

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



Developed by:

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

Acknowledgements

Many people, agencies, and organizations have contributed to the development of *A Resource Guide for Independent Case Managers for the Developmental Disabilities (DD) Waiver*. The collaborative nature required of this project was impressive, as was the individual effort put forth by each contributor. All of these individuals are commended for their time, initiative, and commitment to relationships of quality shared by case managers and the individuals and families they serve.

The following deserve special acknowledgement due to the critical roles they played from the inception of this project to its final outcome:

The Case Management Unit, Developmental Disabilities Supports Division

Jennifer Thorne-Lehman, Deputy Director

The Columbus Organization

Many representatives of provider organizations as well as other individuals within New Mexico's service system shared their time and thoughtful consideration of the content proposed for this manual. Their feedback was invaluable to those crafting the final edition and is well deserving of formal recognition.

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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**.

Chapter	Title
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.*

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

Area to Assess		Procedures to Prepare for Planning	Annual Waiver Requirements
Personal	<ul style="list-style-type: none"> ◆ Community connections ◆ Stress level & coping mechanisms ◆ Interests, preferences, values, dreams, desires 	<ul style="list-style-type: none"> ◆ Annual provider agency assessment summaries ◆ Review history ◆ Observations ◆ Identify planning implications 	<ul style="list-style-type: none"> ◆ ABS ◆ Vineland is optional for children under age 16 ◆ Client Individual Assessment (CIA) ◆ Maintain in primary CM record ◆ Positive Supports Assessment <p>*As appropriate to the individual</p>
Adaptive	<ul style="list-style-type: none"> ◆ Money management ◆ Daily living skills ◆ Independent living skills ◆ Personal care ◆ Formal/informal supports ◆ Community 	<ul style="list-style-type: none"> ◆ Standardized testing ◆ Informal assessment ◆ Observation ◆ Interview with individual, family, friends and/or staff 	<ul style="list-style-type: none"> ◆ ABS/Vineland ◆ CIA ◆ Annual Strengths, Needs & Preferences Summary ◆ Maintain in primary CM record
Vocational	<ul style="list-style-type: none"> ◆ Skills/interests ◆ Job development & coaching support needs ◆ Transportation 	<ul style="list-style-type: none"> ◆ Interview with the individual ◆ Observation ◆ Informal assessment of relevant outcomes, needed supports & accommodations ◆ Standardized assessments 	<ul style="list-style-type: none"> ◆ DVR Individual Work Plan ◆ Formal vocational assessments ◆ Informal assessment of interest ◆ Annual Strengths, Needs & Preferences Summary ◆ Maintain in primary CM record
Educational	<ul style="list-style-type: none"> ◆ Cognitive ◆ Academic ◆ Social/Emotional ◆ Daily Living/Personal Care ◆ Community Awareness 	<ul style="list-style-type: none"> ◆ Standardized testing ◆ Informal testing ◆ Observation 	<ul style="list-style-type: none"> ◆ Diagnostic evaluation reports ◆ Individual Educational Plan (IEP) developed by the Public Schools ◆ Transition Plan (as appropriate) ◆ Maintain in primary CM record
Financial	<ul style="list-style-type: none"> ◆ Amount of Income ◆ Sources of Income 	<ul style="list-style-type: none"> ◆ Asset reporting submitted to ISD 	<ul style="list-style-type: none"> ◆ ISD 381 Determination form ◆ MAW (MAD060)

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

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