapist was able to obtain a new type of padding for his wheelchair; he hasn't had any additional problems with pressure sores so far. Since his father's back injury, the family also requires assistance in helping Bob bathe. The physical therapist and speech language pathologist have both requested 72 hours each of therapy, given the number of hours utilized last year.*

*Desired outcomes from Bob's action plan include:*

- 1. Moving to a place of his own after graduation;*
- 2. Finding a girlfriend; and*
- 3. Getting a job after graduation; preferably in a comic book store or one related to computers.*

*As a Young Adult at Level 2, Bob has \$41,434.00 in his ARA to work with. During the budget caucus with Bob and his parents, the CM discovers that Bob's parents' 25<sup>th</sup> wedding anniversary is coming up in April and they are planning a "second honeymoon" to Australia for three weeks; therefore they are requesting a significant amount of Respite to be included for this purpose, as well as other breaks throughout the year. They also emphasize how important personal care support is to their family in helping Bob bathe three times each week. The team had suggested some Community Access services to support Bob in attending activities where he might meet young women with similar interests. Bob likes this idea very much.*

*Bob's father is concerned that the therapists are asking for more hours than Bob will really need this year. Last year it took a lot of trial and error for the communication device to work for Bob, but now it's working well. Also, last year there was a lot of physical therapy time wrapped up in adjusting Bob's wheelchair, creating a support plan, and training everyone on how to help Bob prevent pressure sores, but now all of that is also going well.*

*Bob's father is questioning why he would need more than one-hour of each therapy per week. In addition, Bob is asking that supported*

*employment be included in his budget starting in June, after he graduates, so he can find a job in order to afford his own place. The CM explains that for approximately the first six months, DVR should pay for job development and so he probably won't need to use his ARA for that purpose until next year.*

*Based upon all these consideration (see below), it looks like the supports that Bob and his family want and need can be provided well within the existing ARA and no exceptions are needed. The CM reminds Bob that she can help him revise the budget at any time if his situation changes and that it will likely be different next year, especially if Bob moves to his own place. The CM, Bob and his family agree to present the following back to the team after lunch:*

<i>Respite:</i>	<i>2,360 (15 minute) units = \$8,142.00</i>
<i>Personal Care:</i>	<i>312 hours = \$4,396.08</i>
<i>Community Access:</i>	<i>384 (15 minute) units = \$1,416.96</i>
<i>Physical Therapy:</i>	<i>58 hours (232 units) = \$5,426.48</i>
<i>Speech Therapy:</i>	<i>58 hours (232 units) = \$5,426.48</i>
<i>Supported Employment:</i>	<i>DVR will fund beginning next summer</i>
<i>Goods and Services:</i>	<i>\$500.00 to purchase wireless Internet hardware and software for his laptop</i>
<b><i>Total:</i></b>	<b><i>\$25,308.00</i></b>

*The team agrees with this proposal as a starting place, with the caveat that PT will be increased if Bob has recurrent problems with pressure sores. The CM completes the MAD 046 and submits it to BC/BS for data entry.*

## Children's Services

- ◆ Environmental Modification
- ◆ Additional Therapy hours (exceptions as per criteria noted in Services in Excess of the ARA, Paragraph # 2)
- ◆ Outlier

## Completing the Waiver Review Form (MAD 046)

The Medical Assistance Division (MAD) Waiver Review form (MAD 046) is to be completed by the CM and signed by all relevant team members to indicate their agreement to provide listed Waiver services in accordance with the ISP. Signatures by providers must be obtained within five (5) working days of the annual ISP meeting (or any interim team meeting resulting in change(s) to the current services and/or budget.

⇒ **Appendix: MAD 046**  
**Sample MAD 046**  
**Case Management Service Standards**

<http://www.health.state.nm.us/dds/regulationsandstandards/ddwaiverstandards/ddwaiverstandards3-1-03.pdf>

## Process for Changing Units

When there is a need for a change within the individual's ISP, the team needs to agree to complete a revision to the budget to either reduce or increase the service units to support the individual's dreams, aspirations and outcomes. The Day Habilitation examples that follow demonstrate this process.

### Example

*In February 2004, Patti's ISP initially requested 1278 units of Day Habilitation services. In July 2004, Patti's circumstances changed, which necessitated a change to Patti's ISP that resulted in the need to reduce Day Habilitation services and increase Respite services. Use this example to review the following formulas to increase or decrease units provided below.*

## Formula for Reducing Units

Use a new MAD 046 form for a revision and clearly mark "Revision" on the form. Indicate which revision number of the ISP this is for tracking purposes and billing issues.

1. In the example above, changes to Patti's life and ISP will result in a decrease in day habilitation services.
2. On the first line item of the Waiver Review form (MAD 046), under the "Units Requested" box write the words: "Reduce to (number) units".
3. The revised number of units entered should reflect the total number of units that have been and will be used for the entire timeframe of the services for **this** plan year. (Not to include services from prior plan year.)
4. To calculate and make the reduction, the CM :
  - ◇ Determines the number of units already used for Day Habilitation services. In this case 552 units were used;
  - ◇ Determines the number of units needed for the remainder of the plan year. In this case, 500 more units are needed for the remainder of the plan year;
  - ◇ Adds the number of units in 1 to the number of units in 2. In this case 552 units + 500 units = 1052 units.
  - ◇ The total number of units (1052 units) for the timeframe of Day Habilitation services for this plan year (February 2004 to February 2005) is written on the first line item of the Waiver Review Form (MAD 046) under the "Units Requested" column. **Example:** *Reduce to 1052 units.*

### Formula for Increasing Units

- 1) On the first line item of the Waiver Review Form (MAD 046), under "Units Requested" write the words: "Increase to (number) units"
- 2) The revised number of units entered should reflect the total number of units that *have been* and *will be* used for the entire timeframe of the services for *this* plan year. (Not to include services from prior plan year.)

- 3) In the example above, the change to Patti's circumstances that necessitated a change to her ISP reducing Day Habilitation services also necessitated an increase in Respite services. Patti's February 2004 budget requested 200 units of Respite services. An additional 100 units of Respite services are needed.

To increase Respite units, the CM:

- ◆ Identifies the number of Respite units requested on the current version of this ISP. In this case 200 units were requested.
- ◆ Identifies the additional number of Respite units now required. In this case 100 additional units are required.
- ◆ Adds the number of units in 1 to the number of units in 2. In this case, 200 units +100 units = 300 units.
- ◆ The total number of units (300 units) for the timeframe of Respite services for this plan year (February 2004 to February 2005) is written on the second line item of the MAD 046 under the "Units Requested" column. Example: *Increase to 300 units.*

## Approval or Denial of the MAD 046

Once the ISP, ARA and MAD 046 are completed, the CM must submit the documents for quality assurance through the agency. Once this process is completed, the agency will submit the documents to NMMUR for utilization review and/or data entry. In some situations NMMUR must authorize services being requested on the MAD 046 (see table below), otherwise the MAD 046 is authorized by the case management supervisor and sent to NMMUR simply for data entry.

The review process by NMMUR results in approval or denial of the MAD 046 based on whether the budget, LOC, and ISP reflect the team's consensus regarding the individual's

service needs. Once NNMUR receives the MAD 046 from the CM, it will have six (6) working days to:

- ◇ Approve it,
- ◇ Deny it, or
- ◇ Return it to the CM for correction or to request additional information, clarification, and/or corrections from the CM regarding proposed services prior to payment authorization. This is often referred to as a “buck back.” This request will be submitted by NNMUR on a standardized form.

Requiring New Mexico Medicaid Utilization Review	Required Supporting Documents
Initial Community Living Services	Documents demonstrating that less restrictive services will not meet the individual's needs (e.g. Respite and Personal Care). See <b>DD Waiver Service Standards</b> for criteria.
A change from one type of Community Living Service to another (e.g. from Supported Living to Family Living)	Documentation from the team explaining why the change is in the individual's best interest.
Request for Outlier Staffing	Outlier Worksheet completed by service provider, and a copy of the ISP and MAD 046. Refer to <b>DD Waiver Service Standards</b> for criteria.
Request for Awake at Night Staffing	Documents justifying the need for this level of staffing (for initial request and every six (6) months thereafter). For example: a letter from the individual's physician indicating the need for frequent monitoring of a medical condition throughout the night.

## Training Resources

Training is available from DDSD Regional Offices regarding completion of the **Outlier Worksheet**.

Exceptions of the ARA for therapies and Supported Employment are approved or denied by the DDSD Regional Office. See the **DD Waiver Service Standards** for information on requesting an exception to the ARA.

⇒ **DD Waiver Service Standards**

[www.health.state.nm.us/ddsd/regulationsandstandards/pg01standards.htm](http://www.health.state.nm.us/ddsd/regulationsandstandards/pg01standards.htm)

## DD Waiver Services and Basic Medicaid Benefits

Individuals on the DD Waiver maintain their eligibility for all basic Medicaid benefits available to other Medicaid recipients. If the individual receives his/her basic Medicaid benefits through one of the three Salud Managed Care contractors, he/she is likely to receive case management and/or care coordination through that contractor as well as from his/her DD Waiver CM. Case management and/or care coordination through the contractor can be very helpful in addressing concerns about accessing necessary medical and/or behavioral health services.

Member Services can help link you with the appropriate Salud CM/care coordinator if the individual has specific questions about his/her Salud benefits. The DD Waiver CM can contact Member Services regarding general questions about Salud benefits.

- ◆ Lovelace Salud:                   **(505) 232-2700** (Albuquerque)  
   **1-888-232-2750** (toll free)
- ◆ Presbyterian Salud: M-F 7:00 am-10:00 pm  
   **(505) 923-5200** (Albuquerque)  
   **1-888-977-2333** (toll free)

- ◇ Molina: M-F 8:00 am-5:00 pm  
(505) 342-0595 (Albuquerque)  
1-800-580-2811 (toll free)

All three Salud contractors use the same agencies for dental and vision services as follows:

- ◇ Doral Dental: 1-800-417-7140
- ◇ Vision Service Plan: 1-800-877-7195

Each Salud contractor uses a separate company to handle transportation to medical appointments as follows:

- ◇ Lovelace Transportation: 1-877-735-0111
- ◇ Presbyterian Transportation  
Northern New Mexico: 1-800-725-3467  
Southern New Mexico: 1-800-432-9630 (Call 24 hours in advance)
- ◇ Molina Transportation-ITM: 1-888-593-2052

The Contract Administration Bureau at MAD oversees the above three managed care contractors. They can be reached at **1-888-997-2583** if the individual has a problem or complaint with his/her Salud benefits. (Be aware that each Salud contractor also has a grievance process in place that can be initiated by calling Member Services for the particular Salud entity.)

If the individual is exempt from Salud and receives Medicaid benefits through the Fee for Service system of independent Medicaid providers, information can be obtained through the Benefits Bureau at MAD by calling the Division Director at **(505) 827-3134** (or call toll free at **1-888-997-2583** and ask to speak to a representative in the Benefits Bureau). In addition, Medicaid has a tribal liaison to assist Native American recipients. The CM can call the above toll free number and ask to be transferred to this individual as well.

## Billable and Non-Billable Activities

Case management providers are obligated to comply with Medicaid Waiver billing rules and regulations. All billable case management activities must be documented. Medicaid requires that providers maintain up-to-date written documentation of all services provided. Date of service, in and out times, legible narratives and CM signature must be provided. This documentation may be maintained in the case management case notes or progress notes. The ***DD Waiver Service Standards: Case Management Services*** states the following regarding billable services:

- ◇ Billable case management activities include services and supports within the Scope of Service.
- ◇ Case management may be provided at the same time on the same day as any other service.

⇒ ***Billing Instructions-Long Term Care Services-Attachment D***

[http://www.state.nm.us/hsd/mad/pdf\\_files/Billinginstructions/8314.pdf](http://www.state.nm.us/hsd/mad/pdf_files/Billinginstructions/8314.pdf)

### Activities that are Billable

- ◇ **Facilitating** team meetings and ongoing eligibility determination for the DD Waiver.
- ◇ **Assessing** an individual's need for services, identifying strengths and desired outcomes.
- ◇ **Service Planning** based on current assessments.
- ◇ **Monitoring** implementation of the service plan and to ensure health and safety.
- ◇ **Re-evaluation** of services for effectiveness and efficiency.
- ◇ **Record keeping** to maintain current service plan, medical information, documentation of monitoring efforts, narratives, and billing requirements.
- ◇ **Coordinating** specialized, generic, and natural supports and services.

## Activities that are Non-Billable

- 1) **Direct clinical services**, therapy and other direct services;
- 2) **Transporting** individuals to medical appointments, therapy sessions, place of employment, etc.;
- 3) **Travel** to and from visits with the individual, team meetings, site visits, etc.
- 4) **Case management** services provided to individuals in nursing homes, hospitals and other such facilities;
- 5) **Discharge planning** for individuals in nursing homes, hospitals and other such facilities;
- 6) **Case management** services provided to individuals who are ineligible for the DD Waiver program;
- 7) **Outreach activities**;
- 8) **Case management** services to individuals that are not residents of New Mexico; and
- 9) **Participation in training** in any educational courses or DDSD required trainings except for Individual-Specific Training in the ISP in which the CM is a required to participate

The CM is eligible to bill for services from the date the signed *Freedom of Choice* (FOC) is received at the agency and work begins on the LOC packet. There are two FOC levels. **Primary FOC** means that an individual or the court appointed legal guardian applying for Waiver services is assured the opportunity to choose his/her own case management agency. **Secondary FOC** refers to the individual's or the court appointed legal guardian's right to choose an authorized service provider as long as the particular service has been approved in the ISP. The decision to change providers can be made by the person or his/her guardian.

The case management agency compiles and submits billing for reimbursement on a monthly basis. The new CM will be trained by the agency. The CM is responsible for submitting information and documentation according to the timelines established by the agency. The CM may be required to complete additional training or mentorship as identified by DDSD.

# Chapter IX

## When an Individual Changes Services



- ◆ When an Individual Changes Case Management Agencies
- ◆ When an Individual Changes Service Providers
- ◆ Suspension of Services
- ◆ When an Individual Withdraws from Services
- ◆ When an Individual's is Terminated from Services
- ◆ Death of an Individual

## **Chapter IX**

### **When an Individual Changes Services**

This section of the manual provides guidance when the individual chooses to change case management or service provider agencies, moves to a different region of the state or out of state, is discharged (either voluntarily or involuntarily) from the Developmental Disabilities Waiver (DD Waiver), or if the individual dies. The role of the case manager (CM) is extremely important to the individual in these situations. If a transition does not occur in a timely manner, the individual could miss out on services he/she needs. This is unacceptable to everyone as a disruption in continuity of services may cause an individual to lose skills or simply become confused and distressed.

It is also imperative that if the individual withdraws from or is suspended from the waiver program, he/she is informed of the consequences of his/her actions. This falls upon the shoulders of the CM. If the individual is suspended or terminated from waiver services, the CM is responsible for providing information and support should the individual care to appeal the decision.

### **When an Individual Changes Case Management Agencies**

If an individual/guardian chooses to select a different case management agency, the steps listed below must be followed so that case management information is provided to the new agency and that critical issues affecting an individual's health and safety do not get 'lost in the shuffle'.

1. ***It is the responsibility of the individual/guardian to contact his/her local Developmental Disabilities Supports Division (DDSD) Regional Office to initiate the Primary Freedom of Choice (FOC).***
2. Once the *Primary* FOC has been received by the receiving agency and by DDSD, file transfers are to be completed within thirty (30) days.
3. The transferring case management agency will contact the receiving case management agency to schedule a transition meeting. The transferring case management agency will also inform the DDSD regional office(s) of the date and time of the transition meeting. This ensures that the regional office(s) are aware of the change and will be available to provide technical assistance as needed.
4. The individual/guardian should be made aware of the date and time for the meeting and encouraged to attend, if at all possible.
5. The transition meeting is to occur in person between the two case management agencies. If necessary, the transition meeting could be held via teleconference. A DDSD Regional Office staff may be requested to attend. The transition meeting will include the following:
  - ◇ Discussion of the critical clinical issues that need immediate follow up as well as historical information regarding the individual which include, but are not limited to:
    - ◇ Date of the Level of Care (LOC) and Individual Service Plan (ISP)
    - ◇ Current services on the budget (in case the new agency needs to address outlier, overnight-awake, or other enhanced service needs)
    - ◇ Any budget revisions in process
    - ◇ Therapy issues
    - ◇ Aspiration Issues
    - ◇ Medical Issues (medications, DNR, adaptive equipment, allergic reactions, etc.)

- ◆ Guardianship orders and related documents
  - ◆ Medicaid/Medicare [identified Health Maintenance Organization (HMO)]
  - ◆ Problems identified by the transferring agency that the receiving case management agency should be aware of.
  - ◆ Agreement on the date that the receiving case management agency will become the official case management agency of record.
6. Transfer of the following documents must be presented to the receiving case management agency in person or via registered mail.
- a. Current year assessments
  - b. LOC
  - c. ISP, ISP revisions, and associated support/therapy/health care plans
  - d. Current *Medical Assistance Worker (MAW) letter*
  - e. Team meeting notes and correspondence
  - f. Medical reports (primary care physician, specialists, vision, hearing, dental)
  - g. Transdisciplinary Evaluation and Support Clinic (TEASC) Evaluations
  - h. Psycho-Sexual Evaluations
  - i. Vocational/Personal Profiles (if any), or results of any personal planning sessions facilitated with the individual within the past 3 years.
  - j. Career Development Plans
  - k. Current Individual Education Plan (if applicable)
  - l. Any other baseline assessments
  - m. Birth Certificate
  - n. Social Security Card
  - o. Medicaid/Medicare Card
  - p. Allocation letter
  - q. Proof of guardianship
  - r. Other pertinent information

s. One full year of case notes (narratives) and site visit forms.

The transferring case management agency retains the original documents, which may be archived but must be available at the request of DDSD. Copies are sent to the receiving case management agency.

7. A *Letter of Transfer and Receipt* must be presented by the receiving case management agency to the transferring case management agency that lists:

- ◇ Documents that are transferred;
- ◇ Missing documents;
- ◇ *LOC, ISP, and MAW* expiration dates;
- ◇ *Release of Information* for the receiving case management agency to complete in order to request documents from generic supports that the transferring case management agency may not have requested; and
- ◇ Issues that need immediate follow-up.

The letter must include signature lines. Representatives of both case management agencies must sign this document. This document may be notarized. The original *Letter of Transfer and Receipt* will be kept with the original case management file. The letter should also include a copy of the transition meeting minutes and an agreement regarding which agency will complete the site visits for the month during which the transition is occurring.

⇒ **Appendix: *Sample Letter of Transfer and Receipt*  
*Transfer of Records List***

It is the responsibility of the transferring case management agency to make the provider changes on the *Waiver Review Form (MAD 046)*, complete an *Addendum C (ISP Revision form)*, and submit both forms to New Mexico Medicaid Utilization Review (NMMUR) within 15 working days.

⇒ **Appendix: *MAD 046***

8. If the individual is also transferring between counties, it is the responsibility of the receiving case management agency to contact **both** Income Support Division (ISD) offices. The receiving CM will complete a *Client Information Update* (CIU) form. The CM will date the form, fill in the individual's name and Medicaid Waiver number, mark the *Other* box and explain that the individual has changed to the specific county, by name, and preferably which agency is providing residential services, as applicable. This written notification is then sent to both ISD offices.
9. In situations when the *LOC* or the *ISP* is in the process of approval, the transferring case management agency is responsible for completing and submitting the *LOC* or the *ISP* for approval and responding to all 'buck backs' (requests for additional information or criteria needed for review or approval) that may occur prior to approval. A copy of the approved *LOC* and/or *ISP* must be transferred to the receiving case management agency.
10. The receiving case management agency has the **AUTHORITY** to refuse the file, reject the transfer date, and request that another transition meeting be convened. The receiving case management agency representative needs to then contact its DDSD Regional Office to assist in coordinating a transition meeting.

## When an Individual Changes Service Providers

If an individual/guardian chooses to select a new provider agency (residential, day habilitation, employment, therapy, personal care and/or respite), the following protocol will be followed.

1. The CM is responsible for providing the individual/guardian with *Secondary* FOC forms when a desire to change one or more of the existing service agencies is expressed.

2. The CM shall also provide factual information about the different provider agencies so that the individual can make an informed choice.
3. Once one or more agencies are chosen and the form signed, the case management agency is responsible for:
  - ◇ Notifying affected agencies, and
  - ◇ Scheduling a Team meeting with the individual/guardian and the selected agency representatives within two weeks of the *Secondary FOC* being signed.

*Note: This does not need to be a full meeting with all team members present.*

4. It is the responsibility of the CM to assure that all parties involved follow the **DDSD CST 150 Policy** pertaining to discharge from programs or transfers between provider agencies. This policy is in the process of being revised.
5. If the CM anticipates that the meeting may be contentious, emotionally charged or difficult to complete, he/she should contact the DDSD Regional Office for assistance.
6. Once a transfer date is confirmed, it is the responsibility of the CM to make the change on a **MAD 046**, complete an **Addendum C ISP Revision form** and submit both to NMMUR.

⇒ **Appendix:**      **MAD 046**

## Suspension of Services

Suspension of Waiver services is a very serious situation with potential negative consequences for the individual. The following scenarios illustrate two types of situations in which an individual may be suspended from services.

*Maddie is a forty four year old woman receiving services from the DD Waiver. She had a small stroke and was transported to the hospital in an ambulance; her direct support staff completed an IMS form and notified all of the appropriate people, including her CM. The CM first*

*called the hospital to verify admission and then contacted the Discharge Planner to inform her that Maddie is on the DD Waiver, which requires suspension of services until discharge from the hospital, and faxed a copy of Maddie's current LOC to him for use when discharge occurred. The CM then completed and submitted a Client Information Update (CIU) form to all providers, ISD, NMMUR and the local DDS regional office to notify them of suspension of services.*

*When Maddie was medically stable, she was transferred to a skilled nursing home for rehabilitation; the CM notified the nursing home of Maddie's waiver status. When Maddie was well enough to return home, the CM and residential provider attended a discharge meeting to ensure all of her needs would be met at home. Maddie's services had been suspended for a total of thirty-one days. When the discharge date was established, the CM first established that the discharge planner at the nursing home had completed a Re-admit LOC, and then submitted a CIU to all parties (listed above) to notify them of the date of release and re-instatement of services.*

***Sam** is a twenty-six year old man who receives Family Living services through the DD Waiver in order to remain at home with his mother. His CM successfully completes site visits at Sam's day habilitation program, but continues to have great difficulty scheduling and completing the required home visits. In the past eight months, she has been able to visit him only once at home. Sam's mother says she does not want anyone in her home. The CM has explained the DD Waiver requirements regarding home visits to her in the past and now reminds her of the Client's Rights and Responsibility form she signed at the annual meeting. The mother continues to resist any visits to the home. The SLP notifies the CM that he is experiencing similar difficulties with both provision of services at the home and consistent implementation of the home-based therapy program.*

*The CM and her supervisor schedule a meeting with Sam and his mother to explain that this lack of cooperation is jeopardizing Sam's waiver services. The mother does not believe services will be*

*suspended and threatens to change case management agencies. The CM then requests intervention from the DDS regional office. A DDS representative meets with Sam and his mother to again explain the DD Waiver requirements and clarify the requirements will continue to be in effect, despite a change in case management agency. Although the mother agrees to monthly home visits by the current CM, neither she nor Sam was home at the time of the next scheduled visit. The CM immediately contacted the DDS regional office and obtained permission for a thirty-day suspension from waiver services. She provided written certified notification to the family specifying both the thirty-day suspension of all paid services and the date of a meeting to establish compliance with requirements in order to reinstate services. She also completed and submitted a CIU to notify the provider agencies, ISD, NMMUR, and DDS regional office of the suspension of all services, instruct agencies to stop bill and the date of the scheduled meeting to establish compliance with requirements of waiver participation.*

Suspension is the *temporary* interruption of authorized Waiver services, for a period not to exceed sixty (60) days. Causes for suspension may include, but are not limited to:

1. The health and welfare of the individual is jeopardized or cannot be assured; (e.g., an individual who abuses substances and refuses to accept treatment or comply with the ISP);
2. The improvement or deterioration in the health or functional status of the individual results in he/she no longer meeting medical LOC;
3. The individual no longer meets financial eligibility requirements;
4. The individual/guardian is repeatedly non-compliant with **Addendum A of the ISP, Client Rights and Responsibilities** ;
5. The individual is institutionalized for short or long-term care in a hospital, nursing facility, rehabilitation center, law enforcement/corrections facility; or
6. The individual takes a leave of absence for a vacation (in or out of state) in excess of 30 days.

**Note:** *If the consumer is suspended from services, it relates to **all** Waiver services. The individual is not able to be suspended from case management and still receive supported living services.*

In the event of a suspension of services, **the CM must:**

1. Immediately (within one work day) notify the direct service provider of any interruption of consumer services by phone and follow-up in writing with a **Client Information Update** form (CIU) notifying them of suspension of services;
2. Notify the DDS Regional Office within five (5) working days of the suspension; and
3. Notify the ISD office immediately (within one working day) of the recommendation of suspension of services and the specific reason for the recommendation. This can be initiated by phone with the identified ISD worker (no messages) and then be followed with a CIU to the worker.

## **When an Individual Withdraws from Services**

When an individual/guardian withdraws from DD Waiver services, either by the display of his/her behavior or by stating the desire to withdraw, the CM must:

1. Contact the guardian (if one is appointed) to discuss the issues and the unwillingness of the individual to accept services;
2. Convene a team meeting, if the individual does not have a guardian, to discuss whether he/she can make informed decisions or needs the assistance of a guardian or friend/advocate;
3. Initiate the process to obtain guardianship, when deemed appropriate, while team members continue attempts to provide adequate services to the individual. It is the responsibility of the CM to facilitate the guardianship process;
4. Convene a team meeting and invite a DDS Regional Office representative to attend, if it is determined that the individual is able to make informed decisions and

does not require the surrogate decision-making function of a guardian. The meeting will enable the individual/guardian to explain why he/she does not want to continue services and provide the team an opportunity to develop an ISP that is acceptable to the individual while ensuring his/her health and safety. If acceptable, services would then continue.

5. Compose a letter that explains the issues listed below, if the team has had one or more opportunities to brainstorm a solution and different *ISPs* have been tried and the individual/guardian still wants to discontinue Waiver services.
  - ◇ How the individual's action will affect his/her Waiver status,
  - ◇ The length of the waiting list should the individual re-apply for the DD Waiver, and
  - ◇ Acknowledgement that the individual/guardian understands the consequences of his/her actions.

The individual/guardian will sign the document and obtain a copy for his/her personal records. The original copy will remain in the individual's primary file at the case management agency.

6. Provide the individual/family with specific information if a move out of state occurs. This includes 1) the waiver is not reciprocal from state to state; 2) if the individual moves back to New Mexico, his/her status on the waiver is active for only 60 days from the date he/she withdraws from the Waiver. If at all possible, the CM should assist the individual and/or family to identify contact information for the departments that administers the waiver in the new state.
7. Notify the provider agencies of record and the local ISD office of the recommendation for termination.
8. It is the responsibility of ISD to formalize the closure of the case.

## When an Individual is Terminated from Services

An individual may be terminated from receiving services through the DD Waiver. Causes of termination include, but are not limited to, the following:

1. Any of the circumstances listed under the Suspension of Services, if they last sixty (60) days or more;
2. The individual receiving services has died;
3. The whereabouts of the individual is unknown;
4. The individual becomes financially ineligible;
5. The individual becomes clinically ineligible;
6. The health and safety of the individual is jeopardized or cannot be assured;
7. Documentation of the individual/guardian's repeated violations of **Addendum A of the ISP: Client Rights and Responsibilities**; or
8. Documented instances of verbal, physical, sexual or psychological abuse of service provider employees and/or DDSD employees by the individual and/or the individual's family, representative or primary caregiver.

The following procedures guide termination from services:

- 1) The CM may initiate termination of services **ONLY AFTER** contacting DDSD.
- 2) The individual's team should meet to try to resolve some of the issues bulleted above. It is the responsibility of all team members, especially the CM, to prevent termination of services, if at all possible.
- 3) If termination of services is finalized, the CM will notify the following entities, in writing, within five (5) working days:
  - ◆ DDSD,
  - ◆ The local ISD office, and
  - ◆ NMMUR agency.

Once termination of services has been finalized, the individual's file may be archived by the CM, but must be made available to Department of Health (DOH) upon request.

**Remember:** *The individual/guardian has a right to appeal the termination (under NMAC 8.200.430.12 Right to Hearing).* There is a formal Appeal Process the individual/guardian may implement. The CM is responsible for informing the individual/guardian of the Fair Hearing Process and assist with initiating the process, if appropriate.

⇒ **New Mexico Administrative Code (NMAC) 8.200.0430 Right to Hearing**  
<http://www.nmcpr.state.nm.us/nmac/parts/title08/08.200.0430.htm>

## Death of an Individual

This section addresses the process that must occur in the event of the death of an individual receiving services through the DD Waiver.

⇒ **DOH Incident Management System Manual, Fiscal Year 2006**  
[www.dhi.health.state.nm.us/elibrary/imbdocs/IMS\\_Booklet\\_SFY2006.pdf](http://www.dhi.health.state.nm.us/elibrary/imbdocs/IMS_Booklet_SFY2006.pdf)

1. The provider agency must notify the CM and the Division of Health Improvement (DHI) within 24 hours of the individual's death.
2. The CM must ensure that any death that is suspected of being related to abuse or neglect is immediately reported to APS/CPS SCI (Adult Protective Services/Children Protective Services Statewide Centralized Intake (SCI). The CM may fax the Incident Report (IR) to SCI (**505-841-6691**) or phone in the report (**1-800-797-3260**) and then mail the hard copy of the report.
3. Regardless of circumstances, the CM must ensure any death is reported to DHI within *24 hours of knowledge of the death*. The IR may be filed on-line or faxed to DHI at **1-800-584-6057**.

4. The CM will be contacted by a representative of the DHI Medical Office and will be expected to provide additional information as requested.
5. The CM must provide the local ISD office with written notification of the individual's death.
6. The individual's primary file may then be archived but must be made available to DOH/DHI upon request.
7. If systemic issues related to case management are identified in the mortality review process, the DDSD will work with the case management agency to address concerns in a quality improvement process.

# Appendix



- ◆ Acronyms, Abbreviations & Terminology
- ◆ ARA Rate Table
- ◆ Client Individual Assessment (CIA) Form
- ◆ Decision Tree: DD Waiver Eligibility
- ◆ Risk Assessment & Planning Worksheet
- ◆ Identifying Individuals at Risk for Aspiration & What to do About It
- ◆ Meal Time Observation Checklist
- ◆ Quarterly Review for Persons with Dysphagia/Risk of Aspiration  
Day Program Site Visit
- ◆ Quarterly Review for Persons with Dysphagia/Risk of Aspiration  
Residential Site Visit
- ◆ Sample ISP Meeting Agenda
- ◆ ISP Form: Electronic Version
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- ◆ Instructions: Developing & Documenting the ISP
- ◆ Letter of Transfer & Receipt
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- ◆ Level of Care (LOC)
- ◆ DDS Decision Justification Form
- ◆ DDS Site Visit Form
- ◆ DDS Site Visit Form Instructions
- ◆ MAD 046: Blank
- ◆ MAD 046 Sample
- ◆ Provider Request Form  
Type 1 Action: Service Authorization
- ◆ Provider Request Form  
Type 2 Action: Personnel Qualifications/Payment Authorization
- ◆ Request for DDS Regional Office Intervention Form
- ◆ Request for DDS Regional Office Intervention Instructions

<b>ACRONYMS, ABBREVIATIONS and TERMINOLOGY</b>	
<b>AAMR</b>	American Association on Mental Retardation
<b>ABS</b>	Adaptive Behavior Scale
<b>ADA</b>	Americans with Disabilities Act
<b>ADD</b>	Attention Deficit Disorder
<b>ADHD</b>	Attention Deficit Hyperactivity Disorder
<b>ADL's</b>	Activities of Daily Living
<b>AG</b>	State Attorney General's Office
<b>AL</b>	Assisted Living
<b>AIMS</b>	Abnormal Involuntary Movements Screening
<b>APS</b>	Adult Protective Services
<b>ARA</b>	Annual Resource Allotment
<b>ARCA</b>	Association for Retarded Citizens of Albuquerque
<b>Arc of NM</b>	State advocacy organization
<b>ASL</b>	American Sign Language
<b>AT</b>	Assistive Technology
<b>BB</b>	Buck Back
<b>BC/BS</b>	Blue Cross/Blue Shield
<b>BID</b>	Twice a day
<b>BSC</b>	Behavior Support Consultant
<b>BSP</b>	Behavior Support Plan
<b>CARF</b>	Commission on the Accreditation of Rehabilitation Facilities
<b>CIA</b>	Client Individual Assessment Form
<b>CM</b>	Case Manager

<b>ACRONYMS, ABBREVIATIONS and TERMINOLOGY</b>	
<b>CMA</b>	Certified Medication Aide
<b>CP</b>	Cerebral Palsy
<b>CPR</b>	Cardiopulmonary Resuscitation
<b>CPS</b>	Children's Protective Services
<b>DSS</b>	Direct Support Staff
<b>DDSD</b>	Developmental Disabilities Supports Division, Department of Health
<b>DDW</b>	Developmental Disability Waiver
<b>DH</b>	Day Habilitation
<b>DHI</b>	Division of Health Improvement
<b>DME</b>	Durable Medical Equipment
<b>DOH</b>	NM Department of Health
<b>DRP</b>	Dispute Resolution Process
<b>DSM</b>	Diagnostic and Statistical Manual of Mental Disorders
<b>Dx</b>	Diagnosis
<b>DVR</b>	Division of Vocational Rehabilitation, Department of Education
<b>ECG/EKG</b>	Electrocardiogram
<b>EEG</b>	Electroencephalogram
<b>EPSDT</b>	Early Periodic Screening Diagnosis & Treatment
<b>FAS</b>	Fetal Alcohol Syndrome
<b>FOC</b>	Freedom of Choice
<b>FSA</b>	Functional Supports Assessment
<b>FTF</b>	Face to Face
<b>GERD</b>	Gastro-Esophageal Reflux Disorder
<b>GSE</b>	Group Supported Employment

<b>ACRONYMS, ABBREVIATIONS and TERMINOLOGY</b>	
<b>G-Tube</b>	Gastrostomy Tube
<b>H &amp; P</b>	History & Physical
<b>HAT</b>	Health Assessment Tool
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HMO</b>	Health Maintenance Organization
<b>HS</b>	At Bedtime (hour of sleep)
<b>HSD</b>	Human Services Department
<b>HUD</b>	Department of Housing and Urban Development
<b>ICAP</b>	Inventory for Client and Agency Planning
<b>ICFMR</b>	Intermediate Care Facility for Persons with Mental Retardation
<b>ISE</b>	Individual Supported Employment
<b>IEP</b>	Individualized Education Plan
<b>IR</b>	Incident Report
<b>ISD</b>	Income Support Division of the NM Human Services Department
<b>ISP</b>	Individual Support Plan
<b>LPN</b>	Licensed Practical Nurse
<b>LOC</b>	Level of Care
<b>MAD</b>	Medical Assistance Division of the Human Services Department
<b>MANDT</b>	Positive Support Intervention System
<b>MAR</b>	Medication Administration Record
<b>MAW</b>	Medical Assistance Worker
<b>MRO</b>	Metro Regional Office, DDSD
<b>MH</b>	Mental Health
<b>MR</b>	Mental Retardation

<b>ACRONYMS, ABBREVIATIONS and TERMINOLOGY</b>	
<b>MTP</b>	Mealtime Plan
<b>MW</b>	Medicaid Waiver
<b>NERO</b>	Northeast Regional Office, DDS
<b>NMCYFD</b>	Children, Youth and Families Department, NM Department of Health
<b>NMMUR</b>	New Mexico Medicaid Utilization Review
<b>NPO</b>	Nothing by mouth
<b>NWRO</b>	Northwest Regional Office
<b>OT</b>	Occupational Therapy
<b>P &amp; A</b>	Protection and Advocacy
<b>PC</b>	Personal Care
<b>PCP</b>	Primary Care Physician
<b>PHI</b>	Protected Health Information
<b>PO</b>	By mouth
<b>PRN</b>	As needed
<b>PRO</b>	Parents Reaching Out
<b>PASRR</b>	Pre-Admission Screening Annual Resident Review
<b>PSD</b>	Personal and Social Development
<b>PT</b>	Physical Therapy
<b>RN</b>	Registered Nurse
<b>OR</b>	Regional Office
<b>ROM</b>	Range of Motion
<b>RX</b>	Prescription
<b>QA</b>	Quality Assurance
<b>QD</b>	Every day

<b>ACRONYMS, ABBREVIATIONS and TERMINOLOGY</b>	
<b>QID</b>	Four times a day
<b>SE</b>	Supported Employment
<b>SERO</b>	Southeast Regional Office, DDS
<b>SGF</b>	State General Fund
<b>SIB</b>	Self-injurious Behavior
<b>SL</b>	Supported Living
<b>SLT/SLP</b>	Speech Language Therapy
<b>SS</b>	Social Security
<b>SSA</b>	Social Security Administration
<b>SSI</b>	Social Security Supplemental Income
<b>SWRO</b>	Southwest Regional Office, DDS
<b>TA</b>	Technical Assistance
<b>TD</b>	Tardive Dyskinesia
<b>TBI</b>	Traumatic Brain Injury
<b>TEASC</b>	Transdisciplinary Evaluation and Support Clinic
<b>TID</b>	Three times a day
<b>UR</b>	Utilization Review
<b>VOC</b>	Vocational
<b>WAIS-R</b>	Wechsler Adult Intelligence Scale

## DD WAIVER ANNUAL RESOURCE ALLOTMENT RATE TABLE

**Effective July 1, 2006**

		SERVICE CATEGORY	CODES	
1730Z	730	Children's Category LOC 1 <b>(with family, Home based not available)</b>		\$ 30,995
1731Z	731	Children's Category LOC 2 <b>(with family, Home based not available)</b>		\$ 25,475
1732Z	732	Children's Category LOC 3 <b>(with family, Home based not available)</b>		\$ 19,953
1733Z	733	Young Adult Category LOC 1 <b>(with family)</b>		\$ 43,958
1734Z	734	Young Adult Category LOC 2 <b>(with family)</b>		\$ 41,434
1735Z	735	Young Adult Category LOC 3 <b>(with family)</b>		\$ 38,910
1736Z	736	Young Adult "Community Supports" Category LOC 1 <b>(In Residential Program)</b>		\$ 23,577
1737Z	737	Young Adult "Community Supports" Category LOC 2 <b>(In Residential Program)</b>		\$ 19,771
1738Z	738	Young Adult "Community Supports" Category LOC 3 <b>(In Residential Program)</b>		\$ 16,300
1739Z	739	Adult Category LOC 1 <b>(with family)</b>		\$ 45,956
1740Z	740	Adult Category LOC 2 <b>(with family)</b>		\$ 40,803
1741Z	741	Adult Category LOC 3 <b>(with family)</b>		\$ 36,527
1742Z	742	Adult "Community Supports" Category LOC 1 <b>(In Residential Program)</b>		\$ 36,436
1743Z	743	Adult "Community Supports" Category LOC 2 <b>(In Residential Program)</b>		\$ 27,847
1744Z	744	Adult "Community Supports" Category LOC 3 <b>(In Residential Program)</b>		\$ 24,055

ALL HOME BASED SERVICES ARE CONSIDERED PART OF RESIDENTIAL AND MUST BE CODED FOR COMMUNITY SUPPORTS

The current fee schedule is located under the heading WAIVER SERVICES at  
[http://www.state.nm.us/hsd/mad/FeeSchedule\\_070106.htm](http://www.state.nm.us/hsd/mad/FeeSchedule_070106.htm)

DDSD is in process of preparing new ARA worksheets which will be available on the DDSD website.

## Client Individual Assessment (CIA)

### I. DEMOGRAPHIC INFORMATION

Name:

Address:

Marital Status

- Single
- Widowed
- Separated
- Married
- Divorced

Ethnicity

- Anglo
- Hispanic
- Black
- American Indian
- Asian
- Other

### II. CLIENT SELF DETERMINATION

**A. Level of Mental Cognitive Developmental Disabilities**

- Mild (IQ 52-70)
- Moderate (IQ 36-51)
- Severe (IQ 20-35)
- Profound (IQ under 20)
- Unknown

**B. Does Client Receive Any of the Following Legal Services**

(Check all that apply)

- Durable Power of Attorney
- Conservatorship
- Guardianship
- Treatment Guardian

**C. Does Client have a Living Will**

- Yes
- No

### III. FACTORS AFFECTING CLIENT CARE

List specific factors in client's living situation that may jeopardize and/or enhance his/her health, welfare and/or emotional well being.

### IV. MEDICAL HISTORY

A. List all medical diagnoses (active and chronic). Include (if known) reason for developmental disability.

B. List all medication currently take:

Drug	Dose	Route	Frequency
------	------	-------	-----------

C. Client Health Status:  
(Check all that Apply)

- Unsteady gait
- Chronic pain
- Paralysis
- Amputation
- Congenital anomalies
- Bed bound
- Visual deficit
- Low hearing
- Decreased sensation in limb(s)

Describe all conditions that apply

## V. DURABLE MEDICAL EQUIPMENT

A. List type of equipment or device currently used by the client.

B. List any equipment needed to ensure health & safety

## VI. COMMUNICATION

A. Can client convey needs?

- Yes
- No
- Sometimes

B. If yes or sometimes, indicate means of communication.

- Verbal
- Sign Language
- Gestures
- Communication board
- Written

Other

C. Primary language spoken at home

D. Describe client's ability to understand and follow directions.

**VII. COMMUNITY LIVING SKILLS**

**A. Participates in supported employment**

Yes

No

Sometimes

**B. Participates in Day Hab**

Yes

No

Sometimes

**C. Language Development:  
Check all that apply**

Able to write

Able to comprehend

Able to read

Able to communicate needs Describe:

**VIII. AFFECTIVE DEVELOPMENT**

Check all that apply

Expresses emotions independently

Limited ability to express emotions

Describe

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Decision Tree: DD Waiver Eligibility

Is condition attributable to a mental or physical impairment, other than mental illness, including the result of trauma to the brain, or combination of mental and physical impairment?

Yes  No *Not Eligible*  
 ↓

Did the mental and/or physical impairment manifest before the person reached 22 years of age?

Yes  No *Not Eligible*  
 ↓

Is the mental and/or physical impairment expected to continue indefinitely?

Yes  No *Not Eligible*  
 ↓

Does it result in substantial functional limitations in three or more areas of major life activity?

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>◆ Self-care</li> <li>◆ Receptive &amp; expressive language</li> <li>◆ Learning</li> <li>◆ Mobility</li> </ul> | <ul style="list-style-type: none"> <li>◆ Self-direction</li> <li>◆ Capacity for independent living</li> <li>◆ Economic self-sufficiency</li> </ul> |
|--|--|

Yes  No *Not Eligible*  
 ↓

Does the person need a combination & sequence of special coordinated treatment, generic or other supports & services of lifelong or extended duration and are individually planned and coordinated?

Yes  No *Not Eligible*  
 ↓

Does the individual also have mental retardation or one of the specific related conditions below?

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>◆ Cerebral palsy</li> <li>◆ Autism (or Asperger's syndrome)</li> <li>◆ Seizure disorder</li> <li>◆ Inborn errors of metabolism</li> </ul> | <ul style="list-style-type: none"> <li>◆ Chromosomal disorder or Syndrome disorder</li> <li>◆ Developmental disorder of brain formation</li> </ul> |
|--|--|

Yes  No *Not Eligible*  
 ↓

Does the individual require the level of care provided by an Intermediate Care Facility for Persons with Mental Retardation (ICFMR)?

Yes *Clinically Eligible*  No *Not Eligible*

## Risk Assessment & Planning Worksheet

<b>Individual's Name:</b>		<b>Date of Discussion:</b>		<b>Date of Note:</b>
<b>Participants:</b>				
Significant Risk Factors (List)	Present		Description of risk, circumstances, frequency	Interventions required to eliminate or minimize risk
	Yes	No		
<b>1. Functional Status</b>				
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>		
b. Ambulation	<input type="checkbox"/>	<input type="checkbox"/>		
c. Transfers	<input type="checkbox"/>	<input type="checkbox"/>		
d. Toileting	<input type="checkbox"/>	<input type="checkbox"/>		
<b>2. Behavioral</b>				
a. Self-abuse	<input type="checkbox"/>	<input type="checkbox"/>		
b. Aggression toward others or property	<input type="checkbox"/>	<input type="checkbox"/>		
c. Use of physical or mechanical restraint	<input type="checkbox"/>	<input type="checkbox"/>		
d. Emergency drug use	<input type="checkbox"/>	<input type="checkbox"/>		
e. Psychotropic meds	<input type="checkbox"/>	<input type="checkbox"/>		
<b>3. Physiological</b>				
a. Gastrointestinal conditions	<input type="checkbox"/>	<input type="checkbox"/>		
b. Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
c. Anticonvulsant meds	<input type="checkbox"/>	<input type="checkbox"/>		
d. Skin breakdown	<input type="checkbox"/>	<input type="checkbox"/>		
e. Bowel function	<input type="checkbox"/>	<input type="checkbox"/>		
f. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>		
g. Treatments	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4. Safety</b>				
a. Injuries	<input type="checkbox"/>	<input type="checkbox"/>		
b. Falls	<input type="checkbox"/>	<input type="checkbox"/>		
c. Community Mobility	<input type="checkbox"/>	<input type="checkbox"/>		
<b>5. Other</b>				
	<input type="checkbox"/>	<input type="checkbox"/>		

## Instructions for Completing Risk Assessment & Planning Worksheet

- Under each specific area, list the Significant Risks identified.
- Indicate “yes” or “no” as to whether a significant risk has been identified in the listed category.
- Indicate “yes” or “no” whether training/service plans are present for the specific risk.
- If training/service plans have been developed, indicate the training/area.
- Briefly, indicate a summary of the intervention required to eliminate or minimize the risk.

## **Identifying Individuals at Risk for Aspiration & What To Do About It**

### **Step One: Identify Risk Factors**

Review the individual's medical record for any of the following:

- ◇ Recurrent pneumonia or other respiratory infections
- ◇ Diagnosis of Dysphagia and/or GERD
- ◇ Repeated unexplained low grade fevers
- ◇ Tube feeding
- ◇ Scoliosis
- ◇ Spasticity
- ◇ Seizure Disorder
- ◇ Rumination
- ◇ Greater than 10% weight loss within 6 months
- ◇ Tracheitis (inflammation of the windpipe)
- ◇ Rales or Rhonchi (rattling or bubbling sounds in the chest when breathing – heard through a stethoscope by nurse or physician)

AND

Observe the individual during a meal noting any of the following:

- ◇ Unable to feed themselves
- ◇ Coughing or gagging during or after meals
- ◇ Gurgling sounds in the throat while breathing
- ◇ Weak or absent cough
- ◇ Choking on food or liquid
- ◇ Wet sounding speech
- ◇ Poor head control and/or not able to remain alert during the meal

- ◇ Increased mucous, especially clear mucous with bubbles
- ◇ Wheezing without asthma
- ◇ Fear of eating or refusal to eat or drink
- ◇ Very slow eating – more than 30 minutes to eat a meal
- ◇ Bluish lips or fingernails
- ◇ Watery eyes during eating or drinking
- ◇ Tendency to swallow food whole without chewing

### **Step Two: Arrange for Further Assessment**

If any of the above are noted, the individual should be assessed to determine if they need a meal time program to reduce their risk. The individual's primary care physician should be made aware of the above risk factors you have noted for the individual – they may wish to order a videofluoroscopy to rule out or confirm aspiration. If you have a speech therapist on the team with expertise in swallowing disorders you should also alert them to your observations. (See the separate handout "Swallowing Studies (MBS/VSA) For Individuals with Developmental Disabilities" for considerations in arranging an effective videofluoroscopy.)

Another good resource for assessment in New Mexico is the Supports and Assessment for Feeding and Eating clinic (SAFE) at the Center for Development and Disability. This clinic has an interdisciplinary team of eating specialists who can evaluate the individual and provide a recommended meal time program. To arrange a SAFE clinic appointment call Elizabeth Ceysens RD at **505-272-0285**.

### **Step Three: Review & Training on the Meal Plan for Completeness and Clarity**

The purpose of the meal plan is to provide easy to understand instructions for the individual and their family or support staff to minimize the risk of aspiration. It is not a fancy medical

report for the therapists. Therefore the plan should be reviewed to assure that it is complete and easy to understand.

A complete plan should address four areas:

- ◇ Appropriate Eating Equipment
  - ◇ Spoons/utensils
  - ◇ Dishes
  - ◇ Cups/straws
- ◇ Proper Positioning
  - ◇ Person eating
  - ◇ Person assisting with the meal
- ◇ Assisted Eating Techniques
  - ◇ Medication to prevent reflux
  - ◇ Food texture
  - ◇ Liquid consistency
  - ◇ Presentation of the food
- ◇ Nutritional Content
  - ◇ Foods to encourage
  - ◇ Foods to avoid
  - ◇ Fluid intake
  - ◇ Calorie requirements

Although some of the above areas may not be relevant for all individuals – all plans should address all areas. So for example, if an individual doesn't require any special equipment, the plan should simply state that no special equipment is needed; or if the individual doesn't have any special considerations for nutritional content, the plan should state that the

individual can eat whatever they choose as long as it is prepared to the texture specified in the plan.

If there are areas that are not addressed, or there are instructions that are not clear – the team should go back to the author(s) and ask for clarification to be written into the plan. Verbal clarification only is often not reliably implemented. So, for example, if the plan calls for all food to be chopped, but it doesn't say how small the pieces should be chopped, ask that a size reference is added to that section. Or, if the plan states that the individual should have "adequate fluid intake" – ask that number of ounces or cups be specified.

Training should be provided by the author(s) of the plan – or a qualified individual who has been trained on the specific meal plan previously – to the individual and all those who assist them with meals. Such training should provide an opportunity for the individual assisting to practice the technique with immediate feedback from the trainer. Periodic review sessions are advised.

#### **Step Four: Assure Proper Implementation**

Both case managers and supervisors should periodically observe the individual during a meal to determine if the plan is being followed consistently, including all four areas of the plan. If equipment is lost or broken it should be replaced promptly. If new staff are hired they should be trained before assisting the individual to eat. The other reason periodic observation is a good idea is that the individual's condition may change over time alerting the team to the need for re-assessment and revision of the meal plan.

Sometimes individuals and/or their families object to certain recommended strategies for reasons of personal preference or cultural beliefs. For example the individual may feel that pureed food stigmatizes them as eating "baby food", or perhaps one of the foods considered

unsafe, is an important part of a cultural celebration. Teams should work together to see if strategies can be creatively identified to address the concern and still maximize safety. For example, can the pureed food be layered to appear like a “casserole”? Or is it possible to compromise on chopping it finely? Can the culturally important food be prepared in a safer manor – or given in small portions to minimize the risk? In the end, self-determination and family preferences must be respected – assuming the risk has been fully explained. However, the issue should be revisited periodically if the individual’s health continues to suffer as a result of not implementing recommended prevention measures – they may change their mind later.

## MEALTIME OBSERVATION CHECKLIST FORM C 6/04

### 1) FOR ORAL EATERS:

*NOTE: If any of the answers to the following questions is "yes," they should be documented and discussed with the IDT.*

- Is the individual gagging, coughing, choking or excessively clearing their throat during the meal?
- Is the person groggy or sleepy during the meal?
- Does the person seem fearful of eating?
- Does the person refuse food or drink?
- Does the person have watery eyes when they eat or drink?
- Does the person seem to swallow their food without chewing?
- Is the person sitting up at less than a 30-degree angle during the meal?
- Is there discomfort, excessive burping and/or food coming back up into the mouth or nose after the meal?

*NOTE: If any of the answers to the following questions is "no," they should be documented and discussed with the IDT.*

- Did the person remain sitting up for 45 minutes after the meal to foster proper digestion?
- Is the adaptive equipment listed in the Mealtime Procedures Packet being used?
- Is the individual's food prepared to the consistency listed in the MPP?
- Has the individual assisting with the meal been trained on the MPP?

### 2) FOR TUBE FEEDING: (FIRST REVIEW THE FEEDING TUBE PROTOCOL)

*NOTE: If any of the answers to the following questions is "no," they should be documented and discussed with the IDT.*

- Did the support person wear gloves during the full process?
- Did the person sit up during the meal at least a 30-degree angle)?
  - If the bolus (liquid presented through a tube, not drip) method was used, were gastric residuals checked?
  - Did the support person flush the tube with water both before and after the feeding?
  - Did the person remain sitting up 45 minutes after the meal to foster proper digestion?
  - Has the individual assisting with tube feeding been trained?

## Quarterly Review for Person with Dysphagia/ Risk of Aspiration Day Program Site Visit

Consumer Name \_\_\_\_\_ CM Agency \_\_\_\_\_

Date \_\_\_\_\_ Regional Office \_\_\_\_\_

**People with Dysphagia/risk of aspiration need to be observed eating/drinking at least every six months using the "Mealtime Observation Checklist"**

1) Does the person receive nutrition or medications through a feeding tube at the day program site?

Yes \_\_\_\_\_ No \_\_\_\_\_

2) Does the day program staff have responsibility for assisting with the feeding tube in any way?

Yes \_\_\_\_\_ No \_\_\_\_\_

3) If yes to both questions #1 and #2:

a) Are the feeding tube guidelines present (usually written by the nurse)?

b) Can staff explain the feeding tube protocol?

3) If the person is an oral eater:

a) Date of the most current Mealtime Procedure Packet:

b) Is it available on site?

c) If adaptive equipment is recommended in the MPP is it available?

d) If adaptive equipment is recommended is it being used?

e) Can staff explain the main components of the MPP (texture, positioning during and after the meal, adaptive equipment, and foods to avoid/encourage)?

3) Date of the current Health Care Plan regarding Dysphagia/aspiration

4) Date of the current Crisis Prevention Plan regarding Dysphagia/aspiration

Can staff describe the plan?

5) Comments/concerns:

## Quarterly Review for Person with Dysphagia/Risk of Aspiration Residential Site Visit

Consumer Name \_\_\_\_\_ CM Agency \_\_\_\_\_

Date \_\_\_\_\_ Regional Office \_\_\_\_\_

**People with Dysphagia/risk of aspiration need to be observed eating/drinking at least every six months using the "Mealtime Observation Checklist".**

- 1) Does the person use a feeding tube? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2) Does the residential staff have responsibility for assisting with the feeding tube in any way?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- 3) If yes to both questions #1 and # 2:
  - a) Are the feeding tube guidelines present (usually written by the nurse)?
  - b) Can staff explain the feeding tube protocol?
- 2) If the person is an oral eater:
  - a) Date of the most current Mealtime Procedure Packet:
  - b) Is it available on site?
  - c) If adaptive equipment is recommended in the MPP is it available?
  - d) If adaptive equipment is recommended is it being used?
  - e) Can staff explain the main components of the MPP (texture, positioning during and after meals, adaptive equipment, and foods to avoid/encourage)?
- 3) Date of the current Health Care Plan regarding Dysphagia/aspiration
- 4) Date of the current Crisis Prevention Plan regarding Dysphagia/aspiration  
Can staff describe the plan?
- 6) Is dental care up to date? If not what is the plan to address this need?
- 7) Is the person's weight stable? If not what is the plan to address this?
- 8) Comments/concerns:

## Sample Annual ISP Meeting Agenda

5 minutes	Introductions State purpose and outcomes of meeting Review agenda State ground rules
15 minutes	Review assessment results
10 minutes	Who is "Betsy Jones?" Have the individual tell first who they are, likes, preferences, etc.
45 minutes	Vision statement Live, work/learn, have fun/develop relationships
30 minutes	Functional assessment
15 minutes	Goals Objectives and strategies due within 10 working days after meeting
10 minutes	Review/complete Addendum B
10 minutes	ARA Discussion
5 minutes	Summarize (who, what)

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**INDIVIDUAL SERVICE PLAN (ISP) (Electronic Version)**  
**FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY**  
**(DDSD FORM REVISED 6-30-06)**

IDENTIFYING INFORMATION			
DATE OF ISP MEETING:		DATE OF NEXT ISP MEETING:	
EFFECTIVE DATES OF ISP: FROM TO		TERM OF LEVEL OF CARE: FROM TO	
<input type="checkbox"/> DEVELOPMENTAL DISABILITIES WAIVER	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> JACKSON CLASS MEMBER	
<input type="checkbox"/> STATE GENERAL FUND	<input type="checkbox"/> REVISION (DATE: )	<input type="checkbox"/> NEW ALLOCATION	
<input type="checkbox"/> WAIVER ID #:	<input type="checkbox"/> LEVEL OF CARE: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<input type="checkbox"/> HAT SCORE: DATE:	
<input type="checkbox"/> MEDICAID #:	<input type="checkbox"/> MEDICARE #:		
<input type="checkbox"/> SALUD! PROVIDER:	<input type="checkbox"/> MEDICAID FEE FOR SERVICE		
INDIVIDUAL'S FULL NAME:			DOB:
ADDRESS:			
CITY AND ZIP:			PHONE:
DIRECTIONS TO HOME:			
INDIVIDUAL'S NATIVE LANGUAGE:			INTERPRETER NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO
CASE MANAGEMENT AGENCY:		CASE MANAGER:	PHONE:
ADDRESS:		E-MAIL:	FAX:
RESIDENTIAL AGENCY:	SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:		E-MAIL:	FAX:
DAY SERVICES AGENCY:	SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:		E-MAIL:	FAX:
DAY SERVICES AGENCY:	SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:		E-MAIL:	FAX:
GUARDIAN:	<input type="checkbox"/> PLENARY	PHONE:	
AGENCY (IF APPLICABLE):	<input type="checkbox"/> LIMITED	FAX:	
ADDRESS:	<input type="checkbox"/> OTHER (SPECIFY):	E-MAIL:	
FAMILY:	RELATIONSHIP:	PHONE:	
ADDRESS:	E-MAIL:	FAX:	
FRIEND/ADVOCATE:	RELATIONSHIP:	PHONE:	
ADDRESS:	E-MAIL:	FAX:	
REPRESENTATIVE PAYEE:	E-MAIL:	PHONE:	
ADDRESS:		FAX:	
PRIMARY CARE PHYSICIAN:	E-MAIL:	PHONE:	
ADDRESS:		FAX:	
PHARMACY/MEDICAL SUPPLIER:	E-MAIL:	PHONE:	
ADDRESS:		FAX:	
OTHER:	SERVICE TYPE(S):	RELATIONSHIP:	PHONE:
ADDRESS:		E-MAIL:	FAX:
OTHER:	SERVICE TYPE(S):	RELATIONSHIP:	PHONE:
ADDRESS:		E-MAIL:	FAX:
OTHER:	SERVICE TYPE(S):	RELATIONSHIP:	PHONE:
ADDRESS:		E-MAIL:	FAX:

## NARRATIVE SECTION

### **LIFE EXPERIENCES:**

Provide background information, including successful past experiences and major life events. Describe what life is like now, including how often the individual has access to desired activities in the home, community and at work/school. Include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political).

### **SCHOOL, WORK, AND/OR VOLUNTEER HISTORY:**

Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Include information about the individual's interests concerning future education, volunteer, and/or work opportunities. Mention any awards or certifications the individual has received.

### **RELATIONSHIPS:**

Provide information about the individual's support network—especially those with whom the individual used to and/or does have frequent contact. Include information about natural supports (e.g., family, friends, close coworkers), community supports (e.g., community groups and organizations), and specialized supports (e.g., support staff that the individual has known for years). Clarify what relationships the individual is interested in forming, maintaining, reestablishing, and/or expanding.

### **HEALTH & SAFETY:**

Provide summary information about significant health/medical/behavioral/environmental concerns (past and present) that impact on the individual's health and safety, including what has been done to address these concerns.

### **STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES:**

Describe what makes the individual unique. Provide detailed information about each of the sections below.

#### **TALENTS, HOBBIES, AND INTERESTS**

#### **STRENGTHS AND GIFTS**

#### **PREFERENCES**

#### **WHAT WORKS FOR AND MOTIVATES THE INDIVIDUAL**

**STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES:**

Describe what makes the individual unique. Provide detailed information about each of the sections below.

**LONG-TERM VISION (WHAT I WANT IN MY FUTURE):**

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles). Describe what anyone in society would need to do to achieve the individual's vision.

**LIVE :**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**WORK/LEARN:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**HAVE FUN/DEVELOP RELATIONSHIPS:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**HEALTH AND/OR OTHER:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**PROGRESS TOWARDS REACHING THE LONG-TERM VISION:**

For each life area, analyze what progress has been made in order to move the individual closer to his/her long-term vision, as well as what still need to occur (e.g., things to accomplish, barriers to overcome). Explain the individual's priorities and desires for completing remaining activities/tasks.

LIFE AREA	WHAT IS IN PLACE	WHAT NEEDS TO OCCUR
LIVE		
WORK/LEARN		
HAVE FUN/DEVELOP RELATIONSHIPS		
HEALTH AND/OR OTHER		

**DESIRED OUTCOMES:**

Focusing on the individual's priorities, identify outcomes that the individual wants to achieve during the next 1 – 3 years. Areas to consider include future desires and anticipated achievements for each life area. Outcome statements need to include measurable criteria for determining success. If a life area will not include a desired outcome statement, provide the rationale for this decision in the space provided.

**LIVE:**

**WORK/LEARN:**

**HAVE FUN/DEVELOP RELATIONSHIPS:**

**HEALTH AND/OR OTHER:**

**THE INDIVIDUAL'S DEFINITION OF A MEANINGFUL DAY (REQUIRED FOR YOUNG ADULTS AND ADULTS ONLY)**

**Skip this section until all action plans are complete** – then come back and create a summary description of activities which are meaningful to this individual which are incorporated into the individual's action plans as well as additional meaningful activities which must be supported during the individual's typical routines, but which are not directly related to the desired outcomes.

**ACTION PLAN FOR A DESIRED OUTCOME**

ORIGINAL

UPDATE

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN:

OUTCOME STATEMENT #\_\_:

<b>PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME</b>

<b>SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME</b>						
Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.						

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

UNAVAILABLE SERVICES OR SUPPORTS	STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS

*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

**ACTION PLAN FOR A DESIRED OUTCOME**

ORIGINAL

UPDATE

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN:

OUTCOME STATEMENT #\_\_:

<b>PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME</b>

<b>SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME</b>						
Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.						

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
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		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

UNAVAILABLE SERVICES OR SUPPORTS	STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS

*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

**ACTION PLAN FOR A DESIRED OUTCOME**

ORIGINAL

UPDATE

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN:

OUTCOME STATEMENT #\_\_:

**PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME**

--

**SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME**  
 Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
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		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

<b>UNAVAILABLE SERVICES OR SUPPORTS</b>	<b>STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS</b>

*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

**ACTION PLAN FOR A DESIRED OUTCOME**

ORIGINAL

UPDATE

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN:

OUTCOME STATEMENT #\_\_:

**PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME**

--

**SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME**  
 Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
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		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

<b>UNAVAILABLE SERVICES OR SUPPORTS</b>	<b>STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS</b>

*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

**ACTION PLAN FOR HEALTH AND SAFETY RELATED SUPPORTS**

ORIGINAL

UPDATE

DATE OF ACTION PLAN:

OUTCOME STATEMENTS:

<b>PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME(S)</b>

**SUPPORTS AND ACTION STEPS NEEDED FOR BASIC HEALTH AND SAFETY OUTCOME STATEMENTS**  
 Identify supports the individual needs beyond those already addressed in action plans for other desired outcomes in order to stay as healthy and safe as possible. These include action steps that have not yet been completed (i.e., actions that are past due) and action steps related to newly identified areas of support (e.g., needed specialized assessments or adaptive equipment). Action steps should be included which address adequate supports for 1) a condition that is worsening, 2) a new diagnosis, 3) new symptoms, and/or 4) the need to obtain medical tests or evaluations.

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

UNAVAILABLE SERVICES OR SUPPORTS	STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS

*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

### ADDITIONAL HEALTHCARE INFORMATION

COORDINATION INFORMATION	
<b>* WHO IS THE DESIGNATED HEALTHCARE COORDINATOR?</b>	<b>PHONE:</b>
<b>DOES THE INDIVIDUAL HAVE AN ADVANCED DIRECTIVE FOR MEDICAL CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>	
<b>IF THE INDIVIDUAL HAS AN ADVANCED MEDICAL DIRECTIVE, WHERE IS IT LOCATED?</b>	
<b>IF APPLICABLE, WHO IS THE SURROGATE HEALTH DECISION MAKER?</b>	<b>PHONE:</b>
<b>DOES THE INDIVIDUAL WANT MORE INFORMATION ABOUT ADVANCED DIRECTIVES? <input type="checkbox"/> YES <input type="checkbox"/> NO</b>	
<b>** IF MORE INFORMATION IS DESIRED, WHO WILL ASSIST THE INDIVIDUAL?</b>	<b>BY WHEN?</b>

*\*A healthcare coordinator must be designated for all individuals; if the individual has a HAT score of 1, 2 or 3 they may choose to designate themselves to do this independently, or another member of the team may be designated. If the individual has a HAT score of 4, 5, or 6 a team member other than the individual must be designated to fulfill this role – assisting the individual to be involved to the maximum extent possible.  
 \*\*Information about advanced directives can be obtained through the Health Decisions Resource Team. Contact Continuum of Care for information at 1-877-684-5259.*

MEDICATION DELIVERY	
<b>*** WHO COMPLETED THE MEDICATION ADMINISTRATION ASSESSMENT TOOL?</b>	<b>AGENCY:</b>
	<b>PHONE:</b>
<b>WHAT RECOMMENDATIONS HAVE BEEN MADE TO THE IDT REGARDING MEDICATION DELIVERY?</b>	
<b>WHAT IS THE TEAM'S FINAL DETERMINATION?</b> <input type="checkbox"/> SELF-ADMINISTRATION <input type="checkbox"/> SELF-ADMINISTRATION WITH PHYSICAL ASSISTANCE <input type="checkbox"/> ASSISTANCE BY STAFF <input type="checkbox"/> ADMINISTRATION BY LICENSED/CERTIFIED PERSONNEL <input type="checkbox"/> PARENT OF A CHILD	
<i>If more than one category applies, include the explanation in the rationale below</i>	
<b>RATIONALE FOR DECISION:</b>	
<b>RESPONSIBLE PARTY(IES) FOR FILLING AND REFILLING PRESCRIPTIONS AND UPDATING THE MEDICATION ADMINISTRATION RECORD?</b>	
<b>CONTACT(S):</b>	<b>PHONE NUMBER(S):</b>

*\*\*\*A nurse must complete the Medication Administration Assessment Tool (MAAT) for all adults receiving community living, day habilitation, employment services or private duty nursing services; for adults who do not receive any of these services and for children it is assumed that the parent/guardian takes full responsibility for medication delivery and completion of the tool is optional.*

**INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: SUPPORT PLANS**

For each targeted area, document the <b>urgency</b> of training, as follows: <ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>		For each IDT member who must complete training, specify the <b>type</b> , as follows: <ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to implement the plan)</li> </ul>		
SUPPORT PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> MEALTIME PLAN	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> TUBE FEEDING PROTOCOL (INCLUDING POSITIONING)	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> BEHAVIOR SUPPORT PLAN <input type="checkbox"/> BEHAVIORAL CRISIS PLAN	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> THERAPY PLAN (COMMUNICATION) <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> COMMUNICATION DICTIONARY <input type="checkbox"/> 24-HOUR COMMUNICATION SYSTEM <input type="checkbox"/> INTERACTIVE COMMUNICATION ROUTINES <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> THERAPY PLAN (OCCUPATIONAL) <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> SENSORY ISSUES <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> THERAPY PLAN (PHYSICAL) <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> LIFTING AND TRANSFERRING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> NUTRITIONAL/DIETARY PLAN	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> HEALTHCARE PLAN (REQUIRED IF HAT SCORE IS 4, 5, OR 6)	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			

**INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: MEDICAL CRISIS PREVENTION/INTERVENTION PLANS**

CRISIS PLAN (ATTACH TO ISP)		WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> CARDIAC CONDITION	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> GASTROINTESTINAL	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> RESPIRATORY/ASTHMA	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> DIABETES	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> ASPIRATION	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
	<input type="checkbox"/> Others:				
	<input type="checkbox"/> Residential Staff				
	<input type="checkbox"/> Day Support Staff				
	<input type="checkbox"/> Ancillary Supports:				
<input type="checkbox"/> Others:					

**INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: OTHER SUPPORTS**

For each targeted area, document the <b>urgency</b> of training, as follows:		For each IDT member who must complete training, specify the <b>type</b> , as follows:		
<ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>		<ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to follow procedures)</li> </ul>		
TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input checked="" type="checkbox"/> <b>SAFETY</b> <input checked="" type="checkbox"/> EMERGENCY PROCEDURES <input checked="" type="checkbox"/> EMERGENCY CONTACTS <input checked="" type="checkbox"/> INCIDENT REPORTING <input checked="" type="checkbox"/> EVACUATION AND ESCAPE ROUTES <input checked="" type="checkbox"/> STATUS OF RIGHTS (E.G., PRIVACY) <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>CHOICE</b> <input checked="" type="checkbox"/> SKILL LEVEL <input checked="" type="checkbox"/> LEVEL OF INFORMED CONSENT <input checked="" type="checkbox"/> LIKES, DISLIKES, AND PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>COMMUNICATION</b> <input checked="" type="checkbox"/> METHODS OF COMMUNICATION <input checked="" type="checkbox"/> EXPRESSIVE AND RECEPTIVE PREFERENCES <input checked="" type="checkbox"/> KEY VOCABULARY <input checked="" type="checkbox"/> PERSONAL SPACE AND TOUCH <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>STRENGTHS AND CAPABILITIES</b> <input checked="" type="checkbox"/> ACTIVITIES OF DAILY LIVING <input checked="" type="checkbox"/> INTERESTS AND HOBBIES <input checked="" type="checkbox"/> SUPPORT STRATEGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>LEARNING STYLE</b> <input checked="" type="checkbox"/> ENVIRONMENTAL FACTORS <input checked="" type="checkbox"/> MOTIVATORS <input checked="" type="checkbox"/> PROMPT LEVELS <input checked="" type="checkbox"/> VISUAL/AUDITORY/TACTILE PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>INDIVIDUAL SERVICE PLAN</b> <input checked="" type="checkbox"/> IDT MEMBER ROLES AND RESPONSIBILITIES <input checked="" type="checkbox"/> NARRATIVE SECTION <input checked="" type="checkbox"/> ACTION PLANS <input checked="" type="checkbox"/> STRATEGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>SUPPORT NETWORK</b> <input checked="" type="checkbox"/> NATURAL SUPPORTS <input checked="" type="checkbox"/> COMMUNITY SUPPORTS <input checked="" type="checkbox"/> VISITATION RIGHTS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>CULTURAL/SPIRITUAL VALUES AND BELIEFS</b> <input checked="" type="checkbox"/> SPIRITUALITY <input checked="" type="checkbox"/> CULTURAL PREFERENCES <input checked="" type="checkbox"/> TRADITIONS AND CELEBRATIONS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>MEDICATIONS</b> <input checked="" type="checkbox"/> LEVEL(S) OF SUPPORT <input checked="" type="checkbox"/> ROUTE-SPECIFIC INFORMATION <input checked="" type="checkbox"/> PURPOSES <input checked="" type="checkbox"/> SIDE EFFECTS <input checked="" type="checkbox"/> ALLERGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			

### INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS FOR OTHER SUPPORTS (Continued)

For each targeted area, document the <b>urgency</b> of training, as follows: <ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>	For each IDT member who must complete training, specify the <b>type</b> , as follows: <ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to follow procedures)</li> </ul>			
TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> <b>SEXUALITY AND RELATIONSHIPS</b> <input type="checkbox"/> INFORMED CONSENT <input type="checkbox"/> PAST HISTORY <input type="checkbox"/> SUPPORTS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>DECISION MAKING</b> <input type="checkbox"/> INDEPENDENT <input type="checkbox"/> GUARDIANSHIP STATUS <input type="checkbox"/> SURROGATE HEALTH DECISION MAKER <input type="checkbox"/> POWER OF ATTORNEY/CONSERVATOR <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>SPECIAL CONCERNS REGARDING ROUTINES</b> <input type="checkbox"/> WEEKDAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> WEEKENDS <input type="checkbox"/> LEISURE PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			

### ISP MEETING PARTICIPANTS

**DATE OF MEETING:**

*By signing below, I am indicating that I participated in the development of this individual service plan and will be responsible for implementing relevant portions of the plan.*

*Individuals who participated in a manner other than attendance at the meeting will be listed with the method of participation stated in the signature column*

MEETING PARTICIPANTS (PRINT NAME AND AGENCY)	PHONE NUMBER, FAX, AND E-MAIL	SIGNATURE
<b>INDIVIDUAL:</b>		
<b>GUARDIAN:</b>		
<b>FAMILY (SPECIFY RELATIONSHIP):</b>		
<b>FRIENDS/ADVOCATES:</b>		
<b>CASE MANAGER (SPECIFY AGENCY):</b>		
<b>RESIDENTIAL STAFF (SPECIFY AGENCY):</b> SERVICE COORDINATOR:  DIRECT STAFF:		
<b>DAY SERVICES STAFF (SPECIFY AGENCY):</b> SERVICE COORDINATOR:  DIRECT STAFF:		
<b>DAY SERVICES STAFF (SPECIFY AGENCY):</b> SERVICE COORDINATOR:  DIRECT STAFF:		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		

**INDIVIDUAL SERVICE PLAN (ISP) (Hard Copy Version)**  
**FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY**  
*DDSD FORM.REVISED 6-30-06*

IDENTIFYING INFORMATION		
DATE OF ISP MEETING:		DATE OF NEXT ISP MEETING:
EFFECTIVE DATES OF ISP: FROM TO		TERM OF LEVEL OF CARE: FROM TO
<input type="checkbox"/> DEVELOPMENTAL DISABILITIES WAIVER	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> JACKSON CLASS MEMBER
<input type="checkbox"/> STATE GENERAL FUND	<input type="checkbox"/> REVISION (DATE: )	<input type="checkbox"/> NEW ALLOCATION
<input type="checkbox"/> WAIVER ID #:	<input type="checkbox"/> LEVEL OF CARE: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<input type="checkbox"/> HAT SCORE: DATE:
<input type="checkbox"/> MEDICAID #:	<input type="checkbox"/> MEDICARE #:	
<input type="checkbox"/> SALUD! PROVIDER:	<input type="checkbox"/> MEDICAID FEE FOR SERVICE	
INDIVIDUAL'S FULL NAME:		DOB:
ADDRESS:		
CITY AND ZIP:		PHONE:
DIRECTIONS TO HOME:		
INDIVIDUAL'S NATIVE LANGUAGE:		INTERPRETER NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO
CASE MANAGEMENT AGENCY:	CASE MANAGER:	PHONE:
ADDRESS:	E-MAIL:	FAX:
RESIDENTIAL AGENCY: SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:	E-MAIL:	FAX:
DAY SERVICES AGENCY: SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:	E-MAIL:	FAX:
DAY SERVICES AGENCY: SERVICE TYPE(S):	CONTACT:	PHONE:
ADDRESS:	E-MAIL:	FAX:
GUARDIAN:	<input type="checkbox"/> PLENARY	PHONE:
AGENCY (IF APPLICABLE):	<input type="checkbox"/> LIMITED	FAX:
ADDRESS:	<input type="checkbox"/> OTHER (SPECIFY):	E-MAIL:
FAMILY:	RELATIONSHIP:	PHONE:
ADDRESS:	E-MAIL:	FAX:
FRIEND/ADVOCATE:	RELATIONSHIP:	PHONE:
ADDRESS:	E-MAIL:	FAX:
REPRESENTATIVE PAYEE:	E-MAIL:	PHONE:
ADDRESS:		FAX:
PRIMARY CARE PHYSICIAN:	E-MAIL:	PHONE:
ADDRESS:		FAX:
PHARMACY/MEDICAL SUPPLIER:	E-MAIL:	PHONE:
ADDRESS:		FAX:

OTHER: ADDRESS:	SERVICE TYPE(S):	RELATIONSHIP: E-MAIL:	PHONE: FAX:
OTHER: ADDRESS:	SERVICE TYPE(S):	RELATIONSHIP: E-MAIL:	PHONE: FAX:
OTHER: ADDRESS:	SERVICE TYPE(S):	RELATIONSHIP: E-MAIL:	PHONE: FAX:
OTHER: ADDRESS:	SERVICE TYPE(S):	RELATIONSHIP: E-MAIL:	PHONE: FAX:

## NARRATIVE SECTION

### **LIFE EXPERIENCES:**

Provide background information, including successful past experiences and major life events. Describe what life is like now, including how often the individual has access to desired activities in the home, community and at work/school. Include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political).

### **SCHOOL, WORK, AND/OR VOLUNTEER HISTORY:**

Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Include information about the individual's interests concerning future education, volunteer, and/or work opportunities. Mention any awards or certifications the individual has received.

**RELATIONSHIPS:**

Provide information about the individual's support network—especially those with whom the individual used to and/or does have frequent contact. Include information about natural supports (e.g., family, friends, close coworkers), community supports (e.g., community groups and organizations), and specialized supports (e.g., support staff that the individual has known for years). Clarify what relationships the individual is interested in forming, maintaining, reestablishing, and/or expanding.

**HEALTH & SAFETY:**

Provide summary information about significant health/medical/behavioral/environmental concerns (past and present) that impact on the individual's health and safety, including what has been done to address these concerns.

**STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES:**

Describe what makes the individual unique. Provide detailed information about each of the sections below.

**TALENTS, HOBBIES, AND INTERESTS**

**STRENGTHS AND GIFTS**

**PREFERENCES**

**WHAT WORKS FOR AND MOTIVATES THE INDIVIDUAL**

**LONG-TERM VISION (WHAT I WANT IN MY FUTURE):**

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles). Describe what anyone in society would need to do to achieve the individual's vision.

**LIVE :**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**WORK/LEARN:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**HAVE FUN/DEVELOP RELATIONSHIPS:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**HEALTH AND/OR OTHER:**

*WHAT IT WOULD TAKE FOR ANYONE TO ACHIEVE THIS VISION:*

**PROGRESS TOWARDS REACHING THE LONG-TERM VISION:**

For each life area, analyze what progress has been made in order to move the individual closer to his/her long-term vision, as well as what still need to occur (e.g., things to accomplish, barriers to overcome). Explain the individual's priorities and desires for completing remaining activities/tasks.

LIFE AREA	WHAT IS IN PLACE	WHAT NEEDS TO OCCUR
LIVE		
WORK/LEARN		
HAVE FUN/DEVELOP RELATIONSHIPS		
HEALTH AND/OR OTHER		

**LONG-TERM VISION (WHAT I WANT IN MY FUTURE):**

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles). Describe what anyone in society would need to do to achieve the individual's vision.

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**DESIRED OUTCOMES:**

Focusing on the individual's priorities, identify outcomes that the individual wants to achieve during the next 1 – 3 years. Areas to consider include future desires and anticipated achievements for each life area. Outcome statements need to include measurable criteria for determining success. If a life area will not include a desired outcome statement, provide the rationale for this decision in the space provided.

**LIVE:**

**WORK/LEARN:**

**HAVE FUN/DEVELOP RELATIONSHIPS:**

**HEALTH AND/OR OTHER:**

**THE INDIVIDUAL'S DEFINITION OF A MEANINGFUL DAY (REQUIRED FOR YOUNG ADULTS AND ADULTS ONLY)**

**Skip this section until all action plans are complete – then come back and create a summary description of activities which are meaningful to this individual which are incorporated into the individual's action plans as well as additional meaningful activities which must be supported during the individual's typical routines, but which are not directly related to the desired outcomes.**

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### ACTION PLAN FOR A DESIRED OUTCOME

ORIGINAL

UPDATE

*NOTE: USE A SEPARATE FORM FOR EACH OUTCOME AND MAKE EXTRA COPIES AS NEEDED*

DATE OF ACTION PLAN:

OUTCOME STATEMENT #\_\_:

**PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME**

**SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME**

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.

ACTION STEPS <small>SKILLS TO LEARN AND TASKS TO DO</small>	FREQUENCY <small>HOW OFTEN, HOW LONG</small>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <small>IF NO PROGRESS, STATE WHY</small>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

UNAVAILABLE SERVICES OR SUPPORTS	STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS
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*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

**ACTION PLAN FOR HEALTH AND SAFETY RELATED SUPPORTS**

ORIGINAL

UPDATE

DATE OF ACTION PLAN:

OUTCOME STATEMENTS:

**PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME(S)**

**SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME**

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include use of assistive technology and environmental modifications, as appropriate.

ACTION STEPS <i>SKILLS TO LEARN AND TASKS TO DO</i>	FREQUENCY <i>HOW OFTEN, HOW LONG</i>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS	PROGRESS/RESULTS OF STEPS TAKEN <i>IF NO PROGRESS, STATE WHY</i>
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO				

<b>UNAVAILABLE SERVICES OR SUPPORTS</b>	<b>STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS</b>
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*After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.*

### ADDITIONAL HEALTHCARE INFORMATION

COORDINATION INFORMATION	
<b>* WHO IS THE DESIGNATED HEALTHCARE COORDINATOR?</b>	<b>PHONE:</b>
<b>DOES THE INDIVIDUAL HAVE AN ADVANCED DIRECTIVE FOR MEDICAL CARE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>IF THE INDIVIDUAL HAS AN ADVANCED MEDICAL DIRECTIVE, WHERE IS IT LOCATED?</b>	
<b>IF APPLICABLE, WHO IS THE SURROGATE HEALTH DECISION MAKER?</b>	<b>PHONE:</b>
<b>DOES THE INDIVIDUAL WANT MORE INFORMATION ABOUT ADVANCED DIRECTIVES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>** IF MORE INFORMATION IS DESIRED, WHO WILL ASSIST THE INDIVIDUAL?</b>	<b>BY WHEN?</b>

*\*A healthcare coordinator must be designated for all individuals; if the individual has a HAT score of 1, 2 or 3 they may choose to designate themselves to do this independently, or another member of the team may be designated. If the individual has a HAT score of 4, 5, or 6 a team member other than the individual must be designated to fulfill this role – assisting the individual to be involved to the maximum extent possible.  
 \*\*Information about advanced directives can be obtained through the Health Decisions Resource Team. Contact Continuum of Care for information at 1-877-684-5259.*

MEDICATION DELIVERY	
<b>*** WHO COMPLETED THE MEDICATION ADMINISTRATION ASSESSMENT TOOL?</b>	<b>AGENCY:</b>
	<b>PHONE:</b>
<b>WHAT RECOMMENDATIONS HAVE BEEN MADE TO THE IDT REGARDING MEDICATION DELIVERY?</b>	
<b>WHAT IS THE TEAM'S FINAL DETERMINATION?</b> <input type="checkbox"/> SELF-ADMINISTRATION <input type="checkbox"/> SELF-ADMINISTRATION WITH PHYSICAL ASSISTANCE <input type="checkbox"/> ASSISTANCE BY STAFF <input type="checkbox"/> ADMINISTRATION BY LICENSED/CERTIFIED PERSONNEL <input type="checkbox"/> PARENT OF A CHILD	
<i>If more than one category applies, include the explanation in the rationale below</i>	
<b>RATIONALE FOR DECISION:</b>	
<b>RESPONSIBLE PARTY(IES) FOR FILLING AND REFILLING PRESCRIPTIONS AND UPDATING THE MEDICATION ADMINISTRATION RECORD?</b>	
<b>CONTACT(S):</b>	<b>PHONE NUMBER(S):</b>

*\*\*\*A nurse must complete the Medication Administration Assessment Tool (MAAT) for all adults receiving community living, day habilitation, employment services or private duty nursing services; for adults who do not receive any of these services and for children it is assumed that the parent/guardian takes full responsibility for medication delivery and completion of the tool is optional.*

### INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: SUPPORT PLANS

For each targeted area, document the <b>urgency</b> of training, as follows:	For each IDT member who must complete training, specify the <b>type</b> , as follows:			
<ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>	<ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to implement the plan)</li> </ul>			
SUPPORT PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> <b>MEALTIME PLAN</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>TUBE FEEDING PROTOCOL</b> <i>(INCLUDING POSITIONING)</i>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>BEHAVIOR SUPPORT PLAN</b> <input type="checkbox"/> <b>BEHAVIORAL CRISIS PLAN</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>THERAPY PLAN (COMMUNICATION)</b> <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> COMMUNICATION DICTIONARY <input type="checkbox"/> 24-HOUR COMMUNICATION SYSTEM <input type="checkbox"/> INTERACTIVE COMMUNICATION ROUTINES <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>THERAPY PLAN (OCCUPATIONAL)</b> <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> SENSORY ISSUES <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>THERAPY PLAN (PHYSICAL)</b> <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> LIFTING AND TRANSFERRING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>NUTRITIONAL/DIETARY PLAN</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>HEALTHCARE PLAN</b> <i>(REQUIRED IF HAT SCORE IS 4, 5, OR 6)</i>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>OTHER (SPECIFY):</b>	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			

**INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: MEDICAL CRISIS PREVENTION/INTERVENTION PLANS**

For each targeted area, document the <b>urgency</b> of training, as follows: <ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>		For each IDT member who must complete training, specify the <b>type</b> , as follows: <ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to implement the plan)</li> </ul>		
CRISIS PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> CARDIAC CONDITION	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> GASTROINTESTINAL	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> RESPIRATORY/ASTHMA	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> DIABETES	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> ASPIRATION	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			

**INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: OTHER SUPPORTS**

For each targeted area, document the <b>urgency</b> of training, as follows:		For each IDT member who must complete training, specify the <b>type</b> , as follows:		
<ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>		<ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to follow procedures)</li> </ul>		
TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input checked="" type="checkbox"/> <b>SAFETY</b> <input checked="" type="checkbox"/> EMERGENCY PROCEDURES <input checked="" type="checkbox"/> EMERGENCY CONTACTS <input checked="" type="checkbox"/> INCIDENT REPORTING <input checked="" type="checkbox"/> EVACUATION AND ESCAPE ROUTES <input checked="" type="checkbox"/> STATUS OF RIGHTS (E.G., PRIVACY) <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>CHOICE</b> <input checked="" type="checkbox"/> SKILL LEVEL <input checked="" type="checkbox"/> LEVEL OF INFORMED CONSENT <input checked="" type="checkbox"/> LIKES, DISLIKES, AND PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>COMMUNICATION</b> <input checked="" type="checkbox"/> METHODS OF COMMUNICATION <input checked="" type="checkbox"/> EXPRESSIVE AND RECEPTIVE PREFERENCES <input checked="" type="checkbox"/> KEY VOCABULARY <input checked="" type="checkbox"/> PERSONAL SPACE AND TOUCH <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>STRENGTHS AND CAPABILITIES</b> <input checked="" type="checkbox"/> ACTIVITIES OF DAILY LIVING <input checked="" type="checkbox"/> INTERESTS AND HOBBIES <input checked="" type="checkbox"/> SUPPORT STRATEGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>LEARNING STYLE</b> <input checked="" type="checkbox"/> ENVIRONMENTAL FACTORS <input checked="" type="checkbox"/> MOTIVATORS <input checked="" type="checkbox"/> PROMPT LEVELS <input checked="" type="checkbox"/> VISUAL/AUDITORY/TACTILE PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>INDIVIDUAL SERVICE PLAN</b> <input checked="" type="checkbox"/> IDT MEMBER ROLES AND RESPONSIBILITIES <input checked="" type="checkbox"/> NARRATIVE SECTION <input checked="" type="checkbox"/> ACTION PLANS <input checked="" type="checkbox"/> STRATEGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>SUPPORT NETWORK</b> <input checked="" type="checkbox"/> NATURAL SUPPORTS <input checked="" type="checkbox"/> COMMUNITY SUPPORTS <input checked="" type="checkbox"/> VISITATION RIGHTS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>CULTURAL/SPIRITUAL VALUES AND BELIEFS</b> <input checked="" type="checkbox"/> SPIRITUALITY <input checked="" type="checkbox"/> CULTURAL PREFERENCES <input checked="" type="checkbox"/> TRADITIONS AND CELEBRATIONS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>MEDICATIONS</b> <input checked="" type="checkbox"/> LEVEL(S) OF SUPPORT <input checked="" type="checkbox"/> ROUTE-SPECIFIC INFORMATION <input checked="" type="checkbox"/> PURPOSES <input checked="" type="checkbox"/> SIDE EFFECTS <input checked="" type="checkbox"/> ALLERGIES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			

### INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS FOR OTHER SUPPORTS (Continued)

For each targeted area, document the <b>urgency</b> of training, as follows: <ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>	For each IDT member who must complete training, specify the <b>type</b> , as follows: <ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to follow procedures)</li> </ul>			
TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input type="checkbox"/> <b>SEXUALITY AND RELATIONSHIPS</b> <input type="checkbox"/> INFORMED CONSENT <input type="checkbox"/> PAST HISTORY <input type="checkbox"/> SUPPORTS <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>DECISION MAKING</b> <input type="checkbox"/> INDEPENDENT <input type="checkbox"/> GUARDIANSHIP STATUS <input type="checkbox"/> SURROGATE HEALTH DECISION MAKER <input type="checkbox"/> POWER OF ATTORNEY/CONSERVATOR <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> <b>SPECIAL CONCERNS REGARDING ROUTINES</b> <input type="checkbox"/> WEEKDAYS <input type="checkbox"/> EVENINGS <input type="checkbox"/> WEEKENDS <input type="checkbox"/> LEISURE PREFERENCES <input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			
<input type="checkbox"/> OTHER (SPECIFY):	<input type="checkbox"/> Case Manager <input type="checkbox"/> Residential Staff <input type="checkbox"/> Day Support Staff <input type="checkbox"/> Ancillary Supports: <input type="checkbox"/> Others:			

### ISP MEETING PARTICIPANTS

**DATE OF MEETING:**

*By signing below, I am indicating that I participated in the development of this individual service plan and will be responsible for implementing relevant portions of the plan.*

*Individuals who participated in a manner other than attendance at the meeting will be listed with the method of participation stated in the signature column*

MEETING PARTICIPANTS (PRINT NAME AND AGENCY)	PHONE NUMBER, FAX, AND E-MAIL	SIGNATURE
<b>INDIVIDUAL:</b>		
<b>GUARDIAN:</b>		
<b>FAMILY (SPECIFY RELATIONSHIP):</b>		
<b>FRIENDS/ADVOCATES:</b>		
<b>CASE MANAGER (SPECIFY AGENCY):</b>		
<b>RESIDENTIAL STAFF (SPECIFY AGENCY):</b>  SERVICE COORDINATOR:  DIRECT STAFF:		
<b>DAY SERVICES STAFF (SPECIFY AGENCY):</b>  SERVICE COORDINATOR:  DIRECT STAFF:		
<b>DAY SERVICES STAFF (SPECIFY AGENCY):</b>  SERVICE COORDINATOR:  DIRECT STAFF:		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		
<b>OTHER (SPECIFY RELATIONSHIP AND AGENCY):</b>		

## Instructions

# Developing and Documenting an Individual Service Plan (ISP)

### PREPARING BEFORE THE ISP MEETING

#### **1. Ensure all Team Members have the Most Current Information about Person**

Prior to the ISP meeting, team members must complete functional and/or health assessments relevant to their discipline and role on the team that will contribute to effective planning. A written copy of these assessments, which includes both findings and recommendations, must be provided by each author to the case manager and other team members two weeks prior to the ISP meeting so that everyone has a chance to review them in preparation for the meeting. The designated healthcare coordinator will work with the individual, family, and/or providers to determine the current status of medical and dental evaluations, testing, and implementation of medical treatment recommendations. (If it is an initial ISP and no healthcare coordinator has yet been designated, the case manager will collect information about current medical and dental evaluations, testing and implementation of treatment.) In order to assure that these assessments are completed and reviewed **prior** to the ISP meeting we have removed the page from the previous ISP form titled "Assessment of Current Status" so that teams do not spend time filling that in during their meetings. However, case managers and designated healthcare coordinators are encouraged to continue using that "old" page prior to meetings as a "checklist" to track receipt of the various assessments and identify any gaps that need to be discussed with the team.

All individuals must receive the following assessments on at least an annual basis:

- physical check up
- dental exam
- Health Assessment Tool (HAT) completed by a nurse on the team
- Medication Administration Assessment Tool completed by a nurse on the team
- Updated Comprehensive Individual Assessment (CIA) completed by the case manager.
- Review of Guardianship status
- Other assessments related to the individual's diagnoses and support needs completed by the relevant discipline. (There must be an assessment for each type of therapy and service the individual has received in the prior year.)
- In addition, the team should review any findings and recommendations made by medical specialists the individual has seen. If the team disagrees with such

recommendations and therefore is not or will not be implementing them, the DDSD Decision Rationale form must be completed and filed with the original document in which the recommendations are contained. (Note: this discussion should occur at an ISP meeting held shortly after receipt of the recommendations and should only be discussed during an annual ISP meeting if the recommendations were part of one of the above assessments or were received just prior to the annual meeting.)

## **2. Ensure Participation of Specialists**

Upon review of assessments, but not later than 5 working days prior to the meeting, any member of the team may call the case manager to request that arrangements be made for one or more therapists on the team and/or an agency nurse to attend the ISP meeting by phone or in person. (Rather than allowing for input and follow up outside the meeting.) Unless the individual or guardian objects, this request shall be honored by the case manager and relevant therapist(s) and nurse(s).

## **3. Prepare with the Person for His/Her ISP**

Before the annual team meeting the case manager must meet with the individual to:

- ❑ Explain his/her rights, review client complaint procedures and dispute resolution process, share the Code of Ethics, and obtain signatures on the Addendum A form.
- ❑ Review results of assessments, helping the individual to understand their content and to add further related information or to state his/her disagreement with findings.
- ❑ Explore his/her long term vision, (ideally the individual will develop draft long term vision statements prior to the meeting that is refined and finalized with the team.)
- ❑ Help him/her prepare for the ISP meeting (including whether the individual wants to lead all or part of the meeting him/her self), and
- ❑ Identify who the individual wants to invite in addition to core members required by the ISP regulations.

### ***Pitfalls to avoid:***

- ❑ *Going to ISP meetings without current functional and medical assessments upon which to base effective planning.*
- ❑ *Not arranging for participation of key team members, including therapists and nurses when warranted based upon assessment results.*
- ❑ *Providing incomplete or inaccurate information that results in team members not knowing the person*

## **UNDERSTANDING THE ISP FORM**

The purpose of the remaining instructions is to assist case managers and inter-disciplinary teams (“team”) in completing the ISP document; it is not intended for guidance on facilitating

the person-centered planning process. For tips on planning and facilitating team meetings, please refer to training materials (e.g., *Promoting Effective Teamwork* handouts and resource pages) as well as “A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver” Chapters III & IV.

It is the collective responsibility of the team to make certain that the content of each ISP reflects the unique desires and characteristics of the individual including health and safety and that supports described will logically lead toward successful achievement of the individual’s vision.

*Each section of the electronic version of the form expands to accommodate information you insert, and will renumber pages and maintain headings. To utilize this feature, click on the grey space to insert information. In the footer, the space next to “Name” will automatically be filled with the name of the electronic file – therefore the individual’s name should be used as the file name. This will assure that the individual’s name appears on each page of the document. A “hard copy” version is available for those who want to take hand written notes during the meeting instead of using a laptop. Also be aware that a separate form is being developed for children, in the meantime this form will be used for children with the understanding that certain aspects may not be relevant depending upon the circumstances of the child and family.*

## **THE FACE SHEET**

In the top box indicate the date the meeting is held to develop the ISP, the tentative date of the next scheduled meeting, and for those individuals funded through the DD Waiver, the dates of the term of the ISP and Level of Care Packet as assigned by Medicaid Utilization Review and the Income Support Division respectively. Check boxes and insert dates and identification numbers as indicated, write in the score from the Health Assessment Tool (HAT) in the space to the right. Complete “Identifying Information” section, assuring that all items include the most current information. If an item is not applicable enter “n/a”.

The “other” sections should be used for therapists, additional family members, additional friend advocates, additional healthcare professionals, etc. If the pharmacy and the medical supply provider are different, that space can list both, or one of the “other” sections could be used for the medical supply provider.

***Pitfall to avoid:*** Copying outdated information off the prior ISP.

## **THE NARRATIVE SECTION**

This section documents the team's comprehensive discussion with the individual about his/her life experiences, strengths, dreams, preferences (likes and dislikes), medical history, health status, general types of supports needed from both natural and paid sources (specific support strategies will come later) and personal definition of meaningful day. A description of self-advocacy efforts and/or leadership roles the person is involved with should be included under strengths and gifts. Assessments shall not merely be referenced in the Narrative section, rather relevant findings and recommendations are to be synthesized and summarized.

The "Life Experiences" section includes both historical information including significant events, and a description of what life is currently like for the individual including routines and activities that are important to him/her.

The narrative also captures what the individual wants for his/her future (long-term vision), progress towards reaching the long-term vision, and which outcomes the individual wants to work on, in the near future, in relation to the vision.

The team's discussion regarding these sections is the basis upon which action plans will be developed. It is strongly suggested that the first time this format is used with any individual a separate meeting be held for the narrative section of the planning process, so that sufficient exploration of the individual's history and future aspirations is facilitated. Then a separate meeting can be focused on the action planning process, and individual specific training needs.

### **The Narrative Section** **A Note about Supporting a Person's *Long-Term Vision***

"For an individual to realize a meaningful life,  
it is important that he or she get the same opportunities  
and choices that are available to all citizens."

*-DDSD-Meaningful Life*

When a person's life experience is limited, as is often the case with people with developmental disabilities, it becomes the mission of the team to:

- 1) Know the person really, really well
- 2) Introduce the person to as many life experiences as possible, because only after knowing what the world has to offer, can people build an informed vision for their lives.

The long-term vision statements must be future-oriented. To the extent possible, use the individual's own words for his/her long-term vision statement for each life area. Then, describe the basic components that are necessary to fulfill that vision, irrespective of particular support needs. Although there are many different ways to achieve a particular vision, some basic components are usually in common regardless of who is working toward it. In other words, what would need to occur or need to be in place? (See Example 2)

***Pitfalls to avoid:***

- *Vision statements that maintain the status quo with no explanation as to why that is appropriate*
- *Vision statements that reflect team preferences rather than the individual's preferences*
- *Vision statements that contain jargon rather than the individual's own words – or words they are unlikely to understand if unable to communicate directly in their own words.*
- *Vision statements that do not relate to the individual's personal definition of a meaningful day.*
- *Listing components necessary to achieve the vision in such a way that they either create a readiness trap – or are specific to a method rather than leaving multiple methods open for consideration.*

**The Narrative Section: Progress towards Reaching the Long-Term Vision**

After identifying “what will it take to achieve this vision,” the team needs to discuss what the person has and has not done to achieve the vision (i.e., what is already in place and what still needs to occur). In describing progress towards reaching the long-term vision, care should be taken to include aspects already in place that can contribute to achieving the vision for all three life areas, what is missing, as well as barriers that must be overcome. This is the baseline from which the individual and team are starting toward achievement of the visions.

## Example 1

<b>PROGRESS TOWARDS REACHING THE LONG-TERM VISION:</b>		
For each life area, analyze what progress has been made in order to move the individual closer to his/her long-term vision, as well as what still need to occur (e.g., things to accomplish, barriers to overcome). Explain the individual's priorities and desires for completing remaining activities/tasks.		
<b>LIFE AREA</b>	<b>WHAT IS IN PLACE</b>	<b>WHAT NEEDS TO OCCUR</b>
<p><b>LIVE</b>  <b>“Live closer to my brother and his kids so I can see them all the time”</b></p> <p><b>What would it take for anyone to achieve the vision?</b> Anyone would need to:</p> <ul style="list-style-type: none"> <li>• Determine which people are willing and able to move</li> <li>• Select from available housing options near brother and his kids</li> <li>• Arrange opportunities to socialize with brother and his kids</li> </ul>	<p>Regular phone calls with brother and nephews in California, willing to consider moving to California, goes to California for holiday visits.</p>	<p>Has not determined brother's interest/intent to return to NM in the future. Does not know of available housing options near brother and his kids.</p> <p>Explore feasibility of relocating to California where brother lives now, including support services in that state. Has not determined additional opportunities to socialize with brother and his kids.</p>
<p><b>WORK/LEARN</b>  <b>“I want to be an astronaut”</b></p> <p><b>What would it take for anyone to achieve the vision?</b> Anyone would need to:</p> <ul style="list-style-type: none"> <li>• Meet education requirements</li> <li>• Meet requirements for related experience</li> <li>• Pass required mental and physical tests</li> <li>• <b>Identify job opportunity</b></li> </ul>	<p>Participation in adult literacy program                      Likes watching planes at airport                      Proximity to White Sands Missile Range</p>	<p>Meet requirements for education, related experience (including finding a relevant job), and mental and physical testing procedures.</p>
<p><b>HAVE FUN/DEVELOP RELATIONSHIPS</b>  <b>“I want to take a long vacation to California to help me decide if I want to move there”</b></p> <p><b>What would it take for anyone to achieve the vision?</b> Anyone would need to arrange:</p> <ul style="list-style-type: none"> <li>• Transportation</li> <li>• Meals</li> <li>• Lodging</li> <li>• <b>Itinerary – plan activities to do on vacation that support a decision regarding a move from New Mexico</b></li> </ul>	<p>Would stay with brother and kids (who live there). Will eat at brother's house one to two times per day. Brother is to provide some transportation while in California (to get to and from different places). Has saved up \$150 for meals and activities.</p>	<p>Determine how to get to California, and schedule date(s) with brother. Make arrangements for remaining meals while brother is at work.</p> <p>Decide what to schedule/experience while there that would help with decision of whether or not to move</p>
<p><b>HEALTH AND/OR OTHER</b>  <b>“Stop smoking”</b></p> <p><b>What would it take for anyone to achieve the vision?</b> Anyone would need to arrange:</p> <ul style="list-style-type: none"> <li>• Identify preferred cessation strategy</li> <li>• Determine type of support needs (if any)</li> <li>• Implement selected cessation strategy</li> </ul>	<p>Desires to stop and realizes he'll save money by stopping</p>	<p>Learn about various cessation strategies, determine type of support needs desired, confer with medical professionals (e.g., PCP), choose cessation strategy, implement cessation strategy with needed/desired supports in place</p>

**Pitfalls to Avoid:**

- ❑ *Failure to acknowledge skills and/or progress the individual already has in place that contribute to achieving the vision.*
- ❑ *Failure to clearly describe the gap between current status and desired status (vision).*
- ❑ *Failure to consider/identify what is most important to the individual about the gap between current status and his/her vision.*

The next step is to brainstorm all the different ways possible for obtaining the basic elements not yet achieved or in place. At this point the team is not evaluating or eliminating any of the ideas based on the particular individual's strengths, preferences and needs – but exploring all the creative options the team can think of. This list of options to consider does not need to be documented on the ISP form itself – however, it is strongly suggested that the team list all these ideas on a flipchart, so that the team can refer back to them when selecting Desired Outcomes and creating the Action Plan.

**Pitfalls to Avoid:**

- ❑ *Limiting ideas based upon perceived limitations of the individual or community.*
- ❑ *Limiting ideas that may be excellent for the individual but less convenient for support providers.*
- ❑ *Not writing all ideas down – no matter how unusual – for future reference (re: in order not to dampen creativity).*
- ❑ *Evaluating ideas as they are each stated instead of just listing all ideas out first.*

## Example 2 (Flipchart)

**Life Area:** Fun

**Vision:** “I want to take a long vacation to California to help me decide if I want to move there”

What Needs to Occur	Options <i>“Brainstorm” prior to selection of Desired Outcomes &amp; Action Steps</i>
<b>Determine how to get to California, and schedule dates with brother.</b>	Bus, car, train, plane Consider when costs are lower and when brother is available
<b>Make arrangements for remaining meals while brother is at work.</b>	Money to eat at restaurants Location of programs offering free meals (e.g. Salvation Army) Pack a cooler full of food to take or get food at grocery stores Stay with friends or relatives who cook Book a tour that includes meals
<b>Decide what to schedule/experience while there that would help with decision of whether or not to move.</b>	Decide what is wanted out of this trip (e.g. explore employment options, explore availability and price of housing, learn about support networks and/or providers in the area, explore public transportation, explore recreational opportunities related to my interests, discuss options with friends/relatives)

The brainstorming activity results in the individual and team being in a position to select measurable desired outcomes that can be achieved in, usually, the coming year. If a longer term or shorter term is needed to achieve a specific outcome, this should be clearly stated on the ISP in the Desired Outcomes narrative section. (No less than 3 months and no more than 3 years should be listed as a time frame for Desired Outcomes.)

### **Narrative Section: Building an ISP that Fosters Meaningful and Purposeful Days**

#### **Employment First**

The Developmental Disabilities Supports Division’s (DDSD) “employment first” policy stresses the value of and preference for employment for adults; teams must assure that adults are making fully informed decisions regarding pursuit of employment. Therefore it is important to explore the individuals’ interests and preferences with an eye toward potential

career opportunities. If the individual is still in school, the team should still explore his/her ideas and preferences for a career so that learning can lead toward future employment. A critical question: How is the ISP moving this person toward competitive employment?

### **Fostering a Sense of Purpose in a Person's Day in addition to Employment**

The ISP must include activities that support an individual to routinely explore, secure, maintain, and/or change memberships, valued roles, and/or personal relationships in the community. Supports that comply with Meaningful Day expectations are age appropriate and provide a wide variety of planned opportunities to build personalized relationships and natural supports in the community. Such supports also include substantial and sustained opportunity for optimal health, self empowerment, and skill development and/or maintenance. If the individual chooses to access Community Access, Supported Employment and/or Adult Habilitation services as a support toward reaching their vision, one or more of the eight types of activities listed below must be included in the individual's action plans:

1. Explore, secure, maintain and/or change supported or competitive jobs;
2. Explore, secure, maintain and/or change post secondary educational activities
3. Explore, secure, maintain and/or change volunteer activities;
4. Experience/participate in community exploration, companionship with friends and peers;
5. Develop and regularly experience chosen hobbies;
6. Maintain family contacts;
7. Engage in community events, education experiences, and those activities and services where person without disabilities are involved.
8. Learn and develop new skills to support purposeful participation and independence in the community.

#### ***Pitfall to Avoid:***

- *Focusing on IF rather than HOW. We are NOT asking IF a person wants to become a respected, contributing, active part of his/her community but asking him/her HOW we support him/her to achieve this universal outcome. A person's vision should provide the guidance to his/her team for how s/he wants to do this.*

### Example 3

<b>An Example of Building A Meaningful Day Outcome from A Person's Vision</b>		
A Person's Vision, (This person communicates non-verbally )	An Acceptable Meaningful Day Outcome based on Vision	An Unacceptable Day Outcome
<b>I want to form close friendships with other retirees like me who share my love of classical music.</b>	I will form new friendships with at least 4 other persons who share my interest in classical music by next March.	Jay plays his classical music to others at the Adult Habilitation Center 3 times a week.

### The Narrative Section: Desired Outcomes

Outcomes must relate to the individual's vision and personal definition of meaningful day, and include a description of how the individual defines success of the outcome in measurable terms. For example, the team clarified with the individual in examples 1-3 that for him success is to "be an astronaut" means being employed as an astronaut not just being a passenger on the space shuttle. This clarification of the vision makes it possible for outcomes to be measurable and still lead toward the vision in a way that the individual defines as meaningful, measurable progress. In most cases there will be at least one Desired Outcome for each life area, but the individual may choose to have multiple Desired Outcomes for each life area.

**Desired Health Outcomes:** In addition, individuals will often have desired outcomes related to their health, which do not directly lead toward achievement of their other Desired Outcomes. for example, "remove feeding tube and return to eating orally," "lose 20 pounds," "get in shape so I can go the whole way at the 10K Zoo Run."

In rare instances, an individual may choose not to have a Desired Outcome for a life area where everything is going well and he/she prefers to prioritize outcomes for the other life areas. In this case, the rationale for not including a Desired Outcome for that particular life area must be stated in the Desired Outcomes box. This rationale should include a summary of the outcomes the individual has already achieved for that life area, including related valued roles and relationships. For example, if the individual is happy to continue living with his/her sister, and the individual does not desire, nor require any services in that setting, then a rationale could be made for not having a Desired Outcome in the area of "Live". Part of the rationale should summarize the individual's valued role within the family and neighborhood and the outcomes already achieved in that home setting.

**A Desired Outcome is required for each live area for which the individual receives paid supports through the DD Waiver.** Even if the individual does not receive paid supports in a particular live area, the individual may still choose to have a Desired Outcome based entirely upon natural supports included in the ISP.

***Pitfalls to Avoid:***

- ❑ *Although learning skills to complete activities of daily living (e.g. laundry, dressing, cooking, cleaning) may be action steps that contribute toward increased independence and therefore may lead to achievement of a particular desired outcome (e.g. living independently), activities of daily living shall not constitute the desired outcome itself.*
- ❑ *Vague or excessively broad desired outcomes that are not easily measured.*
- ❑ *Conversely, desired outcomes that are too narrow or do not provide the individual with opportunities for skill building or personal growth.*
- ❑ *Desired outcomes that are not relevant for the individual or that do not relate to his/her long-term vision.*
- ❑ *No desired outcomes that lead to inclusion of the individual as a valued member of his/her community.*

## Example 4

**Life Area:** Work

**Vision:** I want a job as an astronaut

What Needs to Occur	Options	Desired Outcome
<b>Meet educational requirements</b>	Visit university or technical school Learn about NASA training program(s) Research on Internet	Complete entrance requirements for Community College, including passing GED exam & submitting an application, so I can work toward a college degree.
<b>Meet requirements for related experience</b>	Contact NASA Research on Internet Speak to an astronaut	Participate in a scientific research project related to outer space so I can gain experience. <i>(Note: I decided to wait to explore flying lessons – maybe next year)</i>
<b>Pass mental and physical testing procedures</b>	Contact NASA Research on Internet Speak to an astronaut Get in shape (mentally and physically)	Complete course on stress management and increase physical fitness so that I can run 10 miles and lift 200 pounds.
<b>Obtain a related job</b>	Contact NASA Research on Internet Speak to an astronaut Obtain entry level and/or related job	Obtain a job or volunteer opportunity at White Sands related to space flight.

### The Narrative Section: The Individual's Definition of a Meaningful Day

This part of the narrative is to be reviewed and refined after the action plans are completed. Few of us spend all our waking hours working toward our visions for our lives, yet we do spend most waking hours on activities that are meaningful to us. Those we serve deserve

no less. Therefore the team should reflect upon the completed ISP by answering the following questions:

1. Do action steps include activities:
  - a. the individual likes/wants to do,
  - b. that lead toward the vision statements, and
  - c. that support the individual in socially valued roles?
2. What other activities are important to the individual that have not been captured into the action plans (because they do not relate directly to a desired outcome)?
3. What new opportunities does the individual want to explore that are not captured in the action plans?

The team will use the results of this reflection to assure that each individual has a personal definition of what a meaningful day means to him/her. "One size fits all" descriptions are not acceptable, and this personal definition must comply with the definition of Meaningful Day included in the definitions portion of the 2006 DD Waiver Standards. If the answer to #1 above is not yes, the team should go back to the action plans to refine them. Information added in response to #2 and #3 may be reflected only in this section, but must then be used by the team and especially by Community Living and Community Inclusion providers when developing the schedule to support the individual throughout the week/month.

***If the team feels the person's vision does not adequately articulate a meaningful day for a person, then teams will revisit the vision and also seek technical assistance on how to support meaningful day opportunities.***

## Example 5

### **Personal Definition of Meaningful Day**

Every day: Start the day massaging nice smelling lotion into my dry skin while playing classical music and talking to me about the latest news in town. Tell me what the weather is like so I can pick a pretty outfit to wear. I go to my shredding job from 9-11 am each day and then to swimming group at 11:30. I'll need lotion again after my daily swim, and then enjoy visiting with my swim group friends while they eat lunch (usually at the picnic tables next to the pool, but sometimes I go along when they decide to eat at a restaurant). After lunchtime, I need a two hour nap, during which my feeding tube will be hooked up. Make sure I get out of my wheelchair for awhile several times each day!

Every week: I like a lot of variety in my schedule so offer me choices from among my favorites list at least 4 days each week. My favorite activities are: playing with the animals at the humane society, visiting the zoo and the aquarium, going to the Body Shop to buy new lotions and flavored lip balm (if you take me there in the evening Gina will usually be working and she's my favorite clerk), movies, the flea market and art fairs, classical music concerts, listening to someone read me the newspaper, listening to mystery books on tape, listening to "performance today" on the public radio station, hunting for a better job (my shredding job allows me to buy things, but it is boring), planning for my trip to the beach. Also, make sure I don't miss "Mystery" on Sunday night TV.

Occasionally: Invite my swim group friends over for a party or to watch "Mystery" with me.

## **THE ACTION PLANS**

Each Desired Outcome will have a separate Action Plan and there will also be an action plan for health related issues which do not relate directly to achievement of the Desired Outcomes for Live, Work/Learn, Fun/Relationships or Health/Other. It is important to build upon the individual's strengths when designing action steps; however, it is also important to acknowledge challenges and obstacles the individual and team will need to accommodate or overcome in order to be successful. These challenges and obstacles should be identified and addressed prior to finalizing actions steps.

Respite services do not need to be included in action plans, unless the respite provider is a responsible party for one or more action steps toward one or more desired outcomes. Otherwise it may be reflected solely on the face sheet, individual specific training section and the budget. Those providing substitute care are responsible to work on the desired outcomes in similar fashion to the family living provider.

### ***Pitfalls to Avoid:***

- *Team uses challenges/obstacles to create a "readiness trap"*
- *Team ignores challenges in an attempt to be person-centered and strengths based, but thereby does not arrange necessary supports to achieve success*

### **The Action Plan: Action Steps**

Action Steps (first column) should describe steps the individual will take independently, skills that the individual wants to learn, as well as steps other individuals will take to provide support, including natural supports, community supports and paid supports. The number and complexity of action steps the individual is to complete must be tailored to meet his/her desires, abilities and challenges. Action steps will also specify how the person will be actively and regularly engaged in community exploration so that the person's experiences

and expectations will expand. All Community Inclusion Services listed in the action plan must directly relate to each person's desired outcomes that reference his/her personal definition of a meaningful day. All of these experiences should be planned, purposeful (not just "time fillers") and reflected in daily schedules (schedules may be more specifically reflected in strategies developed to compliment the action plan).

The following are examples of Meaningful Day activities, for use by teams, in creating measurable ISP action plans related to the individual's personal definition of meaningful day. These examples include application of the DDSD "employment first" principle, community inclusion as well as purposeful activities based on each individual's vision and choices.

1. The individual is engaged in daily activities that lead toward his/her desired outcomes, as evidenced by:
  - a. The individual is trying new things, and learning and/or maintaining skills which are intended to result in the attainment of an identified outcome in his/her ISP.
  - b. The individual is doing things on his/her own to gain more confidence and skills.
  - c. The individual is choosing what he/she wants to do and is doing things in the community.
  - d. The individual is engaged in preventative health care activities/interventions as needed.
2. Support provided to an individual while he/she is engaged in work that is compensated under the Fair Labor Standards Act.
3. Work exploration in the community to learn about jobs that might match the individual's interests and skills.
4. Volunteer activities in the community, as long as the individual can be observed to have regular significant personal interactions with non-disabled peers or recipients of the volunteer service.
5. Instruction when it can be demonstrated that learning or skill development is linked directly to the individual's vision and desired outcomes. This includes instruction by direct care staff conducted under a structured plan developed by a therapist or time when the therapist, with the active engagement of the individual, is modeling, instructing or consulting with direct support staff on therapeutic interventions.
6. The individual is engaged in exploring new interests and/or relationships or establishing meaningful social roles consistent with DDSD policy.
7. Retirement activities, as long as such activities are consistent with: 1) the DDSD definition of Meaningful Day, 2) the individual's personal definition of a meaningful day, and 3) activities undertaken by non-disabled retirees in the broader culture.

**Pitfalls to Avoid:**

- ❑ *Action steps that only talk about what the staff will do, but not what the individual will do – or vice versa*
- ❑ *Action steps that are vague, not measurable*
- ❑ *Action steps that are not specific to the individual’s strengths and needs*
- ❑ *Action steps that do not directly contribute to achievement of the desired outcome or personal definition of meaningful day*
- ❑ *Repeating the same action steps under multiple desired outcomes*
- ❑ *Activities that the general population would not engage in on a regular basis for extended periods of time (examples: going to the park every day for several hours; walking in the mall to “window shop” several times a week)*
- ❑ *Extensive time spent in skill building or leisure activities that isolate the individual from non-disabled peers (e.g. extensive TV viewing, volunteer work in isolated or congregate setting, sheltered work for longer than needed for specific skill development)*
- ❑ *Activities which are not age appropriate (e.g. coloring in children’s coloring books, shoe-lace “sewing” cards)*
- ❑ *Action steps that simply reflect routine care and support that is expected as part of the service delivered but doesn’t directly contribute toward achievement of the desired outcome (e.g. staff reminding an individual to shower 3 times per week is not a legitimate action step in most instances)*

**The Action Plan: Frequency**

The second column addresses how frequently the step will occur (e.g. one time only, daily, weekly, monthly, quarterly) as well as time devoted to the step (e.g. 30 minutes, an hour, before bedtime, after lunch) and if relevant, for how long (e.g. for the next 3 months, all year).

***Pitfall to Avoid:*** *Putting frequency without duration or vice versa.*

Some steps are brief and self-explanatory; however, many steps will require expanded detail and strategies to be developed after the meeting in order to support implementation of the step (e.g., when the individual wants to learn a skill/task). Such detailed strategies should be detailed on a “Teaching and Support Strategies” form or in the relevant support plan and are due to the case manager and other team members within two weeks following the ISP meeting. Whether or not such strategies are due is indicated in the third column.

***Pitfall to Avoid:*** *Failure to require detailed strategies when they are needed.*

### **The Action Plan: Responsible IDT Members(s)**

The fourth column lists the individual(s) responsible for carrying out the step, and can include the individual, one or more natural supports, and/or paid providers.

#### ***Pitfalls to Avoid:***

- ❑ *Failure to consider natural supports*
- ❑ *Failure to let the individual complete action steps independently whenever possible*

### **The Action Plan: Target Date(s)**

The fifth column identifies when the step is expected to begin and/or be completed (depending upon the nature of the action step). Please specify whether each date relates to a start date, or completion date.

***Pitfall to Avoid:*** *Putting start dates without completion dates or vice versa (when both are needed)*

### **The Action Plan: Documentation and Reporting Requirements**

The sixth column identifies how objective data/documentation will be collected and reported regarding implementation of each action step. The purpose of data collection is to learn the results of action steps and strategies completed and for the team to use that information to improve practice and assure continued progress toward desired outcomes. Specific data must be collected regarding progress in the context of the individual's personal definition of a meaningful day, based upon staff observation of the person's response to purposeful daily activities. Documentation for some action steps may involve creation of a data collection form as part of the detailed strategies submitted following the meeting. In that case, just state that a form will be designed and submitted with the strategies. Other action steps may be documented on standardized data collection form (e.g. Community Participation/Exploration Form).

#### ***Pitfalls to Avoid:***

- ❑ *Listing documentation that doesn't directly measure progress toward and completion of each action step*
- ❑ *Listing excessive documentation beyond what is required to measure progress toward and completion of each action step*
- ❑ *Designing data collection method or form which interferes with integration in the relevant community setting*

- *Not quickly reporting to the team changes needed based upon lack of progress or realization that activities are not compatible with the individual's preferences.*

### **The Action Plan: Progress/Results of Steps Taken**

The final column is a place to capture team meeting discussion regarding action steps implemented. This will be blank at the initial/annual meeting, but used when the team meets or confers to review progress or to address concerns. If a step is completed, the date of completion and by whom is to be stated in this column. If collection of objective data demonstrates that progress is not being made, the reasons for lack of progress should be listed here and the team should consider revisions to the action plan, strategies and/or support plans to overcome those obstacles (see plan revision section below).

#### ***Pitfalls to Avoid***

- *Failure to address lack of progress*
- *Assuming that lack of progress is the individual's fault (e.g. "not interested, too old, to disabled") rather than changing the steps and/or strategies to ensure success*
- *Failure to revise the action plan when all/most action steps are completed and the individual is ready for more action steps*

### **The Action Plan: Unavailable Services/Supports & Steps to Obtain**

Below the Action Steps table is a place to list services/supports that the individual needs in order to achieve the desired outcome, but which are currently unavailable, and the steps the team will take to obtain those services or supports. If the steps do not result in obtaining the needed service or support, the case manager or other designated team member must complete and submit a "Request for Regional Office Intervention" form to the local regional office for assistance (this form is included in the appendix of the Case Management Operations Manual and is available on the DDS website). This section can be used to list any type of service or support including:

- Natural supports and generic supports
- Specialty Services (e.g. therapy, medical specialists, durable medical equipment, medical supplies, augmentative communication devices, assistive technology)
- Environmental Modifications
- Private duty nursing
- Transportation

**Pitfalls to Avoid:**

- ❑ Failure to consider natural and generic community resources
- ❑ Failure to seek Regional Office Intervention if unable to procure necessary resources

**Example 6**

**Life Area:** Work/Learn      **Vision:** Jane will start a catering business

**Outcome Statement:** Jane will obtain approved certificate from the Department of Health for her catering location and cooking equipment.

**Challenges and Obstacles:** Doesn't yet own commercial stove/oven or chopping equipment; safety concerns for operating chopping equipment and removing hot food given limited muscle control from cerebral palsy.

Action Steps	Frequency	Strategies Needed	Responsible IDT Members	Target Dates	Documentation & Reporting Requirements
Identify equipment which will accommodate muscle control limitations	Explore options every Tuesday	No	Jane, OT, job coach	Start 4/15/06 complete 6/1/06	Job coach quarterly report; plus progress notes for each Tuesday
Create a budget plan to pay for equipment	One time appointment	No	Jane, Jane's sister, DVR	By 5/1/06	Jane gives budget plan to case manager
Call to find out DOH approval criteria	One time	No	Jane and job coach	By 5/1/06	Materials obtained
Arrange purchase and installation of identified equipment	One time	No	Jane, Jane's sister and job coach	Between 5/1/06 & 6/30/06	Case manager monthly visit form note – once Jane gives "tour"
Prepare for Department of Health inspection and arrange for inspection	4 separate days before inspection	Yes	Jane, job coach and OT	By 7/30/06	Progress notes for prep session and date of inspection
<b>Unavailable Services or Supports</b>			<b>Steps to Obtain Needed Services or Supports</b>		
OT resigned and provider agency has not yet identified a replacement			<ol style="list-style-type: none"> <li>1. Therapy agency continue recruitment efforts</li> <li>2. Case manager contact alternative agencies to see if they have an OT and if so, explore possibility with Jane of exercising her freedom of choice to change agencies. If not, will submit Request for Regional Office Intervention form.</li> </ol>		

## **ACTION PLAN FOR BASIC HEALTH AND SAFETY RELATED SUPPORTS:**

Some individuals require supports to assure their health and safety that do not directly relate to achievement of their Desired Outcomes for Live, Work/Learn, and Have Fun/Develop Relationships (although health and safety is vital to all life pursuits). This page captures action steps related to assuring such supports will be put in place. This page is NOT intended to duplicate an individual's Healthcare Plan, Crisis Prevention/Intervention Plan, Mealtime Plan, etc. Rather it is a place to list the need for such plans to be developed or updated and implemented. (If support plans are already in place, just check the relevant box on the page titled "Individual Specific Training Requirements: Support Plans").

The "Results of Steps Taken" will be blank at the initial/annual meeting but will be used when the team meets to review progress or to address concerns. If a step is completed, the date of completion should be noted in this column. This column should also be filled in by the case manager if they become aware of completion or lack of progress through site-visits, review of quarterly reports, or by communication with the responsible party. If progress is not being made, reasons for lack of progress must be listed and the team should consider revisions to the action steps to overcome those obstacles (see plan revision section below).

If the individual feels that certain health information needs to remain private and not shared with the full team, but support is still required for that issue or condition, the action plan step can refer to a private meeting with the individual's healthcare coordinator and/or nurse on the team to identify appropriate ways to address the concern.

### ***Pitfalls to Avoid:***

- ❑ *Failure to address preventative healthcare measure that are needed*
- ❑ *Including detail that is better addressed through the Healthcare Plan and/or Crisis Prevention/Intervention Plan or other support plans*
- ❑ *Failure to determine results*
- ❑ *Demanding particular testing or treatment – usurping the physician's role in determining the most appropriate, least intrusive testing/ treatment to address the symptoms*

## Example 7

### Action Plan for Basic Health and Safety Related Supports

Action Steps	Frequency	Strategies Needed	Responsible IDT Members	Documentation & Reporting Requirements	Target Date(s)	Progress/ Results of Steps Taken
Develop Crisis Prevention Plan: Asthma	One time – review quarterly to assure current	yes	Residential Provider Nurse	Completed Crisis Prevention Plan to CM, House Supervisor, Employment Service Coordinator	By 4/15/06	
Arrange for SAFE evaluation re: suspected aspiration	One time	No	Residential Service Coordinator	Email individual, case manager & sister appointment date. SAFE clinic report of findings to case manager & sister	By 4/15/06	
Assure electric toothbrush is charged	after breakfast & before bed	No	Residential Staff	House lead to monitor weekly and note in house logs.	ongoing	

### ADDITIONAL HEALTHCARE INFORMATION

This is the page to designate the member of the team who will assist the individual in coordinating their healthcare services. The designated healthcare coordinator can be any member of the team, including the individual, family member or other natural support, who is willing and able to arrange medical appointments and lab work, share results with appropriate team members, assure follow through occurs for physician orders and therapy treatments, and assure implementation of medication delivery supports. For individuals with a HAT score of 4, 5, or 6 if the individual wishes to be designated as their own healthcare coordinator, an additional member of the team must also be designated, to assist him/her in fulfilling that role to the maximum extent possible while still assuring coordination of the multiple and/or serious health issues that led to the higher HAT score.

The level of support needed for medication delivery, as well as the responsible party for filling prescriptions and updating the Medication Administration Record (MAR) is to be described and may be a different team member than the designated healthcare coordinator. Please see the DDS Medication Assessment and Delivery Policy and Procedures for details on determining the level of support needed for medication delivery. Some

individuals may require different levels of support for different medications; for example, an individual may be able to self-administer oral medications, but require a nurse to administer injections. If this is the case, use the “rationale for this decision” section to describe the level needed for each type of medication.

There is also space to indicate whether or not the individual has an advanced directive in place and/or desires more information about creating or revising an advanced directive.

## **INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS**

Many ISPs require implementation of a variety of support plans. The most common types of support plans are listed on the page titled “Individual Specific Training Requirements: Support Plans. Such support plans are due to all team members two weeks after the ISP meeting and must be attached to the ISP when submitted to the regional office. In addition, the relevant team member must provide training on the support plan to designated team members.

The page titled “Individual Specific Training Requirements: Medical Crisis Prevention/Intervention Plans” provides space to address these individual specific training requirements. Please note that Behavioral Crisis Prevention/Intervention Plans are included on the previous page with the Behavior Support Plan.

The next two titled “Individual Specific Training Requirements: Other Supports provide space to address a variety of other individual specific training.

If the “others” box is checked under “Who Receives Training,” please list specific parties to be trained in the space to the right. Use the key at the top of the page to indicate the Urgency and Type of training needed by each of the various team members. In the far right column state at least the title and agency that will deliver the training; include a specific name if possible. If different individuals will be conducting individual specific training for differing audiences (e.g. community living versus day service staff), this must be noted in this column. The designated healthcare coordinator should be included in all individual specific training related to at least 1) support plans, 2) crisis prevention/intervention plans, 3) communication, and 4) medications. In some cases a healthcare professional will serve as the designated healthcare coordinator and may be delivering such training rather than attending as a participant.

Some topics are mandatory for all individuals served, although of course the specific information covered will be individualized. Mandatory topics are indicated by the fact that

they are pre-checked in the Topic Area column. The one exception is Medications; in rare instances where there is an individual who does not take any medication (even vitamins or over the counter PRN medications) this box may be unchecked. However, teams are cautioned that should the individual become ill, support persons need to know what level of support is needed as well as purpose and side effects of any medication prescribed at that time.

Per DDS Policy, each provider agency is responsible for implementing a tracking system to prove staff completed individual specific training per each ISP. It is advisable for those who deliver trainings to also keep a copy of participant sign in sheets.

### ***Pitfalls to Avoid:***

- ❑ *Leaving out natural supports when considering who needs to be included in training*
- ❑ *Failure to address urgency of training*
- ❑ *Failure to be specific with regard to who will provide the training*
- ❑ *Failure to follow up to ensure training is provided, including to new staff as they join the team*

## **ISP MEETING PARTICIPANTS**

This page documents the participants of the meeting to develop the ISP. If a team member was unable to participate in person, indicate the mode of participation in place of the signature (e.g. by phone, by input to individual and case manager prior to meeting).

## **THE ISP BUDGET**

*Please note that in addition to the ISP and relevant support plans, a MAD 046 indicating the budget for Waiver funded services must also be attached. For detailed instructions on how to develop the budget and complete the MAD 046 budget form please refer to the Resource Guide for Independent Case Managers chapter VIII.*

## **PLAN REVISIONS**

Updates to the Narrative can be added at any time by adding the new information with a date noted in parentheses immediately in front of the new information. If the new information results in a new desired outcome, or revisions are needed in the action plan for an existing desired outcome, a new action plan sheet should be completed with the “update” box checked and the date indicated in the upper left corner. If the action plan for an existing desired outcome is revised it replaces the previous action plan (with the earlier date), but

the original/earlier action plan should be maintained in the primary record to document the evolution of the ISP. To avoid confusion, the earlier action plan should indicate in the progress/results column the reasons the revision was needed and refer to the updated action plan.

In some situations, the action plan does not need to be revised, but strategies for certain action steps do need to be revised to address lack of progress. Other times, one or more support plans need to be revised. This should be described in the far right column of the action plan and revised strategies and/or support plan(s) submitted to the case manager by the responsible party within two weeks. Revised strategies and support plans will have the new date indicated at the top of each page.

If the Health & Safety Action Plan needs to be revised, a new one should be completed with the “update” box checked and the date indicated in the upper left corner. The original/earlier health & safety action plan should be maintained in the primary record to document the evolution of the ISP. To avoid confusion, the original/earlier health & safety action plan should indicate in the results column reasons the revision was needed and refer to the updated health & safety action plan. (See example 6 below with revisions to example 5 indicated in bold.)

If revisions to an action plan and/or health & safety action plan result in a need to revise individual specific training requirements, in the relevant row(s) of the support plan, crisis plan, and/or topic area column, note the date new training requirement was added then insert new information into the other columns reflecting the specifics of the new training requirements. Revisions may include addition of a new support plan, crisis plan and/or topic area; addition of a target audience or change in type of training for that audience for an existing support plan, crisis plan and/or topic area; a change in urgency, and/or a change in who receives or provides the training.

The case manager must provide all revised pages of the ISP to all team members and the Regional Office. Parties responsible for revising strategies and support plans must provide copies to all team members including the case manager and the DDSD Regional Office within two weeks of the meeting in which the revisions were discussed.

### ***Pitfalls to Avoid:***

- ❑ *Revising part of the ISP without revising related sections*
- ❑ *Losing previous versions of action plans or health & safety action plans*
- ❑ *Waiting until the annual meeting to make revisions, instead of doing them as soon as the need is identified.*

## Example 8

Change to Health & Safety Page with Change to Individual-Specific Training Requirements

*Scenario: The SAFE evaluation in Example 4 above confirmed aspiration risk.*

□ Original

X Update

Date: 5/30/06

Action Steps	Frequency	Strategies Needed	Responsible IDT Member(s)	Documentation & Reporting Requirements	Target Date(s)	Progress/Results of Steps Taken
Develop Crisis Prevention Plan: Asthma	One time – review quarterly to assure current	Yes	Residential Provider Nurse	Completed CPP & training sign in on file & in house	By 4/15/06	completed
SAFE evaluation regarding suspected aspiration	One time	No	Residential Service Coordinator	Requested SAFE clinic send report to case manager & sister upon completion. <b>Verbal results shared at the appointment.</b>	By 4/15/06	Appointment attended 5/23/06 <b>Aspiration risk confirmed</b>
Develop meal time & tooth brushing protocol & train staff to implement	One time – review quarterly to assure current	Yes	<i>SLP &amp; PT</i>	Completed mealtime protocol & tooth brushing protocol; sign in sheet for training;	By 6/20/06	(Insert once completed)
Assure electric toothbrush is charged; <b>CP; oral hygiene reduces pneumonia risk</b>	Twice daily – after breakfast and before bed	No	Residential Staff	House lead to monitor weekly and note in house logs.	ongoing	<b>new brush heads to be purchased ASAP due to evidence of wear &amp; tear</b>

## INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: SUPPORT PLANS

For each targeted area, document the <b>urgency</b> of training, as follows: <ul style="list-style-type: none"> <li>• 1 – Prior to working with the individual</li> <li>• 2 – Prior to working alone with the individual</li> <li>• 3 – Within 30 days of working with the individual</li> <li>• 4 – Other (specify)</li> </ul>	For each IDT member who must complete training, specify the <b>type</b> , as follows: <ul style="list-style-type: none"> <li>• A – Awareness level (e.g., obtains basic familiarity with the plan)</li> <li>• K – Knowledge level (e.g., learns specifics strategies/techniques)</li> <li>• S – Skill level (e.g., demonstrates ability to implement the plan)</li> </ul>			
SUPPORT PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input checked="" type="checkbox"/> <b>MEALTIME PLAN</b> Added 5/30/06	<input checked="" type="checkbox"/> Case Manager	3	A	Mary Chat, SLP (Eating technique) + Joe Muscle, PT (for positioning portion) + Jane Nojunkski, Dietician (for food texture and content)
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input type="checkbox"/> Ancillary Supports:			
	<input checked="" type="checkbox"/> Others: Sister	Prior to next home visit	S	
<input type="checkbox"/> <b>TUBE FEEDING PROTOCOL</b> (INCLUDING POSITIONING)	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> <b>BEHAVIOR SUPPORT PLAN</b> <input type="checkbox"/> <b>BEHAVIORAL CRISIS PLAN</b>	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> <b>THERAPY PLAN (COMMUNICATION)</b> <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> COMMUNICATION DICTIONARY <input type="checkbox"/> 24-HOUR COMMUNICATION SYSTEM <input type="checkbox"/> INTERACTIVE COMMUNICATION ROUTINES <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>THERAPY PLAN (OCCUPATIONAL)</b> <input checked="" type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> SENSORY ISSUES <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			Larry Techsky; OT
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input checked="" type="checkbox"/> Ancillary Supports:	3	K	
	<input type="checkbox"/> Others:			
<input type="checkbox"/> <b>THERAPY PLAN (PHYSICAL)</b> <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> LIFTING AND TRANSFERRING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> <b>NUTRITIONAL/DIETARY PLAN</b> Added 5/30/06 related to mealtime protocol	<input checked="" type="checkbox"/> Case Manager	3	A	Jane Nojunkski, Dietician
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff		S	
	<input type="checkbox"/> Ancillary Supports:			
	<input checked="" type="checkbox"/> Others: Sister	Prior to next home visit	S	
<input checked="" type="checkbox"/> <b>HEALTHCARE PLAN</b> (REQUIRED IF HAT SCORE IS 4, 5, OR 6)	<input checked="" type="checkbox"/> Case Manager	3	A	Residential & Ancillary & Sister: Mary Heart, Nurse Day: Josh Jones, Nurse
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input checked="" type="checkbox"/> Ancillary Supports:	3	K	
	<input checked="" type="checkbox"/> Others: Sister	At next home visit	S	

## **ISP Quality Assurance Process**

In order to ensure that ISPs promote health, safety, quality of life and appropriate support, quality assurance review is required. Case management and DDS staff assigned to review ISPs must complete training through the DDS training unit prior to performing this quality assurance (QA) function.

DDS requires that a quality assurance review is performed using the DDS ISP QA form for:

- ISPs for all Jackson Class Members, and
- A 10% random sample of each case manager's non-Jackson ISPs. For example, if a particular case manager has 20 non-Jackson individuals on his/her caseload, then each quarter the supervisor must select 2 of those ISPs for quality review.
- Quality review will be performed by both 1) the designated ISP QA supervisor within the case management agency and 2) a DDS designated reviewer from the regional office.

Completion of the QA form requires:

- A thorough and thoughtful review of each section of the ISP,
- Positive feedback on what the team and case manager have done well,
- Specific feedback on what is not currently adequate,
- Specific feedback on why a section(s) of the ISP is not adequate, and
- Clear instructions on how to correct the sections(s) of the ISP so it will become adequate.

The steps of the QA process must be followed in the order listed below:

1. The case manager and team develop the ISP.
2. The case manager completes the ISP form and submits it to the case management agency QA supervisor for review.
3. The case management agency QA supervisor reviews the ISP and completes the QA form.
4. The agency QA supervisor puts the completed QA form on top of the ISP and sends both documents to the regional office for review and feedback.
5. The DDS reviewer adds his/her comments to the same QA form used by the case management agency QA supervisor and returns the ISP and QA form to the case management agency. (If the DDS reviewer is not satisfied with the QA review performed by the case management QA supervisor, s/he will require the case management QA supervisor to attend additional training or obtain technical assistance within 10 working days.)

6. The case management agency QA supervisor reviews all feedback on the QA form with the case manager. *Note: the case manager should not make revisions to the ISP until feedback is received from both the agency QA supervisor and the DDSD reviewer.*
7. The case manager makes revisions to the ISP as needed and sends the revised ISP back to the DDSD regional office for review and approval or additional feedback. The case manager may request technical assistance from the regional office if help is needed to develop a quality ISP. In addition, regional office staff may request the opportunity to meet with the team to discuss ways to improve the ISP. Such requests will be made in advance through the case manager and will be handled as a separate agenda item to avoid the perception that DDSD is leading the team meeting. The case management agency has 14 calendar days to submit the newly revised ISP.
8. The regional office has 14 calendar days to review the revised ISP and return it to the case management agency indicating approval or additional feedback. If the ISP is once again not acceptable, the regional office will provide technical assistance; the case management agency will be instructed to contact the regional office to schedule this session, preferable at a time that the case manager and the case management QA supervisor can both attend.

In order to assure no lapse in services, the case manager should not wait until the QA process is complete to distribute the ISP. The ISP must be distributed to NMMUR and team members according to timelines outlined in case management standards and ISP regulations.

Non-compliance with this QA process will be sanctioned as follows:

- The regional office will notify the DDSD Statewide Case Management Unit Coordinator of agencies that are non-compliant.
- A letter will be sent to the case management agency stating instance(s) of non-compliance and DDSD's intent to refer the agency to the Internal Review Committee (IRC), if a trend is detected.
- A letter will be sent to the IRC for determination of action, if non-compliance continues. A copy of the IRC referral letter will be sent to the case management agency.
- IRC will review the situation and specify sanctions and timelines to rectify the problem.

**Pitfalls to avoid:**

- ❑ *Not completing the QA process for the annual ISP of each Jackson Class Member.*
- ❑ *Not completing the QA process for 10% of the annual non-Jackson ISPs for each case manager.*
- ❑ *Not completing required DDS training prior to conducting QA reviews on ISPs.*
- ❑ *Not providing detailed feedback on what the team did well and what, why and how to correct ISP components deemed not adequate.*
- ❑ *Not completing requested revisions to ISPs after feedback is received from both the case management agency QA supervisor and DDS reviewer.*
- ❑ *Not adhering to timelines cited above.*
- ❑ *Waiting for final approval before distributing and implementing the ISP.*

## Letter of Transfer and Receipt

Regarding the transfer of records:

Client:

Medicaid #:

DOB:

Complete address:

Phone number:

This letter is to confirm the transfer of records from the previous case management agency, \_\_\_\_\_, to the new case management agency, \_\_\_\_\_, as of today's date \_\_\_\_\_. The DD Waiver budget will be effective as of \_\_\_\_\_. The new/previous (circle) agency will prepare and submit the budget.

The records included in the transfer contain material and information from what budget year(s): \_\_\_\_\_.

If there are any questions, the previous agency's contact person is (name, title and phone):

---

**Attached** is a list of items transferred to the new case management agency. All items transferred have been inventoried. If further action is needed to obtain the items, it is noted on the form and both parties agree to the documented information.

\_\_\_\_\_  
Signature/title of sending agency/date

\_\_\_\_\_  
Signature/title of receiving agency/date

## Transfer of Records List

The following is a list of items included in the file being transferred from (sending case management agency) \_\_\_\_\_ to (receiving case management agency) \_\_\_\_\_.

Client:  
 Waiver #:  
 Complete address:

DOB:  
 Phone #:

Document	Y/N/NA	Dates of material	Action needed to obtain	Person responsible	Deadline date
Narratives					
Annual ISP					
Goals and objectives					
Annual budget					
Six month ISP					
Goals and Objectives					
Six month budget					
Addendum C (rev)					
Revised Budgets					
Addendum B					
Addendum A					
Client's Rights					
Primary FOC					
Secondary FOC					
Correspondence					
Agency Incident Reports					
Community Incident Reports					
Guardianship Papers					

Document	Y/N/NA	Dates of material	Action needed to obtain	Person responsible	Deadline date
Birth Certificate					
Copy of Social Security Card					
Copy of Medicaid Card					
Copy of Medicare Card					
MAW form					
ISD forms					
Initial Application					
Letter of Eligibility					
Allocation Letter					
Photography of Client					
Annual Physical Examination					
Current LOC					
Client Individual Assessment					
Health Assessment Tool					
Adaptive Behavior Scale					
Psychological evaluation					
Neuropsychological					
Psychiatric evaluation					
BSC evaluation					
Behavior Support Plan					
Behavior Crisis Plan					
BSC Quarterly Reports					
Initial Physical					

Document	Y/N/NA	Dates of material	Action needed to obtain	Person responsible	Deadline date
Therapy Evaluation					
Physical Therapy Quarterly Reports					
Initial OT eval					
OT quarterlies					
Initial SLP eval					
SLP quarterlies					
Vocational eval					
Residential quart					
Day hab quart					
Employment quart					
Swallowing or aspiration eval					
Mealtime plan					
Nutritional eval					
Nursing care plan					
Vision info					
Hearing info					
Dental info					
Neurological eval					
Orthopedic eval					
Podiatry info					
Lab work					
Physician's auth					
School IEP					
Jackson IHP					
CM trans revision					
Additional					

The above records have been reviewed by the sending and receiving case management agencies. Both parties agree to the contents written on the form.

---

signature/title of sending agency - date

---

signature/title of receiving agency - date

MEDICAL ASSISTANCE DIVISION		ICF/MR LONG TERM CARE ASSESSMENT ABSTRACT			
<i>Please Remember This Information is Confidential</i>					
1. Type of Review (Check One) Initial <input type="checkbox"/> Readmit <input type="checkbox"/> Continued Stay <input type="checkbox"/> Transfer <input type="checkbox"/>		2. Date of Current Admission		Mo.	Dy.
3. Patient's Name - Last First MI			4. Facility Name/City		
Individuals Full Legal Name Here			5. Name of Person Completing Abstract Case Manager Name Here		
The information recorded on this abstract should reflect the patients overall condition.					
6. MEDICAID NUMBER		7. ADDRESS OF #4			
Case Management Agency Address Here					
8. Age	9. Date of Birth	10. Sex M <input type="checkbox"/> F <input type="checkbox"/>	11. Source of Admission		12. Preliminary Evaluation Review Performed <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DIAGNOSIS/ PROBLEMS (One per line) If resident hospitalized since last certification - enter reason:			23. ASSESSMENT FACTORS		
13. MR-Level goes first			A. Physical Development & Health		
14. Major Diagnosis			1 Health Care Supervision Nursing care		SCORE
15. Major Diagnosis			2 Med Assessment nursing care		
16. Health Diagnosis			3 Med Administration nursing care		
MEDICATION - List up to four most important medications, method of administration and frequency.			B. Nutritional Status		
17. List Medications for the diagnosis above (if applicable)			1 Eating Skills Occupational Therapy		SCORE
18.			2 Diet Supervision Occupational Therapy		
19.			C. Sensorimotor Development		
20.			1 Mobility Physical Therapy		SCORE
ASSESSMENT FACTORS INDICATING NEED for SPECIALIZED SERVICES. Place the appropriate assessment factor and score in the corresponding boxes.			2 Toileting Physical Therapy		
21. Specialized Services			3 Hygiene Physical Therapy		
Assessment Factors			4 Dressing Physical Therapy		
Factor Score			D. Affective Development		
A. Physical Therapy C1, C2, C3, C4			E. Speech & Language Development		
B. Occupational Therapy B1, B2, B3, B4			1 Expressive Speech Therapy		SCORE
C. Speech Therapy E1, E2, E3, E4			2 Receptive Speech Therapy		
D. Behavior Management J1, J2, J3, j4			F. Auditory Functioning		
E. Nursing Care A1, A2, A3			G. Cognitive Development		
22. SUPPORTING DOCUMENTATION. (Please check each document being submitted and include most current date)			H. Social Development		SCORE
Preliminary Evaluation	ABS	Date	1 Interpersonal Skills Speech Therapy		
Comprehensive Functional Assessment	CIA	Date	2 Social Participation Speech Therapy		
Individual Program Plan	HAT	Date	I. Independent Living Skills		
			1 Home Skills Occupational Therapy		SCORE
			2 Community Skills Occupational Therapy		
24. PHYSICIAN'S STATEMENT I have seen and evaluated this patient and recommend <input type="checkbox"/> MRI <input type="checkbox"/> MR II <input type="checkbox"/> MR III			J. Adaptive Behaviors		SCORE
Physician Name and Address			1 Harmful Behavior Behavior Therapy		
Primary Care Physicians Name and Address Here			2 Disruptive Behavior Behavior Therapy		
			3 Socially Unacceptable, Stereotypic Behavior Therapy		
			4 Uncooperative Behavior Behavior Therapy		
<b>FOR UR AGENCY ONLY</b>					
REVIEW INFORMATION		25. Level of Care	27. Review Decision	28. Effective Date	29. Days
<input type="checkbox"/> Discharge Status		<input type="checkbox"/> MRI <input type="checkbox"/> MR II <input type="checkbox"/> MR III	<input type="checkbox"/> Approved <input type="checkbox"/> Denied		
31. RC No.	32. PA No.	33. UR Agency Reviewer Signature		34. Review Date	35. Date of Discharge
36. DISCHARGED TO: 1 HOSP 3 LNF 5 HOME 7 LAMA 9 OTH 2 HNF 4 INST 6 HHA 8 DIED				37. Facility Discharged to:	
				TOTAL SCORES	
				1.0 - 2.2 = Level I	
				2.3 - 2.9 = Level II	
				3.0 - 3.2 = Level III	
				/ 22 =	
				= .5 round off to next number	

MAD 378 Revised 4/16/95 (Replaces ISD 378)

DISTRIBUTION: White copy - UR Agency; Canary copy - Facility; Pink copy - Fiscal Intermediary; Goldenrod copy - ISD County Office

## DDSD Decision Justification Form

Effective 2/1/06

### A. Team Response to Expert Recommendations

Individuals served through the DD Waiver at times receive evaluations conducted by a variety of professionals. These evaluations typically include recommendations for the individual and the team to consider. This form provides a way to document that the team has given due consideration to the recommendations and either 1) created an action plan to implement the recommendation, or 2) made a thoughtful determination that the recommendation should not be implemented. This form should be filed with the evaluation report in which the recommendation(s) were made.

Recommendation & Source	Accept	Reject	Reason for Acceptance or Rejection	If accepted, Date ISP was revised

### B. Other Decisions Requiring Documentation of Justification:

Use this section to document rationale for any decision for which the team feels it is important to maintain clarity (e.g. recommendation for change in guardianship status, appropriate support related to individual's informed choice associated with significant risk, measures taken to assure informed choice).

Decision	Rationale/Justification	Related Actions	Responsible Party	Timeline

## DD Waiver Case Manager Monthly Site Visit Form

DDSD Version: 7-7-06

Individual's Name:	Date:
Name and Title of Family/Staff Interviewed:	Location:
<input type="checkbox"/> Jackson Class Member:	Case Manager: Agency:

Start Time:	End Time:
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A: Adequate C: Concern ***If a concern or barrier remains unresolved 2 months in a row, identify the barrier, efforts to resolve & submit a "Request for Intervention" form to the local Regional Office.***

#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:
1	<input type="checkbox"/>	Is clothing, food, and structural state of site, adequate and safe? Fire escape plan posted? Smoke alarms and fire extinguisher present?			Monthly	
2	<input type="checkbox"/>	Is <b>staff interaction</b> with the individual appropriate (e.g. supportive rather than coercive, offering choice, respectful)			Monthly	
3	<input type="checkbox"/>	Is individual protected from abuse, exploitation, neglect, injury, physical harm, emotional distress?			Monthly	<i>If "C" is checked report to IMB &amp; relevant protective services agency</i>
4	<input type="checkbox"/>	<b>Change in health status?</b> (e.g. changes in seizure or aspiration frequency, sleep patterns, bowel/bladder function, activity level, mood, or other typical behavior/routines that may indicate a health concern, significant weight gain or loss, wounds, signs of pain, including dental pain).			Quarterly, (Monthly if health concerns or new diagnosis exists)	
5	<input type="checkbox"/>	Has <b>health screening</b> been completed <b>as ordered by physician &amp; as gender/age appropriate?</b>  (e.g. blood work, Tardive Dyskinesia screening, weight, PAP, prostate, mammogram)			Quarterly	

6		If aspiration risk, are dietary instructions, mealtime protocols and/or feeding tube protocols available on site and being followed? (Also, submit quarterly aspiration report.)			Quarterly	
7		Are <b>healthcare plans</b> current & available to staff? (Required if individual has a HAT score of 4,5 or 6)			Quarterly, Monthly if concerns or new diagnosis	
#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:
8		Have there been any medical <b>appointments</b> ? Have any appointments been missed? Any <b>ER visits or hospitalizations</b> ?			Monthly	
9		<b>MARs:</b> Update CM list of medications, note changes in medications, dosages, times, etc. Note frequency of use of PRN medications & medication errors.			Monthly	
10		Is <b>current ISP</b> with associated healthcare, crisis and support plans available on site?			Quarterly	
11		<b>ISP Implementation &amp; Progress:</b>  Review goals, objectives, and data collected for appropriateness, skill level, and progress. Is there evidence that services noted in the ISP are being delivered as written in the ISP?			Monthly	
12		<b>Employment:</b> Is the individual integrated at their job? Are they receiving appropriate job supports?			Every other month	
13		<b>Recommendation Follow-up:</b> Have needed assessments, testing, and evaluations, identified in the ISP been completed and recommendations implemented?			Quarterly	

14		<p><b>Specialty Services:</b> Does the individual have timely* access to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Therapies (as per ISP)</li> <li><input type="checkbox"/> Durable Medical Equipment – in good repair with proper fit</li> <li><input type="checkbox"/> Medical supplies</li> <li><input type="checkbox"/> Specialty medical services (e.g. Neurology, Psychiatry, Cardiology)</li> <li><input type="checkbox"/> Assistive Technology, Augmentative Communication devices present, in good repair, and being used?</li> </ul>			Monthly		<p>* For DME “timely” is defined as receipt of new equipment within 150 days of request and repairs of DME within 60 days of request.</p>
15		<p><b>Behavior Supports Implementation:</b> Verify relevant documentation completed for behavioral events (e.g. data sheets) &amp; appropriate team members notified.</p>			Monthly		
#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:	
16		<p><b>Individual Satisfaction:</b> Extent of the individual’s interest in &amp; satisfaction with current environments, services, choices, relationships, privacy &amp; supports?</p>			Monthly		
17		<p>Is the individual participating in <b>integrated community activities</b> based on their interests and desires indicated in the ISP? Access to natural &amp; generic supports?</p>			Every other month		
18		<p><b>Transportation:</b> Does the individual have adequate access to transportation for employment &amp; community activities?</p>			Every other month		
19		<p>Have there been any significant <b>life changes</b> for the individual since last visit?</p>			Monthly		
Individual/Staff/Family Concerns:							
Additional Notes:							

<p>Status of Issues Identified at Previous Visits, IDT Meetings, etc.: <i>(If a concern or barrier remains unresolved 2 months in a row, identify the barrier, efforts to resolve &amp; submit a "Request for Intervention" form to the local Regional Office.)</i></p>	
<p>Follow-up Actions Required by CM:</p>	
<p>_____</p> <p>Case Manager signature</p>	<p>_____</p> <p>Date</p>

## DD Waiver Case Manager Monthly Site Visit Form Instructions

DDSD Version: 7-7-06

Name and Title of Family/Staff Interviewed:		Location:					
<input type="checkbox"/> Jackson Class Member:		Case Manager:		Agency:			
Start Time:			End Time:				
#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:	
1		Is clothing, food, and structural state of site, adequate and safe? Fire escape plan posted? Smoke alarms and fire extinguisher present?			Monthly	DESCRIBE ANY CONCERNS	
2		Is <b>staff interaction</b> with the individual appropriate (e.g. supportive rather than coercive, offering choice, respectful)			Monthly	DESCRIBE ANY CONCERNS AND/OR POSITIVE OBSERVATIONS	
3		Is individual protected from abuse, exploitation, neglect, injury, physical harm, emotional distress?			Monthly	<i>If "C" is checked report to IMB &amp; relevant protective services agency</i>	
4		<b>Change in health status?</b> (e.g. changes in seizure or aspiration frequency, sleep patterns, bowel/bladder function, activity level, mood, or other typical behavior/routines that may indicate a health concern, significant weight gain or loss, wounds, signs of pain, including dental pain).			Quarterly, (Monthly if health concerns or new diagnosis exists)	DESCRIBE CHANGES NOTED	
5		Has <b>health screening</b> been completed <b>as ordered by physician &amp; as gender/age appropriate?</b>  (e.g. blood work, Tardive Dyskenesia screening, weight, PAP, prostate, mammogram)			Quarterly	DESCRIBE ANY MISSING FROM MEDICAL SECTION OF HOME SITE RECORDS. MAY NOT BE APPLICABLE FOR DAY PROGRAM SITE VISITS.	
6		If aspiration risk, are dietary instructions, mealtime protocols and/or feeding tube protocols available on site and being followed? (Also, submit quarterly aspiration report.)			Quarterly	DESCRIBE MISSING PROTOCOLS AND/OR CONCERNS	

7		Are <b>healthcare plans</b> current & available to staff? (Required if individual has a HAT score of 4,5 or 6)			Quarterly, Monthly if concerns or new diagnosis	DESCRIBE CONCERN
#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:
8		Have there been any medical <b>appointments</b> ? Have any appointments been missed? Any <b>ER visits or hospitalizations</b> ?			Monthly	SEE SITE LOGS TO DETERMINE APPOINTMENTS SCHEDULED AND KEPT AND OCCURANCE OF EMERGENCIES OR ADMISSIONS.
9		<b>MARs:</b> Update CM list of medications, note changes in medications, dosages, times, etc. Note frequency of use of PRN medications & medication errors.			Monthly	DESCRIBE CONCERNS, INCLUDING ALARMING FREQUENCY OF PRN USE OR MEDICATION ERRORS. MARs MUST BE AVAILABLE ON SITE FOR REVIEW
10		Is <b>current ISP</b> with associated healthcare, crisis and support plans available on site?			Quarterly	
11		<b>ISP Implementation &amp; Progress:</b>  Review goals, objectives, and data collected for appropriateness, skill level, and progress. Is there evidence that services noted in the ISP are being delivered as written in the ISP?			Monthly	DESCRIBE CONCERNS OR LACK OF PROGRESS – OR COMPLETION OF OUTCOMES AND GOOD PROGRESS
12		<b>Employment:</b> Is the individual integrated at their job? Are they receiving appropriate job supports?			Every other month	DESCRIBE CONCERNS AND/OR POSITIVE OBSERVATIONS
13		<b>Recommendation Follow-up:</b> Have needed assessments, testing, and evaluations, identified in the ISP been completed and recommendations implemented?			Quarterly	LIST ITEMS LACKING FOLLOW THROUGH

14		<b>Specialty Services:</b> Does the individual have timely* access to: <ul style="list-style-type: none"> <li><input type="checkbox"/> Therapies (as per ISP)</li> <li><input type="checkbox"/> Durable Medical Equipment – in good repair with proper fit</li> <li><input type="checkbox"/> Medical supplies</li> <li><input type="checkbox"/> Specialty medical services (e.g. Neurology, Psychiatry, Cardiology)</li> <li><input type="checkbox"/> Assistive Technology, Augmentative Communication devices present, in good repair, and being used?</li> </ul>			Monthly	<p><i>* For DME “timely” is defined as receipt of new equipment within 150 days of request and repairs of DME within 60 days of request.</i></p>
15		<b>Behavior Supports Implementation:</b> Verify relevant documentation completed for behavioral events (e.g. data sheets) & appropriate team members notified.			Monthly	DESCRIBE CONCERNS AND/OR POSITIVE FINDINGS
#	N A	Items Reviewed:	A	C	Frequency	Description of concerns/barriers and/or description of remarkable successes:
16		<b>Individual Satisfaction:</b> Extent of the individual’s interest in & satisfaction with current environments, services, choices, relationships, privacy & supports?			Monthly	DESCRIBE CONCERNS THE INDIVIDUAL EXPRESSES REGARDING ANY OF THEIR CURRENT SERVICES, OPPORTUNITY FOR CHOICE, ETC.
17		Is the individual participating in <b>integrated community activities</b> based on their interests and desires indicated in the ISP? Access to natural & generic supports?			Every other month	DESCRIBE CONCERNS AND/OR POSITIVE FINDINGS
18		<b>Transportation:</b> Does the individual have adequate access to transportation for employment & community activities?			Every other month	DESCRIBE CONCERNS
19		Have there been any significant <b>life changes</b> for the individual since last visit?			Monthly	THIS SHOULD NOT DUPLICATE HEALTH STATUS CHANGES, BUT RATHER OTHER SIGNIFICANT LIFE CHANGES SUCH AS DEATH OF A RELATIVE, LOSS OF FAVORITE STAFF MEMBER, JOB CHANGE, ETC.
Individual/Staff/Family Concerns: DESCRIBE CONCERNS SHARED WITH YOU BY THE INDIVIDUAL, STAFF AND/OR FAMILY NOT CAPTURED ABOVE						
Additional Notes: DESCRIBE YOUR OBSERVATIONS NOT CAPTURED ABOVE						

Status of Issues Identified at Previous Visits, IDT Meetings, etc.: <i>(If a concern or barrier remains unresolved 2 months in a row, identify the barrier, efforts to resolve &amp; submit a "Request for Intervention" form to the local Region Office.)</i> NOTE FOLLOW UP OR LACK OF FOLLOW UP FOR ITEMS NOTED AT PREVIOUS VISIT	
Follow-up Actions Required by CM: LIST FOLLOW UP ACTIONS THE CASE MANAGER WILL TAKE BASED ON FINDINGS OF THIS VISIT	
_____ Case Manager signature	_____ Date

OTHER INSTRUCTIONS:

1. SPACE FOR DESCRIPTION OF CONCERNS/FINDINGS WILL EXPAND AS NEEDED. YOU MAY WISH TO EXPAND THE SPACE BEFORE PRINTING THE FORM AND GOING TO THE SITE VISIT LOCATION – ESPECIALLY IF USING HANDWRITTEN NOTES INSTEAD OF A LAPTOP OR NOTEBOOK.
2. AGENCIES MAY REFORMAT THIS FORM AS LONG AS:
  - a. ALL ELEMENTS OF THIS FORM ARE INCORPORATED, AND
  - b. THE AGENCY FORMAT IS APPROVED BY DDS CASE MANAGEMENT UNIT
3. N/A MAY NOT BE USED FOR ITEMS WHERE THE N/A COLUMN IS SHADED AS THOSE ITEMS APPLY TO ALL INDIVIDUALS SERVED.
4. IF ANY "PROMPT" TOPIC IS MISSING OR OF CONCERN, THEN THE WHOLE ITEM SHOULD BE CHECKED AS "C" AND THE SPECIFIC CONCERN DESCRIBED.
5. FOLLOW UP FOR SOME CONCERNS MAY INVOLVE CONVENING A TEAM MEETING TO RESOLVE
6. SITE SUPERVISORS FOR THE PROVIDER AGENCIES SHOULD BE NOTIFIED OF CONCERNS SO THAT THEY HAVE AN OPPORTUNITY TO CORRECT BEFORE THE NEXT SITE VISIT. CASE MANAGERS MAY WISH TO SHARE A COPY OF THE COMPLETED SITE VISIT FORM TO ACCOMPLISH THIS.
7. INDIVIDUAL SATISFACTION DOES NOT RELATE TO THE CASE MANAGEMENT AGENCY'S ANNUAL SATISFACTION SURVEY TO DETERMINE SATISFACTION WITH CASE MANAGEMENT SERVICES, RATHER IT RELATES TO POTENTIAL DIS-SATISFACTION WITH SERVICES TO BE DELIVERED BY DIRECT SERVICE PROVIDERS.

MEDICAL ASSISTANCE DIVISION	<h1>WAIVER REVIEW FORM</h1>					MEDICAID UR MAIL TO: P.O. BOX 27950 Albuquerque, NM 87125-7950			
<b>AGENCY NAME AND ADDRESS</b>	Name		Provider Number	PATIENT	Name-Last	First	MI	Date of Birth	
	Address-Street/P.O. Box/R.Rt			Sex	Medicaid II.D. Number		Social Security Number		
	City	State	Zip Code	WAIVER TYPE <input type="checkbox"/> DD <input type="checkbox"/> D/E <input type="checkbox"/> MF <input type="checkbox"/> HIV/AIDS DIAGNOSES (List Primary First) 1. _____ 3. _____ 2. _____ 4. _____			TYPE OF REVIEW <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> 6 Mo. Review <input type="checkbox"/> Revision # _____		
ATTENDING PHYSICIAN (Print or Type) Name-last   First   MI				REGIONAL OFFICE <input type="checkbox"/> NW <input type="checkbox"/> SW <input type="checkbox"/> NE <input type="checkbox"/> METRO <input type="checkbox"/> SE			TERM OF ISP from _____ to _____		DD Waiver ARA Category Code: _____ Term: _____ to _____
<b>SERVICES REQUESTED</b>					<b>Services Certified (Shaded Area for UR USE ONLY)</b>				
<b>1. Type of Service</b>	Units Requested	Procedure Code/Modifier		<b>1. Procedure Code/Modifier(s)</b>	Units Approved	Start Date	End Date		
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.			
<b>2. Type of Service</b>	Units Requested	Procedure Code/Modifier		<b>2. Procedure Code/Modifier(s)</b>	Units Approved	Start Date	End Date		
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.			
<b>3. Type of Service</b>	Units Requested	Procedure Code/Modifier		<b>3. Procedure Code/Modifier(s)</b>	Units Approved	Start Date	End Date		
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.			
<b>4. Type of Service</b>	Units Requested	Procedure Code/Modifier		<b>4. Procedure Code/Modifier(s)</b>	Units Approved	Start Date	End Date		
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.			
<b>5. Type of Service</b>	Units Requested	Procedure Code/Modifier		<b>5. Procedure Code/Modifier(s)</b>	Units Approved	Start Date	End Date		
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.			
Waiver Client Signature:			Date	Parent/Guardian Signature			Date		
Case Manager's Signature:		Telephone No.	Date	UR Physician/Review Coordinator			Date		

**MAD 046 Rev. 10/17/03    DISTRIBUTION: White-UR Agency   Canary-CM Agency   Pink-ISD Field Office   Goldenrod-MCO**

MEDICAL ASSISTANCE DIVISION	<h1 style="margin:0;">WAIVER REVIEW FORM <i>Sample</i></h1>					MEDICAID UR MAIL TO: P.O. BOX 27950 Albuquerque, NM 87125-7950		
<b>AGENCY NAME AND ADDRESS</b>	Name <i>Sunshine Case Management</i>		Provider Number <i>D4081</i>		PATIENT Name-Last <i>FOGG</i>		First <i>Phineas</i>	
	Address-Street/P.O. Box/R.Rt <i>413 W. Main Street</i>		Sex <i>M</i>	Medicaid I.D. Number <i>96-216-522-15-0987</i>		Social Security Number <i>522-15-0987</i>		
	City <i>Jacket</i>	State <i>Ohio</i>	Zip Code <i>85279</i>		TYPE OF REVIEW <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Annual <input type="checkbox"/> 6 Mo. Review <input type="checkbox"/> Revision # _____			
ATTENDING PHYSICIAN	(Print or Type) Name-last <i>Hunter, John</i>		First <i>MI</i>		MI <i>L.</i>		DIAGNOSES (List Primary First) 1. <i>Seizure Disorder</i> 2. <i>Mental Retardation</i> 3. <i>Atypical Psychosis</i> 4. _____	
REGIONAL OFFICE	<input type="checkbox"/> NW <input type="checkbox"/> SW <input checked="" type="checkbox"/> NE <input type="checkbox"/> METRO <input type="checkbox"/> SE		TERM OF ISP from <i>5/01/06</i> to <i>04/30/07</i>			DD Waiver ARA Category Code: <i>17437</i> Term: <i>5/01/06</i> to <i>4/30/07</i>		
<b>SERVICES REQUESTED</b>				<b>Services Certified (Shaded Area for UR USE ONLY)</b>				
1. Type of Service <i>OCM</i>		Units Requested <i>12</i>	Procedure Code/Modifier <i>T2022</i>		1. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>Sunshine CM/D4081</i>		Provider Signature/Date		UR No./Date	Prior Authorization No.	
2. Type of Service <i>SL II ASL</i>		Units Requested <i>340</i>	Procedure Code/Modifier <i>T2033/U2</i>		2. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>Slater Inc/D6378</i>		Provider Signature/Date		UR No./Date	Prior Authorization No.	
3. Type of Service <i>Adult Hab II</i>		Units Requested <i>2556</i>	Procedure Code/Modifier <i>T2021/U2</i>		3. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>Able/XY123</i>		Provider Signature/Date		UR No./Date	Prior Authorization No.	
4. Type of Service <i>Community Access</i>		Units Requested <i>2556</i>	Procedure Code/Modifier <i>H2015</i>		4. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>Able/XY123</i>		Provider Signature/Date		UR No./Date	Prior Authorization No.	
5. Type of Service <i>BT (CB)</i>		Units Requested <i>80</i>	Procedure Code/Modifier <i>H2019/TT</i>		5. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>XY340</i>		Provider Signature/Date		UR No./Date	Prior Authorization No.	
Waiver Client Signature: <i>Phineas</i>			Date <i>4/4/06</i>	Parent/Guardian Signature			Date	
Case Manager's Signature: <i>Susie Q</i>		Telephone No. <i>425-8190</i>	Date <i>4/4/06</i>	UR Physician/Review Coordinator			Date	

**MAD 046** Revised 10/17/03 **DISTRIBUTION:** White-UR Agency Canary-CM Agency Pink-ISD Field Office Goldenrod-MCO

MEDICAL ASSISTANCE DIVISION	<h1 style="margin:0;">WAIVER REVIEW FORM <i>Sample</i></h1>					MEDICAID UR MAIL TO: P.O. BOX 27950 Albuquerque, NM 87125-7950	
<b>AGENCY NAME AND ADDRESS</b>	Name <i>Sunshine Case Management</i>		Provider Number <i>D4081</i>		PATIENT Name-Last <i>FOGG</i>		First <i>Phineas</i>
	Address-Street/P.O. Box/R.Rt <i>413 W. Main Street</i>		Sex <i>M</i>	Medicaid I.D. Number <i>96-216-522-15-0987</i>		Social Security Number <i>522-15-0987</i>	
	City <i>Jacket</i>	State <i>Ohio</i>	Zip Code <i>85279</i>	WAIVER TYPE <input checked="" type="checkbox"/> DD <input type="checkbox"/> D/E <input type="checkbox"/> MF <input type="checkbox"/> HIV/AIDS		TYPE OF REVIEW <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Annual <input type="checkbox"/> 6 Mo. Review <input type="checkbox"/> Revision #	
ATTENDING PHYSICIAN	(Print or Type) Name-last   First   MI <i>Hunter,   John   L.</i>		DIAGNOSES (List Primary First) 1. <i>Seizure Disorder</i> 3. <i>Atypical Psychosis</i> 2. <i>Mental Retardation</i> 4.				
REGIONAL OFFICE	<input type="checkbox"/> NW <input type="checkbox"/> SW <input checked="" type="checkbox"/> NE <input type="checkbox"/> METRO <input type="checkbox"/> SE		TERM OF ISP from <i>5/01/06</i> to <i>04/30/07</i>			DD Waiver ARA Category Code: <i>17437</i> Term: <i>5/01/06</i> to <i>4/30/07</i>	
<b>SERVICES REQUESTED</b>				<b>Services Certified (Shaded Area for UR USE ONLY)</b>			
1. Type of Service <i>BT (CL)</i>	Units Requested <i>336</i>	Procedure Code/Modifier <i>H2019</i>		1. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date <i>5/1/06</i>	End Date <i>4/30/07</i>	Provider Name/Provider Number <i>Supports/XY340</i>		Provider Signature/Date	UR No./Date	Prior Authorization No.	
2. Type of Service	Units Requested	Procedure Code/Modifier		2. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.	
3. Type of Service	Units Requested	Procedure Code/Modifier		3. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.	
4. Type of Service	Units Requested	Procedure Code/Modifier		4. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.	
5. Type of Service	Units Requested	Procedure Code/Modifier		5. Procedure Code/Modifier(s)	Units Approved	Start Date	End Date
Begin Date	End Date	Provider Name/Provider Number		Provider Signature/Date	UR No./Date	Prior Authorization No.	
Waiver Client Signature: <i>Phineas</i>			Date <i>4/4/06</i>	Parent/Guardian Signature			Date
Case Manager's Signature: <i>Susie Q</i>		Telephone No. <i>425-8190</i>	Date <i>4/4/06</i>	UR Physician/Review Coordinator			Date

**MAD 046** Revised 10/17/03    **DISTRIBUTION:** White-UR Agency   Canary-CM Agency   Pink-ISD Field Office   Goldenrod-MCO

DD WAIVER STANDARDS REQUIREMENT FOR PRIOR APPROVAL BY DDSD  
CENTRAL OFFICE

PROVIDER REQUEST FORM

Effective 8/1/02

Requestor: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_

Specify Address where DDSD should send response:

TYPE 1 ACTION: SERVICE AUTHORIZATION

**Instructions:** Check the type(s) of prior approval being requested. For information about how to justify this request, refer to the "Documentation Required" column below.

**Submit this form and justification to: DDSD Regional Office that is applicable to the individual's address.**

Name of Individual: \_\_\_\_\_ SSN: \_\_\_\_\_

Request is applicable to (check one):  Current ISP  Proposed ISP

Annual ISP Dates: \_\_\_\_\_ to \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

Type of Action/Approval Requested: (Check all that apply)

Documentation Required – Refer to:

1.  Family Living- more than 2 individuals w/DD (same home) Service Standards  
p. 43/DDSD TAG

2.  In-Home Day Habilitation Service Standards  
p. 58/DDSD TAG

3.  Community Living Service for individual under age 18 Service Standards  
p. 45-46/DDSD  
TAG

\_\_\_\_ Assisted Living \_\_\_\_ Family Living \_\_\_\_ Supported Living

4.  Therapy exception to ARA \_\_ PT \_\_ SLP \_\_ OT \_\_ BT Service Standards  
p. 104/DDSD TAG

5.  Personal Care by a Family Member Service Standards  
p. 86/DDSD TAG

6.  Supported Employment under age 18

DDSD Technical Assistance Guideline

7.  Adult Habilitation under age 18

DDSD Technical Assistance Guideline

8.  14-Day emergency approval of services

DDSD Technical Assistance Guideline

DDSD will respond in approximately 30 days with the Notice of Action completed (below). If your request is incomplete or denied, you may resubmit with additional information. (See other side).

**Do not write below this line**

DDSD NOTICE OF ACTION ON PRIOR APPROVAL	
Date Received: _____	Date Sent to Requestor: _____
Reason Returned: <input type="checkbox"/> Incomplete _____	
<input type="checkbox"/> Denied _____	
<input type="checkbox"/> Approved Effective Date: _____	
Reviewer(s): _____	

DD WAIVER STANDARDS REQUIREMENT FOR PRIOR APPROVAL BY DDS  
CENTRAL OFFICE

PROVIDER REQUEST FORM

Effective 8/1/02

Requestor: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_

Specify Address where DDS should send response:

TYPE 2 ACTION: PERSONNEL QUALIFICATIONS/PAYMENT AUTHORIZATION

**Instructions:** Check the type(s) of prior approval being requested. For information about how to justify this request, refer to the "Reference" shown below.

**Submit this form with:**

1. a letter of justification for request and/or
2. pertinent documentation about the individual's qualifications as required in the related standard

**Submit this form to: Community Programs bureau, DDS/DOH \* 1190 St. Francis Drive, Santa Fe, NM 87502-6110**

Full name of Personnel for Whom this Request is Being Submitted:

\_\_\_\_\_

Type of Action/Approval Requested: (Check only one) \_\_\_\_\_ Reference:

- |   |                                     |
|---|-------------------------------------|
| 1. <input type="checkbox"/> Case Management (intern)                              | Service Standards<br>p. 32/DDS TAG  |
| 2. <input type="checkbox"/> Behavior Therapy (intern)                             | Service Standards<br>p. 108/DDS TAG |
| 3. <input type="checkbox"/> Behavioral Support Consultation (clinical experience) | Service Standards<br>p. 108/DDS TAG |
| 4. <input type="checkbox"/> Speech Therapy (intern)                               | Service Standards<br>p. 118/DDS TAG |
| 5. <input type="checkbox"/> Physical Therapy (intern)                             | Service Standards<br>p. 118/DDS TAG |
| 6. <input type="checkbox"/> Occupational Therapy (intern)                         | Service Standards<br>p. 118/DDS TAG |

- 7.  Sub-contract for Professional Services (direct services)      General Provisions  
for Agency  
Contracts and  
Provider  
Agreements,  
Article 7
  
- 8.  Partial Payment for Environmental Modification Consultant      Service Standards  
p. 24-25/DDSD  
TAG

DDSD will respond in approximately 30 days with the Notice of Action completed (below). If your request is incomplete or denied, you may resubmit with additional information. (See other side).

**Do not write below this line**

<b>DDSD NOTICE OF ACTION ON PRIOR APPROVAL</b>	
Date Received: _____	Date Sent to Requestor: _____
Reason Returned: <input type="checkbox"/> Incomplete _____	
<input type="checkbox"/> Denied _____	
<input type="checkbox"/> Approved Effective Date: _____	
Reviewer(s): _____	

**Developmental Disabilities Supports Division (DDSD) Regional Office Intervention**

**This is not an incident report form. Submission of this form does not constitute reporting as required under state law.**

Date of Request: \_\_\_\_\_

Name of Individual \_\_\_\_\_ SS# \_\_\_\_\_

Jackson Class Member

<b>Box A: Contact Information</b>	
Case management Agency	Case Manager:
Submitted By: (If other than the than Case Manager)	
Telephone Number:	Email Address:

**Box B: Issue/ Barrier /Problem/Request (If this is a specialty service need, skip to Box C):**

What has already been done to address this issue?

**Box C: Specialty Services - Please identify and describe specialty service(s) individual needs but cannot access and the date that the team first identified this service as a need for the person:**

**DME/Augmentative Communication Devices** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Supplies** (*items that get used up*) \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Specialists** \_\_\_\_\_ **Date:** \_\_\_\_\_

(*state type e.g. Dental, Cardiologist, Neurologist, Psychiatrist*)

**Augmentative Communication Devices** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapies**

(*State type(s) OT, PT, SLP, Behavioral Support Consultant*)

**Identify barrier(s):**

**What has already been done to attempt to address this issue?**

**Timeframes:**

- DME and Augmentative Communication Devices should receive approval/denial within 7 days of request and the item should be received within 150 days of approval.
- Repairs or modification to DME are required to be complete within 60 days from date of request.
- Therapy assessments should begin within 30 days of receipt of the FOC by the therapy provider and be complete no later than 90 days of the need being identified by the team.
- Appointments with medical specialists must be scheduled with the relevant practitioner no later than 14 days after receipt of the referral from the PCP if referral is needed, or 14 days after the need was identified if PCP referral is not required.

**Box D: DDSD Staff Responder:** \_\_\_\_\_ **Date Received** \_\_\_\_\_

Action Taken and Outcome (chronological summary):

**If this is a specialty service need, when was it entered into database?** \_\_\_\_\_

Date closed by Regional Office: \_\_\_\_\_

**Referral to Division of Health Improvement (DHI) or other State Agency needed?**  Yes  No

Date of referral if yes \_\_\_\_\_ Name of DHI/other agency contact \_\_\_\_\_

Comments:

Date final response received by Case Manager \_\_\_\_\_ CM initials \_\_\_\_\_

## DDSD Request for Regional Office Intervention: INSTRUCTIONS

**DATE:** Enter the date the report is submitted to the Regional Office.

**NAME OF INDIVIDUAL:** Use the full first and last name of the individual receiving services (name on records, not nickname).

**S.S. #:** The nine (9) digit Social Security Number of the person receiving services.

If the person for whom you are requesting assistance is a Jackson Class Member, place a check mark in the box under the name of the individual.

### Box A: Contact Information- *Complete the following:*

- Name of the case management agency serving the individual
- Name of the individual's case manager
- Name the person making the request, leave this line blank if the case manager is submitting this request.
- Role of the person making the request. For example: IDT member, service provider, agency nurse, etc.
- Telephone number and e-mail address of the person making the request.

### Box B: Issue/Barrier/Problem/Request:

- If this is a specialty service need, skip to Box C.
- Summarize the reason for the request.
- **Must specify what has already been done to address the situation.**
- Include timelines, with exact dates, persons contacted, and any other information that will help us assist you to solve this problem

### Box C: Specialty Services

- Identify and describe **which** specialty service is at issue.
- Specify the date this was first identified as a need.
- What are the barrier(s) to the need being met?
- **Must specify what the case manager and others have already done to address this issue.**

**Fax or email the form with the individuals' information, Box A and Box B or Box C completed to the appropriate Regional Office Manager.**

- Metro: Yvonne Martelle-Gurule,
  - Email: [yvonne.martelle-gurule@state.nm.us](mailto:yvonne.martelle-gurule@state.nm.us) Fax 841-5546
- North West: Crystal Wright,
  - Email: [crystal.wright@state.nm.us](mailto:crystal.wright@state.nm.us) Fax- 863-4978
- North East: Charlene Cain,
  - Email: [charlene.cain@state.nm.us](mailto:charlene.cain@state.nm.us) Fax: 758-5973
- South West: Scott Doan,
  - Email: [scott.doan@state.nm.us](mailto:scott.doan@state.nm.us) Fax 528-5194
- South East: Jon Hellebust
  - Email: <mailto:jon.hellebust@state.nm.us> Fax 624-6104

### DDSD REGIONAL OFFICE INSTRUCTIONS

- Respond appropriately if situation places an individual in immediate jeopardy.
- If request is not urgent complete **Box C** within five working days. If resolution will take longer contact the sender to verify receipt of and action on the request.
- List steps taken and all contacts made, including contacting the CM if someone other than the CM made the report.
- Indicate if a referral to DHI or other state agency is needed and when made. Include name of contact and any comments regarding action taken.
- Once the issue is resolved send a copy of the completed form back to the sender and the CM.