

# *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

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

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 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.*

**1. 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)
- ◆ DDS 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).

**2. 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
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

Step	Responsible Parties	Tasks	Time Lines
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: \_\_\_\_\_

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, DDS 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.*

<b>How to be Helpful: The Perspective of an Individual Receiving Hospice Services</b>
<p><b>Don't feel sorry for me.</b>  <i>When you understand I am dying, you respect me and help me have dignity and pride.</i></p>
<p><b>Touch me.</b>  <i>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.</i></p>
<p><b>Laugh with me, cry with me.</b>  <i>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.</i></p>
<p><b>Let me talk about my illness if I want to.</b>  <i>Help me work through my feelings by listening to me.</i></p>
<p><b>Let me be silent if I want to.</b>  <i>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.</i></p>
<p><b>Continue to be my friend.</b>  <i>Don't let my illness overshadow the good times we have had together. I know that my dying is hard for you too.</i></p>
<p><b>Offer to help me with the simple chores.</b></p>

*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*

